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 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0104 Worksheet S Peri od. From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 8/2/2021 1:50 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 8/2/2021 Time: 1:50 pm]Manually prepared cost report use only 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 0 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
 10. NPR Date:

 (11. Contractor's Vendor Code:
 4

 (12. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11. Contractor's Code:

 (13. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11.

 [N] Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) GEORGE POGAS Officer or Administrator of Provider(s) SR VP CF0 Title

(Dated when report is electronically signed.)

			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	297, 460	122, 684	0	542, 570	1.00
2.00	Subprovider - IPF	0	4, 684	449		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	588		0	7.00
200.00	Total	0	302, 144	123, 721	0	542, 570	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX	TDENTIFICATION DA	ATA	Provid		N: 15-01		Period: From 01/01 To 12/31	/2020 /2020	Part I	ieet S-2 ime Pre	
	1.00	2	. 00		3.00			10 12/01	4.00		021 1:50	
	Hospital and Hospital Health Care Co		. 00		3.00				4.00			
. 00	Street: 2605 N. LEBANON STREET	P0 Box:		7. 0.1		50	0	DOONE				1.00
. 00	City: LEBANON	State: I Component Na		Zip Code CCN	e: 460 CBS		jcount ovi der	y: BOONE Date	Pavme	ent Sys	tem (P.	2.00
				Number	Numb		Гуре	Certi fi ed	Ι <u>Τ</u>	, 0, or	- N)	
		1.00		2.00	3.0		4.00	5.00	V 6.00	XVIII 7.00	-	-
	Hospital and Hospital-Based Componer		1:	2.00	3.0	10 1 2	+. 00	5.00	0.00	/ / /.00	8.00	
. 00	Hospi tal	WI THAM MEMORI AL	1	150104	2690	00	1	07/01/1966	5 N	Р	0	3.00
. 00	Subprovi der – IPF	HOSPI TAL WI THAM HOSPI TAL GEROPSYCH	1	15S104	2690	00	4	01/01/2000	N C	Р	N	4.00
. 00 . 00 . 00 . 00 . 00 0. 00 1. 00	Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC	WI THAM HOSPI TAL	ECU	155832	2690	00		05/07/201	5 N	P	N	5.00 6.00 7.00 8.00 9.00 10.00 11.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other											12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
								From		T		
0 00	Cost Reporting Period (mm/dd/yyyy)							1.00			00	20.0
	Type of Control (see instructions)							9	2020	12/51	72020	20.0
												_
	Inpatient PPS Information					I.	00	2.00)	პ.	00	
2. 00 2. 01	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per	istment, in accor or yes or "N" for 412.106(c)(2)(Pi or yes or "N" for accompensated care umn 1, "Y" for ye priod occurring p	dance with no. Is th ckle amend no. payments s or "N" 1 rior to 00	n 42 CFI nis dment for thi for no t ctober	s for 1.		Y	Y				22.0
2. 02	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	er October 1. (s requires final port settlement? " for no, for th per 1. Enter in c	ee instruc uncompensa (see inst e portion olumn 2, '	ctions) ated can truction of the 'Y" for	re ns) yes	ſ	N	N				22.0
2. 03	03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) N N Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for N N					I	Ν	22.0				
3. 00	yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 of identifying t method used in t	if census he days in he prior o "N" for n	days, d n this d cost no.	or 3 cost			3 N				23.0
			In-State Medicaid paid days	In-S Medio seligi unpa day	caid ble aid ys	Out-c Stat Medica paid d	e aid M ays e	State ledi cai d el i gi bl e unpai d	Medica HMO da	ys Me	Other di cai d days	
00	If this provider is an IPPS hospital	enter the	1.00	2.0	00 1, 505	3.00) ()	4.00	5.00	391	6.00	24.0
t. UU	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible b	nn 1, in-state umn 2, column 3, d days in column		2	1, 000		U	U		571	(, 24.0

OSPI T	Financial Systems WITHAM AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	MEMORIAL H	Provider CC	CN: 15-0104	Peri od:	In Lieu	Worksh	eet S-2	
					From 01/0 To 12/3	01/2020 31/2020		ime Pre 21 1:50	
		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medica HMO da	id C)ther di cai d	
		paid days	el i gi bl e unpai d days	Medicaid paid days	Medicaid eligible unpaid			days	
		1.00	2.00	3.00	4.00	5.00		6.00	-
5.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0 0	0		0		25.0
					Urban/F	Rural S		F Geogr 00	-
5.00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the be	ginning of		1			26. (
7.00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If a		st	1			27.0
5. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status i		0	E a all		35.0
					Begi n 1.	ni ng: 00	Endi 2.	ng: 00	
5.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for num	ber				36.0
7.00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.	r the numbe	r of perio	ods MDH stat	us	0			37.
7.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)									37.
. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.
					Y/	′N 00		/N	-
9.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (íi), or the mileage	(iii)? En requireme	nter in colu ents in	ume N mn			<u>00</u> {	39.
). 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for			J	1	N	40.
						V 1.00	XVIII 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital								
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)		•				N	N	45.
	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and Wks	st. L-1, Pt.	I through	N	N	N	46.
7.00 8.00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N N	N N	N N	47. 48.
	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by no in colu	CR 11642	(or subsequ	ent CR), M/				56.
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N th of this Y", complet I, if appli	" for no i cost repor e Workshee cable.	n column 1. ting period et E-4. lf c	lf column ? Enter "` olumn 2 is	("			57.
. 00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes,			ans' servi c	es as				58.
9.00	Are costs claimed on line 100 of Worksheet A? If ye	•		1		N		1	59.
				NAHE 413.8 Y/N		neet A e #	Qualifi Crite		
				1.00	2.	00		de 00	-
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent	.85? (see lumn 1. lf	column 1	N					60.

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΑΤΑ	Provider C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 8/2/2021 1:50	pared:
	Y/N	IME	Direct GME	IME	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	61.00
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 0 [.]
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.02
ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted 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
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 				0.00		61.20
					1.00	-
ACA Provisions Affecting the Health Resources and Se			· · ·			(2.0)
 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction) Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovid 	ctions) a Teach gram. (ing Health Cer see instructio	nter (THC) into			62.00
3.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, completion	ettings	during this o			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo			-This base year	r is your cost	reporti ng	
4.00 Enter in column 1, if line 63 is yes, or your facili- in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty trai n-prima all no d non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.00

	LEX IDENTIFICATION D			eriod:	Workshee	
			Fr To	rom 01/01/2020 p 12/31/2020) Date/Tim	ne Prepare
	Dragrom Nomo	Dragram Cada	Upwei abted	Upwoi abtod		1:50 pm
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (3/ (col.	3 +
			Nonprovi der	Hospi tal	col. 4	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63 is yes, or your facility			0.00	0.0	0 0.0	00000 65.
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)			Unweighted	Unweighted	Ratio (col
			FTEs	FTEs in	1/ (col .	
			Nonprovi der	Hospi tal	col . 2	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Settin	gsEffective f	for cost repor	ting peric	ods
beginning on or after July 1, 20 00 Enter in column 1 the number of		ary care resident	0.00	0.0		00000 66.
FTEs attributable to rotations of			0.00	0.0	0.0	.00000 00.
Enter in column 2 the number of						
FTEs that trained in your hospit		3 the ratio of				
FTEs that trained in your hospit (column 1 divided by (column 1 +	- column 2)). (see ir	3 the ratio of <u>structions)</u>				
		3 the ratio of	Unweighted	Unweighted FTFs in	Ratio (
	- column 2)). (see ir	3 the ratio of <u>structions)</u>	FTĔS	FTEs in	3/ (col .	3 +
	- column 2)). (see ir	3 the ratio of <u>structions)</u>				3 +
(column 1 divided by (column 1 +	- column 2)). (see ir	3 the ratio of <u>structions)</u>	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 +	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	3/ (col . col . 4	3 +
(column 1 divided by (column 1 +	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
 (column 1 divided by (column 1 + column 1, the program name associated with each of your primary care programs in which you trained residents. 	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
<pre>(column 1 divided by (column 1 +</pre>	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
<pre>(column 1 divided by (column 1 +</pre>	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
<pre>(column 1 divided by (column 1 +</pre>	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + (column 1 divided by (column 1 + 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	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
<pre>(column 1 divided by (column 1 +</pre>	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
<pre>(column 1 divided by (column 1 +</pre>	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
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(column 1 divided by (column 1 + Column 1 divided by (column 1 + DO 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	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + (column 1 divided by (column 1 + 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	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4	3 + +))
(column 1 divided by (column 1 + Column 1 divided by (column 1 + DO 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	<u>- column 2)). (see ir</u> Program Name	3 the ratio of nstructions) Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	3/ (col . col . 4 5.00 0 0.0	3 +))))))))))))))))))))))))))))))))))))
(column 1 divided by (column 1 + Column 1 divided by (column 1 + Do 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)	 col umn 2)). (see ir Program Name 1.00 	3 the ratio of structions) Program Code 2.00	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.0	3/ (col . col . 4 5.00 0 0.0	3 + ()) 0000000 67. 3.00
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F 00	<u>Program Name</u> <u>1.00</u> <u>2PPS</u> Sychiatric Facility 0	3 the ratio of structions) Program Code 2.00	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.0	3/ (col . col . 4 5.00 0 0.0	3 + ()) 0000000 67. 3.00
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility F 00 Inpatient Psychiatric Facility F 01 Is this facility an Inpatient Psychiatric Facility F	<u>PPS</u> <u>Program Name</u> <u>1.00</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>2255</u> <u>22555</u> <u>22555</u> <u>22555</u> <u>22555</u> <u>225555</u> <u>2255555555555555555555555555555555555</u>	3 the ratio of nstructions) Program Code 2.00 (1PF), or does it con	FTEs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.0 0.0	3/ (col . col . 4 5. 00 0 0. 0	3 + 1)) 000000 67. 3.00 70.
(column 1 divided by (column 1 + (column 1 divided by (column 1 + 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) Inpatient Psychiatric Facility F 00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no of recent cost report filed on or b	Column 2)). (see in Program Name 1.00 1.00 PPS Sychiatric Facility 0 1 the facility have a pefore November 15, 2	3 the ratio of hstructions) Program Code 2.00 (IPF), or does it con an approved GME teach 2004? Enter "Y" for	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF sub ing program in yes or "N" for	FTES in Hospital 4.00 0.0 1.0 provider? Y the most N no. (see	3/ (col . col . 4 5. 00 0 0. 0	3 + 1)) 000000 67. 3.00 70.
<pre>(column 1 divided by (column 1 +</pre>	Column 2)). (see in Program Name 1.00 1.00 200 200 200 200 200 200 200 200 200	3 the ratio of structions) Program Code 2.00 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident	FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subj ing program in yes or "N" for is	FTES in Hospital 4.00 0.0 1.0 provider? Y the most N no. (see hing	3/ (col . col . 4 5. 00 0 0. 0	3 + 1)) 000000 67. 3.00 70.
(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 5, the ratio of (column 3 + column 4)). (see instructions) 00 Inpatient Psychiatric Facility F 01 Is this facility an Inpatient Psychiatric Facility F 02 Inpatient 29 (column 1: Did recent cost report filed on or b 42 CFR 412. 424(d)(1)(iii)(c)) Cd	Program Name 1.00 1.00 Program Name 1.00 PPS Sychiatric Facility fave a pefore November 15, 2 Jumn 2: Did this fave R 412.424 (d)(1)(iii	3 the ratio of nstructions) Program Code 2.00 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for	FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for in s in a new teacl yes or "N" for in	FTES in Hospital 4.00 0.0 0.0 1.0 provider? Y the most no. (see hing no.	3/ (col . col . 4 5. 00 0 0. 0	3 + 1)) 000000 67. 3.00 70.
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(column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 10 Inpatient Psychiatric Facility F 00 Is this facility an Inpatient Pse Enter "Y" for yes or "N" for no 1f line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412. 424(d)(1)(iii)(c)) Cc	PPS Sychiatric Facility (1. 00 1. 00 2. 00 2. 00 3. 00 4. 00 5.	3 the ratio of nstructions) Program Code 2.00 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident)(D)? Enter "Y" for	FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for in s in a new teacl yes or "N" for in	FTES in Hospital 4.00 0.0 0.0 1.0 provider? Y the most no. (see hing no.	3/ (col . col . 4 5. 00 0 0. 0	3 + 1)) 000000 67. 3.00 70.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-0104	Period: From 01/01/202 To 12/31/202			
		10 12/31/202	8/2/202		
		1	00 2.00	3.00	
6.00 If line 75 is yes: Column 1: Did the facility have an approved GM recent cost reporting period ending on or before November 15, 200 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colum indicate which program year began during this cost reporting period.	D4? Enter "Y" for yes g program in accordan umn 3: If column 2 is	n the most or "N" for ce with 42 Y,		0	76.0
			1.0	0	
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no. TEFOR Devidence		ng period? Ente	er N		80. 0 81. 0
 TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFF 6.00 Did this facility establish a new Other subprovider (excluded uni §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 		D. N		85. 0 86. 0	
7.00 Is this hospital an extended neoplastic disease care hospital cla 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	assified under sectio		N		87.0
		V 1.00	2. C		
Title V and XIX Services		1.00	2.0	0	
D. 00 Does this facility have title V and/or XIX inpatient hospital ser yes or "N" for no in the applicable column.			Y		90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the confusion full or in part? Enter "Y" for yes or "N" for no in the applicable 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual confusion)	e column.	N	Y N		91.(
instructions) Enter "Y" for yes or "N" for no in the applicable $(add add)$ 8.00 Does this facility operate an ICF/IID facility for purposes of ti	column.	N	N		93.
"Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and '	'N" for no in the	N	N		94.
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the application of the applica		0. 00 N	0. C N		95. 96.
7.00 If line 96 is "Y", enter the reduction percentage in the applicat B.00 Does title V or XIX follow Medicare (title XVIII) for the interns stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for ye	s and residents post	0. 00 Y	0. C Y		97. (98. (
 column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporti C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V 			Y		98.
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calcula bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for title V, and in column 2 for title XIX.		Y	Y		98.
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or	access hospital (CAH "N" for no in column) N 1	N		98.
for title V, and in column 2 for title XIX. B.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimboutpatient services cost? Enter "Y" for yes or "N" for no in colum 1 for title XIX.		N	N		98.
.05 Does title V or XIX follow Medicare (title XVIII) and add back th Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y		98.
.06 Does title V or XIX follow Medicare (title XVIII) when cost reimb Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX. Rural Providers		Y	Y		98.
15.00 Does this hospital qualify as a CAH? 16.00 If this facility qualifies as a CAH, has it elected the all-inclu	usive method of payme	nt N			105. 106.
for outpatient services? (see instructions) 7.00Column 1: If line 105 is Y, is this facility eligible for cost re- training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you 1 approved medical education program in the CAH's excluded IPF and Enter "Y" for yes or "N" for no in column 2. (see instructions)	(see instructions) train I&Rs in an	Ν			107.
28.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee schedul e? See 4	2 N			108.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2020	Worksheet S- 0 Part I	-2
			o 12/31/2020		
	Physi cal	Occupati onal	Speech	Respi ratory	
09.00 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.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109.0
			1	1.00	_
10.00 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 o	r "N" for no. I	f yes,	N	110. C
			1.00	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.0
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.0
Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	- "N" for no	N			0115.0
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	93" percent (includes				
6.00 s this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
7.001s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	Y			117.
8.00 is the maipractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr			2		118.
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
8.01 List amounts of malpractice premiums and paid losses:		984, 175	5	0	0118.
			1.00	2.00	
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N		118.
				N	120.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	n column 1, " ualifies for	Y" for yes or the Outpatient	N	N N	
D. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1,'" ualifies for nts? (see ins	Y" for yes or the Outpatient tructions)	N Y	N	121.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	n column 1, " ualifies for nts? (see ins antable devic fined in §190	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the		N	121. 122.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for 	n column 1, " ualifies for nts? (see ins antable devic fined in §190 I is "Y", ent	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y		
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, enter entered taxes and the set of the se	n column 1, " ualifies for nts? (see ins antable devic fined in §190 I is "Y", ent or yes and "N nter the cert	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	YN	N	122.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified heart transplant center, enter and the set transplant center. 	n column 1, " Jalifies for hts? (see ins antable devic fined in §190 l is "Y", ent or yes and "N hter the cert 2. ter the certi	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	YN		122.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2. 	n column 1, " Jalifies for Its? (see ins antable devic Fined in §190 I is "Y", ent or yes and "N of the cert 2. ter the certi 2. ter the certi	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	YN		122. 125. 126. 127.
 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	n column 1, " Jalifies for Ints? (see ins antable devic Fined in §190 I is "Y", ent or yes and "N hter the cert 2. ter the cert 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date	Y N		122. 125. 126.
 "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	n column 1, " Jalifies for hts? (see ins antable devic fined in §190 l is "Y", ent or yes and "N hter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2.	Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date in	Y N		122. 125. 126. 127. 128.

Health Financial Systems	WI THAM MEMORI A	L_HOSPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0104		l:)1/01/2020	Worksheet S-2 Part I	
				To 1	2/31/2020	Date/Time Pre	
						8/2/2021 1:50	pm
					1.00	2.00	
132.00 If this is a Medicare certified is in column 1 and termination date,			ication d	ate			132.00
133.00 Removed and reserved				1			133.00
134.00 If this is an organ procurement or and termination date, if applicabl All Providers							134.00
140. 00 Are there any related organization	n or home office costs as c	lefined in CMS	Pub. 15-	1,	N		140.00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If home office chain number.	yes, and home (see instruct	office c tions)	osts			
	2.00				3.00	.	
If this facility is part of a chai office and enter the home office of			ugn 143 t	ne name a	nd address	s or the nome	
141. 00 Name:	Contractor's Name:		Contr	actor's N	umber:		141.00
142.00 Street:	PO Box:						142.00
143. 00 Ci ty:	State:		Zip C	ode:			143.00
						1.00	-
144.00 Are provider based physicians' cos	sts included in Worksheet A	\?				Y	144.00
					1.00	2.00	
145.00 If costs for renal services are cl	aimed on Wkst. A. line 74.	are the costs	s for		1.00	2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for no in clude Medicare utilization	column 1. If a	column 1				
period? Enter "Y" for yes or "N"		cly filed cost	t roport?		N		146.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir					Ν		146.00
yes, enter the approval date (mm/c			107 91020	<u> </u>			
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for	no			1.00 N	147.00
148.00 Was there a change in the order of							148.00
149.00 Was there a change to the simplifi	ed cost finding method? Er						149.00
	-	Part A 1.00	Part 2.00		<u>Fitle V</u> 3.00	Title XIX 4.00	
Does this facility contain a provi	der that qualifies for an						
or charges? Enter "Y" for yes or '	N" for no for each compone			B. (See		· · · ·	
155.00Hospital 156.00Subprovider - IPF		N N	N N		N N	N N	155.00 156.00
157. 00 Subprovi der – TRF		N	N		N		157.00
158. 00 SUBPROVI DER							158.00
159.00 SNF		N	N		N		159.00
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N		N N		160.00
			IN	I	in the second se	14	101.00
						1.00	
Multicampus 165.00 s this hospital part of a Multica	ampus hospital that has one	e or more campu	uses in d	ifferent (CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Nome	County	Stata	7: n Codo	CDCA		
	Name O	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00 fline 165 is yes, for each			2.00	0.00			166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HI	() incentive in the America	an Recovery an	d Rei nves	tment Act		1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "Y	" for yes or '	"N" for n	0.		Y	167.00
168.00 If this provider is a CAH (line 10			e 167 is	"Y"), ente	er the		168.00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r			r qualif∨	for a ha	dshi p		168.01
exception under §413.70(a)(6)(ii)?	P Enter "Y" for yes or "N"	for no. (see i	instructi	ons)	·		
169.00 If this provider is a meaningful u		is not a CAH	(line 105	is "N"),	enter the	9.99	169.00
transition factor. (see instruction	ons)					I	I

Health Financial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA		Period:	Worksheet S-2	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
			10 12/31/2020	8/2/2021 1:50	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provider	⁻ have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans repor	ted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1	l. lf column 1 is yes, e	enter the number of sectio	n		
1876 Medicare days in column 2. (see i	nstructions)				

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		repared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	N for all NO r	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in o	column 2. (see	i nstructi ons			
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N			2.
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of 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" to or "R" for Reviewed. Submit complete copy or enter date ave column 2: cost instructions) if no cost instructions	for Compiled,	Y	A		4.
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		Ν			5.
				Y/N	Legal Oper.	_
			-	1.00	2.00	_
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf vos ist	he provider i	s N		6.
00	the legal operator of the program?	11 yes, 13 t		3 11		0.
00 00	Are costs claimed for Allied Health Programs? If "Y" see instructions.NWere nursing school and/or allied health programs approved and/or renewed during theN					
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	Ν		11.
				-	Y/N 1.00	
	Bad Debts				1.00	_
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	nstructions.	N	14.
5.00	Did total beds available change from the prior cost reporti	21	yes, see ins t A	structions. Par	N + P	15.
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	-
	PS&R Data			· · · · · · · · · · · · · · · · · · ·		
5.00	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.
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 in columns 2 and 4. (see instructions)	Y	07/01/2021	Y	07/01/2021	17.
3. 00	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.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.

5	ORIAL HOSPITAL	NON 15 0401		u of Form CM			
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020		repare		
	Descr	iption	Y/N	Y/N			
		0	1.00	3.00			
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		_	N	Ν	20.		
	Y/N	Date	Y/N	Date			
	1.00	2.00	3.00	4.00	-		
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.		
				1.00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (E Capital Related Cost	XCEPT CHILDRENS	HOSPI TALS)			_		
2.00 Have assets been relifed for Medicare purposes? If yes,	see instructions	3			22.		
 8.00 Have changes occurred in the Medicare depreciation exper reporting period? If yes, see instructions. 			uring the cost		23.		
	00 Were new leases and/or amendments to existing leases entered into during this cost reporting period?						
00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.							
00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.							
7.00 Has the provider's capitalization policy changed during copy.	00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit						
3.00 Were new Loans, mortgage agreements or letters of credit	: entered into du	iring the cos	st reporting		28.		
period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and		ebt Service	Reserve Fund)		29.		
1.00 treated as a funded depreciation account? If yes, see in Has existing debt been replaced prior to its scheduled m		/debt?lfye	es, see		30.		
 instructions. Has debt been recalled before scheduled maturity without instructions. 	issuance of new	√debt?lfy€	es, see		31.		
2.00 Have changes or new agreements occurred in patient care		ned through d	contractual		32.		
arrangements with suppliers of services? If yes, see ins 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 no, see instructions.		ng to compet	titive bidding? If		33.		
Provi der-Based Physi ci ans							
4.00 Are services furnished at the provider facility under ar	n arrangement wit	h provider-b	based physicians?		34.		
If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended	existing agreeme	ents with the	e provider-based		35.		
physicians during the cost reporting period? If yes, see	e instructions.						
			Y/N	Date	_		
Home Office Costs			1.00	2.00			
6.00 Were home office costs claimed on the cost report?				1	36.		
7.00 If line 36 is yes, has a home office cost statement beer	n prepared by the	e home office	?		37.		
If yes, see instructions. 8.00 If line 36 is yes, was the fiscal year end of the home the provider2 If yes, order in column 2 the fiscal year			of		38.		
9.00 If line 36 is yes, did the provider render services to a see instructions.			es,		39.		
0.00 If line 36 is yes, did the provider render services to 1 instructions.	he home office?	lf yes, see	9		40.		
		00		00			
Cost Peport Preparer Contact Information	1	. 00	2.	00			
 Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, 	TI NA		SEVERS		41.		
respecti vel y.	BLUE & CO., LI	C			12		
2.00 Enter the employer/company name of the cost report	BLUL & CO., LI	20			42.		

Health Financial Systems WI	THAM MEMORIA	AL HOSPI TAL	 In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provider CCN: 15-010	eriod: rom 01/01/2020	Worksheet S-2 Part II	
				Date/Time Pre 8/2/2021 1:50	pared:
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/po	osition M	IANAGER			41.00
held by the cost report preparer in columns 1, 2	2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the cost repo	ort				42.00
preparer.					
43.00 Enter the telephone number and email address of	the cost				43.00
report preparer in columns 1 and 2, respectively	y.				

HOSPI 1	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>WITHAM MEMORIA</u> AL DATA	Provider C	CN: 15-0104	Peri od:	Worksheet S-3	2552-10
					From 01/01/2020 To 12/31/2020	Part I	pared:
						I/P Days / 0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	63	22, 40		5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	50.00	00	22, 1	0.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		63	22, 40	0. 00	0	7.00
	beds) (see instructions)		-			_	
8.00	INTENSIVE CARE UNIT	31.00	8	2, 9	28 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12.00 13.00
14.00	Total (see instructions)	43.00	71	25, 3	36 0.00	0	14.00
15.00	CAH visits		71	20, 5	0.00	0	1
16.00	SUBPROVIDER - IPF	40, 00	7	1, 5	48	0	
17.00	SUBPROVI DER – I RF	41.00	, 0		0	0	17.00
18.00	SUBPROVI DER	42.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	44.00	18	6, 5	38	0	
20.00	NURSING FACILITY		-				20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		96				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
31.00 32.00	Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0		U		32.00
JZ. UI	outpatient days (see instructions)						JZ. UI
33.00	LTCH non-covered days						33.00
20.00	LTCH site neutral days and discharges						33.01

10SPI 1	<u>Financial Systems</u> FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0104		eriod: com 01/01/2020 0 12/31/2020		pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,060	141	5, 1 ⁻	15			1.0
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	1, 190 67	1, 818 0					2.0 3.0
4.00 5.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	0 0	0 0 0		0			4.0 5.0 6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,060	141	5, 11	15			7.0
3.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	1, 046	67	2, 81				8.0 9.0 10.0 11.0 12.0
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	3, 106	97 305 0	96 8, 89	52 92	0.00	687.00	13.0 14.0 15.0
6.00 7.00 8.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	1, 001 0	0 0 0	1, 40	0 00 0 0	0.00 0.00 0.00	28. 16 0. 00 0. 00	16.0 17.0
9.00 0.00 1.00 2.00 3.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	2, 342	0	4, 03	39	0. 00	31. 75	
4.00 4.10 5.00 6.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC			3	31			24.0 24.1 25.0 26.0
6. 25 7. 00 8. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0	2, 35	0	0. 00 0. 00	0. 00 746. 91	
8.00 9.00 0.00 1.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	1, 761	0	16	69 0			28.0 29.0 30.0 31.0
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	85	14	47 0			32. (32. (
3.00	LTCH non-covered days LTCH site neutral days and discharges	0						33. (33. (

HOSPI T	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 8/2/2021 1:50	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		14.00	2, 100	1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 17.00 18.00 19.00 21.00 22.00 23.00 24.00 24.00 24.10 25.00 24.00 25.00 26.00 27.00 28.00 29.00 29.00	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 BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLTY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0.00 0.00 0.00 0.00 0.00 0.00		7	34 421 0 0 16 55 74 0 0 0 0	2, 100 128 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 13.00 14.00 15.00 14.00 15.00 14.00 22.00 21.00 22.00 23.00 24.00 25.00 26.25 27.00 28.00 29.00
30.00 31.00 32.00 32.01 33.00 33.01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		30.00 31.00 32.00 32.0 33.00 33.00

SPI T	Financial Systems AL WAGE INDEX INFORMATION		WI THAM MEMORI	Provi der C		eriod:	u of Form CMS-2 Worksheet S-3	
					F	rom 01/01/2020 o 12/31/2020	Date/Time Pre	par
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Paid Hours	8/2/2021 1:50 Average	pm
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Salaries (from Wkst.	(col.2 ± col. 3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
				A-6)				
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
00	Total salaries (see	200.00	69, 391, 575	1, 645, 932	71, 037, 507	2, 057, 118. 00	34. 53	1
00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	
	A					0.00		
00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3
0	Physician-Part A -		0	0	0	0.00	0.00	4
)1	Administrative Physicians – Part A – Teaching		0	0	0	0.00	0.00	
00	Physician and Non		0	-	-	0.00		
00	Physician-Part B Non-physician-Part B for		0	0	0	0.00	0.00	6
,0	hospital -based RHC and FQHC		0		0	0.00	0.00	
00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
0	approved program)	21.00	0		0	0.00	0.00	1
D1	Contracted interns and		0	0	0	0.00	0.00	7
	residents (in an approved programs)							
00	Home office and/or related		0	0	0	0.00	0.00	8
00	organization personnel SNF	44.00	1, 011, 576	39, 468	1, 051, 044	66, 032. 00	15. 92	
00	Excluded area salaries (see		34, 490, 285			673, 844. 00		
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		769, 367	0	769, 367	11, 404. 00	67.46	11
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	1.
00	management and other		0		0	0.00	0.00	11
	management and administrative services							
00	Contract Labor: Physician-Part		0	0	0	0.00	0.00	1:
~~	A - Administrative		0	0	0	0.00	0.00	1
00	Home office and/or related organization salaries and		0	0	0	0.00	0.00	
0.1	wage-related costs					0.00		
01 02	Home office salaries Related organization salaries		0	-	0	0.00 0.00	0.00 0.00	
	Home office: Physician Part A		0	0	0		0.00	1
00	- Administrative Home office and Contract		0	0	0	0.00	0.00	1
	Physicians Part A - Teaching		0					
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	10
02	Home office contract		0	0	0	0.00	0.00	10
	Physicians Part A - Teaching WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		12, 469, 195	0	12, 469, 195			11
00	instructions) Wage-related costs (other)							10
00	(see instructions)							18
00	Excluded areas		8, 752, 014	0	8, 752, 014			19
00	Non-physician anesthetist Part A		0	0	0			20
00	Non-physician anesthetist Part		0	0	0			2'
00	B Physician Part A -		0	∩	n			22
	Administrative		0					
	Physician Part A - Teaching Physician Part B		0		0			22
	Wage-related costs (RHC/FQHC)		0	0	0			24
00	Interns & residents (in an		0	0	0			25
50	approved program) Home office wage-related		0	0	0			2!
	(core)		-	_				
51	Related organization wage-related (core)		0	0	0			25
52	Home office: Physician Part A		0	o	0			25
	- Administrative - wage-related (core)							

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
		1.00	2.00	A-6) 3.00	4.00	5.00	6, 00	
25 53	Home office: Physicians Part A		2.00	0.00	4.00	0	0.00	25.53
20.00	- Teaching - wage-related		0	0		0		20.00
	(core)							
	OVERHEAD COSTS - DIRECT SALARI	ES			1			
26.00	Employee Benefits Department	4.00	210, 304	0	210, 30	4 11, 605. 00	18. 12	26.00
27.00	Administrative & General	5.00	7, 479, 547	523, 285	8, 002, 83	2 225, 717.00	35.46	27.00
28.00	Administrative & General under		376, 920		376, 92	662.00	569.37	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0. 00	29.00
30.00	Operation of Plant	7.00	671, 946	29, 538	701, 48	4 25, 510. 00	27.50	30.00
31.00	Laundry & Linen Service	8.00	33, 387	1, 973	35, 36	0 1, 963. 00	18. 01	31.00
32.00	Housekeepi ng	9.00	509, 937	24, 156	534, 09	43, 709. 00	12. 22	32.00
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	929, 751	-324, 627	605, 12	4 35, 100. 00	17.24	34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	371, 105	371, 10	5 29, 100. 00	12.75	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	
38.00	Nursing Administration	13.00	610, 807	19, 005	629, 81	2 17, 219. 00	36. 58	38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00	0.00	39.00
40.00	Pharmacy	15.00	677,003	20, 879	697, 88	32, 867. 00	21. 23	40.00
41.00	Medical Records & Medical	16.00	1, 403, 258	83, 208	1, 486, 46	6 41, 336. 00	35.96	41.00
	Records Library							
42.00	Soci al Servi ce	17.00	0	0		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		69, 768, 495	1, 645, 932	71, 414, 42	7 2, 057, 780. 00	34.70	1.00
	instructions)							
2.00	Excluded area salaries (see		35, 501, 861	151, 580	35, 653, 44	1 739, 876. 00	48. 19	2.00
	instructions)							
3.00	Subtotal salaries (line 1		34, 266, 634	1, 494, 352	35, 760, 98	6 1, 317, 904. 00	27.13	3.00
	minus line 2)							
4.00	Subtotal other wages & related		769, 367	0	769, 36	7 11, 404. 00	67.46	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		12, 469, 195	0	12, 469, 19	5 0.00	34.87	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		47, 505, 196	1, 494, 352	48, 999, 54	8 1, 329, 308. 00	36.86	6.00
7.00	Total overhead cost (see		12, 902, 860	748, 522	13, 651, 38	2 464, 788. 00	29.37	7.00
	instructions)							
								-

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN: 15-0104	Period: From 01/01/2020	Worksheet S-3	pared:
					Amount	
				-	Reported 1.00	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				3, 123, 716	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ution			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i	nstructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	tructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External ()rgani zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla				0	6.00
7.00	Employee Managed Care Program Administration	Fees			0	7.00
	HEALTH AND INSURANCE COST			1		
8.00	Health Insurance (Purchased or Self Funded)				0	8.00
8.01	Health Insurance (Self Funded without a Third				0	8.01
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	ir)		9, 607, 022	8.02
8.03	Heal th Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				2, 424, 629	
10.00	Dental, Hearing and Vision Plan Life Insurance (If employee is owner or bene	61 a 1 a 1 a 1			483, 688	
11.00					106, 544 0	
12.00 13.00	Accident Insurance (If employee is owner or I Disability Insurance (If employee is owner or				286, 614	
14.00	Long-Term Care Insurance (If employee is owned of				200, 014	13.00
14.00	Workers' Compensation Insurance	er of beneficially			605, 206	
16.00	Retirement Health Care Cost (Only current yea	ar not the extra	ordinary accrual requir	red by FASB 106	005, 200	16.00
10.00	Non cumulative portion)			cd by 1735 100.	0	10.00
	TAXES			I		
17.00	FICA-Employers Portion Only				4, 442, 208	17.00
18.00	Medicare Taxes - Employers Portion Only				0	18.00
19.00	Unemployment Insurance				141, 582	19.00
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
21.00	Executive Deferred Compensation (Other Than I instructions))	Retirement Cost R	eported on lines 1 thro	ough 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	22.00
	Tuition Reimbursement				0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)				21, 221, 209	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th I	Financial Systems	WITHAM MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPI TA	AL CONTRACT LABOR AND BENEFIT COST	Provi der C	F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet S-3 Part V Date/Time Pre 8/2/2021 1:50	
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
-	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi			-	-	
	Total facility's contract labor and benefit	cost		0	0	1.00
	Hospi tal			0	0	2.00
	Subprovider - IPF			0	0	3.00
	Subprovider - IRF			0	0	4.00
	Subprovider - (Other)			0	0	5.00
	Swing Beds - SNF			0	0	6.00
	Swing Beds - NF			0	0	7.00
	Hospital-Based SNF			0	0	8.00 9.00
	Hospital-Based NF					9.00 10.00
	Hospital-Based OLTC Hospital-Based HHA					10.00
	Separately Certified ASC					12.00
	Hospital -Based Hospice					12.00
	Hospital-Based Health Clinic RHC					13.00
	Hospital-Based Health Clinic FQHC					14.00
	Hospital-Based-CMHC					16.00
	Renal Dialysis					17.00
	Other			0	0	18.00
10.00 [0				U U	0	10.00

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0104	Peri od:	Worksheet S-1	
				From 01/01/2020 To 12/31/2020		
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	divided by I	ine 202 colum	n 8)	0. 224699	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				-3, 213, 184	2.00
	Did you receive DSH or supplemental payments from Medicaid?			0	Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemented			ai d <i>?</i>	N 1 704 204	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	IT OIII Medi ca	i u		1, 724, 304 42, 297, 081	5.00 6.00
7.00	Medicaid cost (line 1 times line 6)				9, 504, 112	7.00
	Difference between net revenue and costs for Medicaid program	m (lino 7 mi)	nus sum of Li	nos 2 and 5, if	10, 992, 992	8.00
	< zero then enter zero)				10, 992, 992	0.00
	Children's Health Insurance Program (CHIP) (see instructions	for each li	ne)		0	0.00
	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00
	Difference between net revenue and costs for stand-alone CHI) (lino 11 m	inus lino 0:	if < zoro thon	0	12.00
12.00	enter zero)		THUS TITLE 9,		0	12.00
	Other state or local government indigent care program (see in	nstructions ·	for each line)		
	Net revenue from state or local indigent care program (Not in				0	13.00
	Charges for patients covered under state or local indigent ca				0	
	10)	1 3				
15.00	State or local indigent care program cost (line 1 times line	14)			0	15.00
16.00	Difference between net revenue and costs for state or local i	ndigent car	e program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, (CHIP and sta	te/local indi	gent care progra	ams (see	
47.00	instructions for each line)	<u> </u>				1 7
	Private grants, donations, or endowment income restricted to				0	
	Government grants, appropriations or transfers for support of			o (oum of lines	0	18.00 19.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)	Lai muryem		s (suil of filles	10, 992, 992	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ 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 t	Facility	2, 540, 70	03 0	2, 540, 703	20.00
01 00	(see instructions)		570.00		570.000	01 00
21.00	Cost of patients approved for charity care and uninsured disc instructions)	counts (see	570, 89	03 0	570, 893	21.00
22.00	Payments received from patients for amounts previously writte	on off as		0 0	0	22.00
22.00	chari ty care			0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		570, 89	03 0	570, 893	23.00
20100			0,0,0	<u> </u>	0101010	20100
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati		yond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent ca					
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigen	t care progra	m's length of	0	25.00
	stay limit					
	Total bad debt expense for the entire hospital complex (see i				11, 407, 563	
	Medicare reimbursable bad debts for the entire hospital compl				148, 275	
	Medicare allowable bad debts for the entire hospital complex	(see instru	ctions)		228, 116	
	Non-Medicare bad debt expense (see instructions)		1	`	11, 179, 447	
	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (see	Instructions)	2, 591, 852	•
	Cost of uncompensated care (line 23 column 3 plus line 29)	Line 20)			3, 162, 745	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	iiile 30)			14, 155, 737	131.00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	WI THAM MEMORI AL EXPENSES	Provider CC	CN: 15-0104 P	Period: From 01/01/2020	u of Form CMS-2 Worksheet A	
					o 12/31/2020	Date/Time Pre 8/2/2021 1:50	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)		
		1.00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS		4 472 424	4 472 424	14 002	4 450 442	1 1 00
	00200 NEW CAP REL COSTS-BLDG & FIXT		4, 473, 436 0	4, 473, 436 C		4, 458, 443 5, 105, 187	
. 00	00300 OTHER CAPITAL RELATED COSTS		0	C	-	0	
. 00 . 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	210, 304 7, 479, 547	16, 704, 941 17, 945, 018	16, 915, 245 25, 424, 565		16, 284, 887 23, 618, 029	
	00700 OPERATION OF PLANT	671, 946	2, 581, 244	3, 253, 190			
	00800 LAUNDRY & LINEN SERVICE	33, 387	574, 968	608, 355			
	00900 HOUSEKEEPI NG	509, 937	420, 904	930, 841		951, 105	
	01000 DI ETARY 01100 CAFETERI A	929, 751 0	1, 146, 923 0	2, 076, 674 0		1, 235, 631 857, 726	
	01300 NURSI NG ADMI NI STRATI ON	610, 807	77, 085	687, 892		689, 862	
	01500 PHARMACY	677, 003	8, 456, 431	9, 133, 434			
6.00	01600 MEDICAL RECORDS & LIBRARY	1, 403, 258	303, 874	1, 707, 132	74, 393	1, 781, 525	16.0
0.00	03000 ADULTS & PEDIATRICS	3, 812, 143	999, 201	4, 811, 344	-264, 498	4, 546, 846	30.00
1.00	03100 I NTENSI VE CARE UNI T	1, 985, 350	605, 772	2, 591, 122		2, 411, 577	
	04000 SUBPROVI DER - I PF	842, 876	136, 320	979, 196		986, 559	
	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0		0	
	04300 NURSERY	0	56, 752	56, 752		56, 752	
4.00	04400 SKILLED NURSING FACILITY	1, 011, 576	290, 298	1, 301, 874	-52, 601	1, 249, 273	
	ANCILLARY SERVICE COST CENTERS	0 /75 554	F (07 (F)	0.0(0.010	4 504 000	2 77 227	
	05400 RADI OLOGY-DI AGNOSTI C	2, 675, 554 1, 580, 984	5, 687, 656 4, 160, 943	8, 363, 210 5, 741, 927		3, 776, 227 5, 104, 566	
	05500 RADI OLOGY-THERAPEUTI C	0	0	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	
	05501 ULTRA SOUND	427, 152	341, 402	768, 554		640, 972	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	193, 799 359, 565	1, 140, 457 743, 234	1, 334, 256 1, 102, 799		921,059	
	05900 CARDIAC CATHETERIZATION	424, 771	2,023,146	2, 447, 917		1, 032, 622 1, 475, 121	
	06000 LABORATORY	3, 195, 699	5, 258, 990	8, 454, 689		8, 218, 442	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	183, 681	183, 681		182, 144	
	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0 1, 531, 855	0 236, 495	0 1, 768, 350	-	0 1, 798, 646	
	06700 OCCUPATI ONAL THERAPY	467, 834	67, 380	535, 214		551, 339	
	06701 AUDI OLOGY	208, 076	208, 545	416, 621			
	06800 SPEECH PATHOLOGY	162, 795	32, 732	195, 527		201, 017	
	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	1, 308, 368	0 650, 103	C 1, 958, 471	-	0 1, 686, 443	1
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	52	29, 606	29, 658			
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C			
	07300 DRUGS CHARGED TO PATIENTS	0	13, 596	13, 596	7, 249, 906	7, 263, 502	73.0
	OUTPATI ENT_SERVI CE_COST_CENTERS 09000 CLI NI C	0	0	C	0	0	90.0
	09001 OTHER OUTPATIENT SERVICE COST CENTER	140, 751	79, 373	220, 124	856	220, 980	
	09002 CLINIC	0	0	0	-	0	
	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	3, 035 20	3, 035 20		3, 035 63	
	09005 SURGERY CLINIC	0	889	889		177	
	09007 UROLOGY CLINIC	0	-80	-80			
	09009 GASTROENTEROLOGY CLINIC	254	8, 790	9,044		13, 058	
	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC	0	7, 129 15, 640	7, 129 15, 640		7, 129 7, 622	
	09013 ALLERGY CLINIC	69, 977	29, 109	99, 086		100, 002	
	09014 WOUND CARE	258, 552	463, 343	721, 895		681, 736	
	09100 EMERGENCY	2, 560, 243	5, 891, 921	8, 452, 164	-383, 750	8, 068, 414	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.0
	09500 AMBULANCE SERVICES	2, 330, 994	475, 235	2, 806, 229	-54, 684	2, 751, 545	95.0
18.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	38, 075, 160	82, 525, 537	120, 600, 697	462, 003	121, 062, 700	118.0
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	C	0	0	190. C
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	30, 962, 139	10, 177, 105	41, 139, 244	-	40, 679, 866	192.0
	07950 THORNTOWN OFFICE BUILDING	0	0	0	-		194.0
	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB		0 43, 159	115 014	0 0	0 114, 441	194.0
	07953 RETAIL PHARMACY	72, 055 282, 221	43, 159 1, 987, 770	115, 214 2, 269, 991	-1,852	2, 268, 139	
	TOTAL (SUM OF LINES 118 through 199)	69, 391, 575	94, 733, 571	164, 125, 146		164, 125, 146	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	WITHAM MEMORI	AL HOSPITAL Provider CCN: 1	5-0104 Peri		u of Form CM Worksheet	
RECLASS	SIFICATION AND ADJUSTMENTS OF IRIAL BALANCE O	F EAPENSES	PLOVIDEL CCN. I	From	01/01/2020		
				То	12/31/2020	Date/Time 8/2/2021 1	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For				
		(300 / 0)	Allocation				
		6.00	7.00				_
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	-272, 741	4, 185, 702				1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	5, 105, 187				2.0
	00300 OTHER CAPI TAL RELATED COSTS	0	0				3.0
		-5, 385, 670					4.0
	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT	-9, 182, 383 375					5.0
	00800 LAUNDRY & LINEN SERVICE	0	610, 168				8.0
	00900 HOUSEKEEPI NG	-469					9.0
	01000 DI ETARY	-339, 078					10.0
	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	0	857, 726 689, 862				11.0
	01500 PHARMACY	-11, 690					15.0
	01600 MEDI CAL RECORDS & LI BRARY	-53, 087	1, 728, 438				16.0
	INPATIENT ROUTINE SERVICE COST CENTERS	0	4 546 046				- 20.0
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0					30.0
	04000 SUBPROVI DER – I PF	0	986, 559				40.0
	04100 SUBPROVI DER – I RF	0	0				41.0
	04200 SUBPROVI DER	0	0 E4 750				42.0
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	56, 752 1, 249, 273				43.0
-	ANCI LLARY SERVICE COST CENTERS		172177270				
	05000 OPERATING ROOM	-12, 250					50.0
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-379, 824 0	4, 724, 742				54.0 55.0
	05500 RADIOLOGI - THERAPEOTIC	0	640, 972				55.0
	05700 CT SCAN	0	921, 059				57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,032,622				58.0
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	-23, 999 -100, 000					59.0 60.0
	06300 BLOOD STORING, PROCESSING & TRANS.	- 100, 000	8, 118, 442 182, 144				63.0
	06400 I NTRAVENOUS THERAPY	0	0				64.0
	06600 PHYSI CAL THERAPY	0	1, 798, 646				66.0
	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	0 -229, 742	551, 339 173, 183				67.0 67.0
	06800 SPEECH PATHOLOGY	-229, 742	201, 017				68.0
	06900 ELECTROCARDI OLOGY	0	0				69.0
	06901 CARDI OLOGY	0	1, 686, 443				69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	-5, 215	2, 630, 139 3, 838, 343				71.0
	07300 DRUGS CHARGED TO PATIENTS	0					72.0
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0					90.0
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0	220, 980				90. 0 90. 0
1	09003 DERMATOLOGY CLINIC	-3, 035	-				90.0
90.04	09004 ENT CLINIC	-63	0				90.0
	09005 SURGERY CLINIC	-177	0				90.0
	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	550 13, 058-					90.0 90.0
	09011 NEUROLOGY CLINIC	- 13, 038 0	7, 129				90.0
90.12	09012 OPTHAMOLOGY CLINIC	-7, 622	0				90. 1
	09013 ALLERGY CLINIC	0	100, 002				90.1
	09014 WOUND CARE 09100 EMERGENCY	-105, 686 -2, 602, 200					90.1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,002,200	5, +00, 214				91.0
C	OTHER REIMBURSABLE COST CENTERS		· · ·				
	09500 AMBULANCE SERVICES	-4, 950	2, 746, 595				95.0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-18, 732, 014	102, 330, 686				118.0
ا 190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0				190. 0
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0					192.0
	07950 THORNTOWN OFFICE BUILDING	0	0				194.0
		0	0				194.0
	07952 OTHER NONREI MB 07953 RETAI L PHARMACY	0	114, 441 2, 268, 139				194. 0 194. 0
	TOTAL (SUM OF LINES 118 through 199)	-18, 732, 014					200.0

	Financial Systems SIFICATIONS		WITHAM MEMORIA	AL HOSPITAL Provider CCN: 15-	-0104 Period: Works	orm CMS-2552-10 heet A-6
					From 01/01/2020 To 12/31/2020 Date/ 8/2/2	Time Prepared: 2021 1:50 pm
	Cost Center	I ncreases Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
1 00	A - EMPLOYEE BENEFITS RECLASS	4 00		F40, 005		1.00
1.00	EMPLOYEE BENEFITS DEPARTMENT		0	<u>512, 335</u> 512, 335		1.00
	B - INSURANCE RECLASS			012,000		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	74, 826		1.00
2.00	FIXT NEW CAP REL COSTS-BLDG &	1.00	o	122, 195		2.00
21.00	FIXT			.22, 170		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	<u>o</u>	51 <u>2, 335</u>		3.00
	TOTALS C - CAFETERIA RECLASS		0	709, 356		
1.00	CAFETERI A		<u> </u>	486, 621		1.00
	TOTALS		371, 105	486, 621		
1.00	D - MME DEPRECIATION RECLASS NEW CAP REL COSTS-MVBLE	2.00	0	5, 105, 187		1.00
1.00	EQUI P	2.00	0	3, 103, 107		1.00
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
4.00 5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00 9.00		0.00 0.00	0	0 0		8.00 9.00
10.00		0.00	0	Ö		10.00
11.00		0. 00	0	0		11.00
12.00 13.00		0.00	0	0		12.00
13.00		0.00 0.00	0	0		14.00
15.00		0.00	Ő	Ő		15.00
16.00		0.00	0	0		16.00
17.00 18.00		0.00 0.00	0	0 0		17.00 18.00
19.00		0.00	0	0		19.00
20.00		0.00	Ő	Ő		20.00
21.00		0.00	0	0		21.00
22.00 23.00		0.00 0.00	0	0 0		22.00 23.00
23.00		0.00	0	0		23.00
25.00		0.00	0	0		25.00
27.00		0.00	0	0		27.00
29.00 30.00		0.00 0.00	0	0		29.00 30.00
31.00		0.00	Ö	Ő		31.00
32.00		0.00	0	0		32.00
33.00 34.00		0.00 0.00	0	0		33.00 34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00 38.00		0.00 0.00	0	0		37.00 38.00
39.00		0.00	0	0		39.00
	TOTALS		0	5, 105, 187		
1 00	E - DRUGS RECLASS	72.00	0	7 (22 710		1.00
1.00	DRUGS_CHARGED_TO_PATIENTS	73.00	<u>o</u>	<u>7,622,710</u> 7,622,710		1.00
	F - IMPLANTABLES RECLASS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	3, 838, 343		1.00
2.00	PATI ENT	0.00	О	0		2.00
2.00 3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	TOTALS G - CHARGEABLE SUPPLIES RECLAS	SS	0	3, 838, 343		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 605, 696		1.00
	PATI ENTS					
2.00	ENT CLINIC	90.04	0	43		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
+. 00 5. 00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00

In Lieu of Form CMS-2552-10

Provi der CCN: 15-0104

Peri od:	Worksheet A-6 Date/Time Prepared:
From 01/01/2020	
To 12/31/2020	Date/Time Prepared:

					To 12/31/2020 Date/Time Pr 8/2/2021 1:5	
		Increases				1
	Cost Center	Line #	Sal ary	Other		
0.00	2.00	3.00	4.00	5.00		0.00
9. 00 10. 00		0. 00 0. 00	0	0 0		9.00 10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	o	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	О	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0 0		19.00
20.00 21.00		0. 00 0. 00	0	0		20.00 21.00
21.00		0.00	0	0		21.00
23.00		0.00	0	0		23.00
24.00		0.00	o	0		24.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0 0		29.00 30.00
30. 00 31. 00		0. 00 0. 00	0	0		30.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00	L	0.00	o	0		34.00
	TOTALS		0	2,605,739		
	H - BONUS RECLASS	5.00	500.005			1
1.00 2.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	523, 285 29, 538	0 0		1.00 2.00
2.00 3.00	LAUNDRY & LINEN SERVICE	8.00	29, 536	0		3.00
4.00	HOUSEKEEPI NG	9.00	24, 156	0		4.00
5.00	DI ETARY	10.00	46, 478	0		5.00
6.00	NURSING ADMINISTRATION	13.00	19, 005	0		6.00
7.00	PHARMACY	15.00	20, 879	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	83, 208	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	127, 942	0		9.00
10. 00 11. 00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	63, 380 34, 913	0 0		10.00 11.00
12.00	SKILLED NURSING FACILITY	40.00	39, 468	0		12.00
13.00	OPERATING ROOM	50.00	91, 308	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	69, 555	0		14.00
15.00	ULTRA SOUND	55.01	12, 855	0		15.00
16.00	CT SCAN	57.00	7, 498	0		16.00
17.00	MAGNETIC RESONANCE IMAGING	58.00	11, 824	0		17.00
18.00	(MRI) CARDIAC CATHETERIZATION	59.00	19, 600	0		18.00
19.00	LABORATORY	60.00	128, 683	0		19.00
20.00	PHYSI CAL THERAPY	66.00	48, 570	0		20.00
21.00	OCCUPATI ONAL THERAPY	67.00	16, 530	0		21.00
22.00	AUDI OLOGY	67.01	7,447	0		22.00
23.00	SPEECH PATHOLOGY	68.00	5, 490	0		23.00
24.00	CARDI OLOGY	69.01	44,007	0		24.00
25.00	OTHER OUTPATIENT SERVICE	90. 01	5, 062	0		25.00
26.00	GASTROENTEROLOGY CLINIC	90.09	4, 014	0		26.00
27.00	ALLERGY CLINIC	90.13	1, 801	0		27.00
28.00	WOUND CARE	90.14	13, 454	0		28.00
29.00	EMERGENCY	91.00	66, 810	0		29.00
30.00	AMBULANCE_SERVICES	95.00	77, 199	<u>0</u>		30.00
E00 00	TOTALS Grand Total: Increases		1, 645, 932			E00.00
500.00	orania rotar. Thereases	I	2, 017, 037	20, 880, 291		500.00

	Financial Systems		WITHAM MEMORIA		CCN: 15-0104	In Lie Period:	u of Form CMS-2552-10 Worksheet A-6
						From 01/01/2020 To 12/31/2020	Date/Time Prepared:
		Decreases					8/2/2021 1:50 pm
	Cost Center	Decreases	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	A - EMPLOYEE BENEFITS RECLASS ADMINISTRATIVE & GENERAL	5.00	0	512, 335	:	0	1.00
1.00	TOTALS		0	<u>512, 3</u> 35 512, 335			1.00
	B - INSURANCE RECLASS				- I		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	709, 356			1.00
2.00 3.00		0.00 0.00	0	C		2	2.00
3.00	TOTALS	0.00	0	709, 356	·		3.00
	C - CAFETERIA RECLASS			, , , , , , , , , , , , , , , , , , , ,			
1.00	DI ETARY		<u>371, 1</u> 05	<u>486, 6</u> 21		0	1.00
			371, 105	486, 621			
1.00	D - MME DEPRECIATION RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	212, 014	ı	9	1.00
1.00	FI XT	1.00	0	212,011			1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 987		o	2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	1,097,899		0	3.00
4.00 5.00	OPERATION OF PLANT	7.00 8.00	0	155, 658		0	4.00
5.00 6.00	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	9.00	0	160 3, 169		0	5.00
7.00	DI ETARY	10.00	0	29, 623		0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	17,023		0	8.00
9.00	PHARMACY	15.00	0	4,860		0	9.00
10.00	MEDI CAL RECORDS & LI BRARY	16.00	0	8, 697		0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	151, 742		0	11.00
12.00 13.00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	102, 089 13, 686		0	12.00
13.00	SKILLED NURSING FACILITY	40.00	0	54, 675		0	14.00
15.00	OPERATING ROOM	50.00	0	640, 527		0	15.00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	554, 601		0	16.00
17.00	ULTRA SOUND	55. 01	0	131, 727		0	17.00
18.00	CT SCAN	57.00	0	405,006		0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	76, 134	ł	0	19.00
20.00	CARDI AC CATHETERI ZATI ON	59.00	О	168, 832	,	0	20.00
21.00	LABORATORY	60.00	0	338, 684		0	21.00
22.00	BLOOD STORING, PROCESSING &	63.00	0	1, 537	7	o	22.00
~~ ~~	TRANS.			1 (
23.00 24.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66.00 67.00	0	16, 924 372		0	23.00 24.00
24.00 25.00	AUDI OLOGY	67.01	0	20, 974		0	24.00
27.00	CARDI OLOGY	69.01	0	303, 430		0	27.00
29.00	OTHER OUTPATIENT SERVICE	90. 01	0	2, 170		0	29.00
	COST CENTER						
30.00	SURGERY CLINIC	90.05	0	566		0	30.00
31.00 32.00	UROLOGY CLINIC OPTHAMOLOGY CLINIC	90. 07 90. 12	0	293 8, 018		0	31.00 32.00
33.00	ALLERGY CLINIC	90.12	0	701		0	33.00
34.00	WOUND CARE	90.14	0	26, 184		0	34.00
35.00	EMERGENCY	91.00	0	124, 202		o	35.00
36.00	AMBULANCE SERVICES	95.00	0	115, 900		0	36.00
37.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	306, 575		0	37.00
38.00 39.00	OTHER NONREIMB RETAIL PHARMACY	194. 02 194. 03	0	771 1, 777		0	38.00 39.00
57.00	TOTALS			5, 105, 187			37.00
	E - DRUGS RECLASS				1	1	
1.00	PHARMACY		0	7,622,710		0	1.00
	TOTALS		0	7, 622, 710)		
1 00	F - IMPLANTABLES RECLASS	31.00	0	2 025	:	0	1.00
1.00 2.00	OPERATING ROOM	50.00	0	2, 825 2, 554, 591		0	2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	119, 571		0	3.00
4.00	CARDI AC CATHETERI ZATI ON	59.00	0	788, 552		0	4.00
5.00	DRUGS_CHARGED_TO_PATIENTS		0	37 <u>2, 8</u> 04		o	5.00
			0	3, 838, 343	3		
1.00	G - CHARGEABLE SUPPLIES RECLA EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1 100		0	1.00
1.00 2.00	ADMINISTRATIVE & GENERAL	4.00 5.00	0	1, 109 10, 231		0	2.00
2.00 3.00	OPERATION OF PLANT	7.00	0	39		0	3.00
4.00	HOUSEKEEPING	9.00	Ö	723		0	4.00
5.00	DI ETARY	10. 00	0	172	2	o	5.00
6.00	NURSI NG ADMI NI STRATI ON	13.00	0	12		0	6.00
7.00		15.00	0	16, 577		0	7.00
8.00 9.00	MEDI CAL RECORDS & LI BRARY ADULTS & PEDI ATRI CS	16.00 30.00	0	118 240, 698		0	8.00 9.00
9.00	ADULIS & PEDIAIRIUS	30.00	U	240, 698	2	Ч	9.0

Health Financial Systems RECLASSIFICATIONS

WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0104 P

 Period:
 Worksheet A-6

 From 01/01/2020
 Date/Time Prepared:

 To
 12/31/2020

 Bate/Time Prepared:
 8/2/2021

						8/2/2021 1:5	<u>o pm</u>
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
10.00	INTENSIVE CARE UNIT	31.00	0	138, 011	0		10.00
11.00	SUBPROVI DER – I PF	40.00	0	13, 864	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	37, 394	0		12.00
13.00	OPERATING ROOM	50.00	0	1, 483, 173	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	0	32, 744	0		14.00
15.00	ULTRA SOUND	55.01	0	8, 710	0		15.00
16.00	CT SCAN	57.00	0	15, 689	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	5, 867	0		17.00
18.00	CARDÍ AC CATHETERI ZATI ON	59.00	o	35, 012	0		18.00
19.00	LABORATORY	60.00	0	26, 246			19.00
20.00	PHYSI CAL THERAPY	66.00	0	1, 350			20.00
21.00	OCCUPATI ONAL THERAPY	67.00	0	33			21.00
22.00	AUDI OLOGY	67.01	0	169			22.00
23.00	CARDI OLOGY	69.01	o	12, 605			23.00
24.00	OTHER OUTPATIENT SERVICE	90.01	o	2,036			24.00
21100	COST CENTER	, , , , , , , , , , , , , , , , , , , ,	Ű	2,000			200
26.00	SURGERY CLINIC	90.05	0	146	0		26.00
27.00	UROLOGY CLINIC	90.07	0	177	0		27.00
28.00	ALLERGY CLINIC	90.13	0	184	0		28.00
29.00	WOUND CARE	90. 14	0	27, 429	0		29.00
30.00	EMERGENCY	91.00	0	326, 358			30.00
31.00	AMBULANCE SERVICES	95.00	0	15, 983			31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	152, 803			32.00
33.00	OTHER NONREI MB	194.02	0	2	0		33.00
34.00	RETAIL PHARMACY	194.03	0	75	-		34.00
01100	TOTALS		— — — ö	2,605,739			0.1.00
	H - BONUS RECLASS	I	-	_/	1		1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 645, 932	0		1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0	-		4.00
5.00		0.00	o	0			5.00
6.00		0.00	0	0	-		6.00
7.00		0.00	o	0			7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	-		9.00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	-		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	-		18.00
19.00		0.00	0	0			19.00
20.00		0.00	0				20.00
20.00		0.00	0	0			20.00
22.00		0.00	0	0			21.00
22.00		0.00	0	0			22.00
23.00		0.00	0	0	0		23.00
24.00 25.00		0.00	0	0			24.00
25.00 26.00		0.00	0	0	0		25.00
		0.00	0	0	-		26.00
27.00			0	0	0		
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0			29.00
30.00	TOTALS	0.00	— — — ¥	1, 645, 932	<u> </u>		30.00
500 00	Grand Total: Decreases		371, 105	22, 526, 223			500.00
500.00		I I	371, 100	22, 020, 220	I I	I	1 300.00

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2020 To 12/31/2020		pared:
				Acqui si ti on:			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
. 00	Land	2, 845, 261	0		0 0	0	1.00
. 00	Land Improvements	3, 054, 058	0		0 0	475	2.00
3.00	Buildings and Fixtures	87, 433, 726	41, 320, 158		0 41, 320, 158	100, 614	3.00
4.00	Building Improvements	0	0		0 0	0	4.0
5.00	Fixed Equipment	5, 037, 483	245, 485		0 245, 485	290, 345	5.0
6.00	Movable Equipment	67, 721, 331	5, 127, 546		0 5, 127, 546	-309, 982	6.0
7.00	HIT designated Assets	0	0		0 0	0	7.00
3.00	Subtotal (sum of lines 1-7)	166, 091, 859	46, 693, 189		0 46, 693, 189	81, 452	8.0
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	166, 091, 859	46, 693, 189		0 46, 693, 189	81, 452	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	2, 845, 261	0				1.00
2.00	Land Improvements	3, 053, 583	0				2.0
3.00	Buildings and Fixtures	128, 653, 270	0				3.0
4.00	Building Improvements	0	0				4.0
5.00	Fixed Equipment	4, 992, 623	0				5.0
6.00	Movable Equipment	73, 158, 859	0				6.00
7.00	HIT designated Assets	0	0				7.00
B. 00	Subtotal (sum of lines 1-7)	212, 703, 596	0				8.0
9.00	Reconciling Items	0	0				9.0
10.00	Total (line 8 minus line 9)	212, 703, 596	0				10.0

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0104	Period: From 01/01/2020	Worksheet A-7 Part II	
						Date/Time Pre	pared:
						8/2/2021 1:50	pm
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 473, 436	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)	4, 473, 436	0		0 0	0	3.00
		SUMMARY 0	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4, 473, 436				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4, 473, 436				3.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 To 12/31/2020		pared:
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	139, 544, 737 73, 158, 859 212, 703, 596	0	139, 544, 737 73, 158, 859 212, 703, 596	0. 343947 1. 000000	0 0	1.00 2.00 3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other Capital-Relat ed 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 C		r .	r			
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		4, 261, 422 5, 105, 187	0	1.00
3.00 Total (sum of lines 1-2)	0		IMMARY OF CAPI	9, 366, 609 TAL	-6, 034	3.00
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI 1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP	ENTERS -266, 707 0		(4, 185, 702 5, 105, 187	1.00 2.00
3.00 Total (sum of lines 1-2)	-266, 707	197, 021	(0 0	9, 290, 889	3.00

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

IIth Financial Systems JUSTMENTS TO EXPENSES		WI THAM MEMORI	Provider CCN: 15-0104 Pe	eriod:	u of Form CMS-2 Worksheet A-8	
				rom 01/01/2020 0 12/31/2020	Date/Time Pre 8/2/2021 1:50	pare
·			Expense Classification on		07272021 1.30	
			To/From Which the Amount is ⁻	to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref. 5.00	
00 Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG &	1.00	0	1.
REL COSTS-BLDG & FIXT (chapter 2)					_	
00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
2) D0 Investment income - other		0		0.00	0	3.
(chapter 2) D0 Trade, quantity, and time		0		0.00	0	4.
discounts (chapter 8) DO Refunds and rebates of		0		0.00	0	5.
expenses (chapter 8) DO Rental of provider space by		0		0.00	0	
suppliers (chapter 8)	D	_				
00 Tel ephone services (pay stations excluded) (chapter	В	-4, U66	ADMI NI STRATI VE & GENERAL	5.00	0	7
21) Tel evi si on and radi o servi ce		0		0. 00	0	8
(chapter 21) D0 Parking lot (chapter 21)		0		0.00	0	9
00 Provider-based physician adjustment	A-8-2	-3, 082, 024			0	10
00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11
00 Related organization	A-8-1	0			0	12
transactions (chapter 10) 00 Laundry and linen service		0		0. 00	0	
00 Cafeteria-employees and guests 00 Rental of quarters to employee	В	-272, 222 0	DI ETARY	10. 00 0. 00	0 0	
and others 00 Sale of medical and surgical		0		0.00	0	16
supplies to other than patients						
00 Sale of drugs to other than patients		0		0.00	0	17
00 Sale of medical records and	В	-44, 347	MEDI CAL RECORDS & LI BRARY	16.00	0	18
abstracts 00 Nursing and allied health		0		0. 00	0	19
education (tuition, fees, books, etc.)						
00 Vending machines 00 Income from imposition of	В	-1, 706 0	DI ETARY	10. 00 0. 00	0 0	
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
repay Medicare overpayments	A-8-3	0	*** Coot Conton Dolated ***	(F. 00		23
00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23
limitation (chapter 14) 00 Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24
therapy costs in excess of limitation (chapter 14)						
00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25
(chapter 21) 00 Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26
COSTS-BLDG & FIXT			FIXT			
00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	
00 Non-physician Anesthetist00 Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28 29
00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	-	30
limitation (chapter 14)				20.00		20
99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.

Health Financial Systems		WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-					
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0104	Worksheet A-8 Date/Time Pre	epared:		
			Expense Classification or To/From Which the Amount is		8/2/2021 1:50	pm	
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7		
	(2)	2.00	3.00	4.00	<u>Ref.</u> 5.00		
31.00 Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00	0.00	31.00	
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for		0		0.00	C	32.00	
Depreciation and Interest 33.00 HOSPITAL ADMINISTRAT	A	-7, 379	ADMI NI STRATI VE & GENERAL	5.00	C	33.00	
SPONSORSHI PS/DO 33. 01 BANK FEES	А	0	OPERATING ROOM	50.00	C	33.01	
33. 02 HEARING AID COSTS	A		AUDI OLOGY	67.01	C		
33. 03 BANK FEES 33. 04 LOBBYING EXPENSE-IHA DUES	A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	C		
33. 05 LOBBYING EXPENSE-AHA DUES	A		ADMI NI STRATI VE & GENERAL	5.00	C		
33. 06 NON-REI MBURSABLE ADVERTI SI NG COSTS	A	-141, 869	ADMINISTRATIVE & GENERAL	5.00	C	33.06	
33.07 SELF INSURANCE CLAIMS PAID	В		EMPLOYEE BENEFITS DEPARTMEN		12		
33.08 HAF FEE 33.09 WIT ADMIN HOSPITAL MEDICAL	A A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5. 00 5. 00	C C		
33. 10 WI T AMBULANCE EDUCATION REIMBURSEM	A	-4, 950	AMBULANCE SERVI CES	95.00	C	33.10	
33. 12 WIT DIETARY HOME DELIVERED MEALS	В	-36, 083	DI ETARY	10. 00	C	33.12	
33.13 WIT DIETARY HEAD START 33.14 WIT DIETARY CICOA MEAL	B B		DI ETARY DI ETARY	10. 00 10. 00	C		
VOUCHERS WIT PLANT OPERATIONS LB WATER	В	375	OPERATION OF PLANT	7.00	C	33.15	
FOUNTA 83.16 WIT FINANCE HOSPITAL BIL RETURNED CH	В	-150	ADMI NI STRATI VE & GENERAL	5.00	C	33.16	
33. 17 WIT FINANCE HOSPITAL BIL CASH (SHORT	В	-470	ADMI NI STRATI VE & GENERAL	5.00	C	33.17	
3. 18 WIT FINANCE HOSPITAL BIL COLLECTION	В	-832	ADMI NI STRATI VE & GENERAL	5.00	C	33.18	
33.19 WIT HEALTH INFORMATION M PHYSICIAN Q	В		MEDICAL RECORDS & LIBRARY	16.00	C		
3.20 WIT FINANCE PHYSICIAN BI PHYSICIAN Q	В		ADMI NI STRATI VE & GENERAL	5.00	C		
33.21 WIT FINANCE HOSPITAL BIL INTEREST IN	В		NEW CAP REL COSTS-BLDG & FIXT	1.00		33. 2	
33. 22 WIT OPERATING ROOM PURCHASING DISCOU	В		OPERATING ROOM	50.00		33.22	
33. 23 WI T PHARMACY LB PURCHASI NG DI SCOUNTS	В		PHARMACY	15.00	C		
 33. 24 WI T CENTRAL SUPPLY PURCHASING DI SCOU 33. 25 WI T ENVI RONMENTAL SERVIC 	B		MEDI CAL SUPPLI ES CHARGED TO PATI ENTS HOUSEKEEPI NG	71.00 9.00	c		
PURCHASI NG 33. 26 WIT FINANCE MATERIALS MG	В		ADMI NI STRATI VE & GENERAL	5.00	C		
PURCHASI NG 33. 27 WI T CARDI AC CATHETERI ZAT	В		CARDI AC CATHETERI ZATI ON	59.00	C		
PURCHASING 3.28 WIT FINANCE MATERIALS MG	В	-6, 476	ADMI NI STRATI VE & GENERAL	5.00	C	33.2	
PURCHASING VOL VOLUNTEERS VOLUNTEER MISC	В	-1, 413	ADMI NI STRATI VE & GENERAL	5.00	C	33.3	
3.31 REV WIT DERMATOLOGY CLINIC RENTAL REVENU	A	-3, 035	DERMATOLOGY CLINIC	90. 03	C	33.3	
13. 32 WIT EAR NOSE THROAT CLIN RENTAL REVE	А	-63	ENT CLINIC	90.04	C	33.32	
33. 33 WIT SURGERY CLINIC RENTAL REVENUE	A	-177	SURGERY CLINIC	90. 05	C	33.33	
33.34 WIT UROLOGY CLINIC RENTAL REVENUE	A	550	UROLOGY CLINIC	90.07	C	33.34	
33. 35 WIT GASTROENTEROLOGY CLI RENTAL REVE	A		GASTROENTEROLOGY CLINIC	90.09	C		
33. 36 WIT DIALYSIS CENTER RENTAL REVENUE	A	-105, 686	WOUND CARE	90. 14	C	33.36	

	Financial Systems		WITHAM MEMORIA		In Lie	u of Form CMS-2	
ADJUST	IUSTMENTS TO EXPENSES				Period: From 01/01/2020 To 12/31/2020		pared:
				Expense Classification or To/From Which the Amount is		8/2/2021 1:50	pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.37	WIT EYE INSTITUTE RENTAL	A	-7, 622	OPTHAMOLOGY CLINIC	90.12	0	33.37
33. 38	REVENUE WIT PO 1208 N LEBANON BL RENTAL REVE	В		NEW CAP REL COSTS-BLDG & FLXT	1.00	10	33. 38
33.39	WIT ADMIN HOSPITAL LAND LEASE REVENU	В	-20, 484	NEW CAP REL COSTS-BLDG &	1.00	10	33. 39
33.40	WIT ADMIN HOSPITAL MANAGEMENT FEE RE	В		ADMI NI STRATI VE & GENERAL	5.00	0	33. 40
33. 41	WIT ADMIN HOSPITAL OTHER OPERATING R	В	-199	ADMINISTRATIVE & GENERAL	5.00	0	33. 41
33. 42	WIT HR WELLNESS PROGRAM OTHER OPERAT	В	-49, 289	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33. 42
	WIT INSURANCE INSURANCE CLAIM PROC	В		ADMI NI STRATI VE & GENERAL	5.00	12	33. 43
	WIT HR EMPLOYEE BENEFITS EMPLOYEE DR	A		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	
	WIT ADMIN HOSPITAL GAIN(LOSS) ON INV	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	WIT ADMIN HOSPITAL INTEREST ON INVES	В		NEW CAP REL COSTS-BLDG & FIXT	1.00		33.46
	INVESTME	В	I	NEW CAP REL COSTS-BLDG & FIXT	1.00		33.47
	BCH 2015 BOND INTEREST ON INVESTME	В		NEW CAP REL COSTS-BLDG & FIXT	1.00		33.48
	BCH 2017 BOND INTEREST ON INVESTME	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18, 732, 014				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Additional environment of the second perturbation of the second perturbatio

(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	I AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider (Provider CCN: 15-0104		Worksheet A-8-2	
						To 12/31/2020) Date/Time Pre 8/2/2021 1:50	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		RADI OLOGY-DI AGNOSTI C	379, 824		(1.00
2.00		LABORATORY	100, 000		(2.00
3.00		EMERGENCY	2, 602, 200		(-	-	3.00
4.00	0.00		0	0	(4.00
5.00	0.00		0	0		0	0	5.00
6.00	0.00		0	0	(°	0	6.00
7.00	0.00		0	0	(0	0	7.00
8.00	0.00		0	0	(0	8.00
9.00	0.00		0	0	(0	9.00
10.00	0.00		2 002 024	0	(° °	0	10.00
200.00	Wkst. A Line #	Cost Center/Physician	3, 082, 024 Unadj usted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSL A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		ruenti i rei		Limit	Continuing	Share of col.		
					Education	12	Thou ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		RADI OLOGY-DI AGNOSTI C	0	0	(1.00
2.00	60.00	LABORATORY	0	0	(0 0	0	2.00
3.00	91.00	EMERGENCY	0	0	(o o	0	3.00
4.00	0.00		0	0	(0 0	0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(-	0	
200.00			0	0	(00	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00	-	
1.00		RADI OLOGY-DI AGNOSTI C	13.00	0	17.00			1.00
2.00		LABORATORY	0	-	(2.00
3.00		EMERGENCY	0	0	(3.00
4.00	0.00		0	0	(4.00
5.00	0.00		0	0	(5.00
6.00	0.00		0	0	(0		6.00
7.00	0.00		0	0	(0		7.00
8.00	0.00		0	0	(0 0		8.00
9.00	0.00		0	0	(0 0		9.00
10.00	0.00		0	0	(0 0		10.00
200.00			0	0	(3, 082, 024		200.00

Heal th	Financial Systems	WI THAM MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre	pared:
			CAPITAL RELATED COSTS			8/2/2021 1:50 pm	
Cost Center Description		Net Expenses for Cost Allocation	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		(from Wkst A col. 7)					
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	4, 185, 702	4, 185, 702				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	5, 105, 187		5, 105, 187			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	10, 899, 217 14, 435, 646	8, 724 278, 804	10, 640 340, 050		16, 288, 201	4.00 5.00
7.00	00700 OPERATION OF PLANT	3, 127, 406	365, 263	445, 502		4, 046, 310	•
8.00	00800 LAUNDRY & LINEN SERVICE	610, 168	0	0	-,	615, 619	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	950, 636 896, 553	42, 060 94, 149	51, 300 114, 831		1, 126, 331 1, 198, 818	
11.00	01100 CAFETERI A	857, 726	94, 149	031		914, 935	
13.00	01300 NURSING ADMINISTRATION	689, 862	0	0		786, 953	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 498, 476 1, 728, 438	29, 065 45, 913	35, 449 55, 998		1, 670, 574 2, 059, 500	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,720,430	43, 713	33, 770	227,101	2,037,300	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 546, 846	305, 380	372, 464			
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	2, 411, 577 986, 559	83, 866 96, 022	102, 289 117, 116		2, 913, 560 1, 335, 015	
41.00	04100 SUBPROVI DER – I RF	900, 339	90, 022 0	0	0	1, 333, 013	40.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	56, 752 1, 249, 273	0 72, 714	0 88, 687	0 162, 027	56, 752 1, 572, 701	1
44.00	ANCI LLARY SERVICE COST CENTERS	1, 247, 273	72,714	00,007	102, 027	1, 372, 701	44.00
50.00	05000 OPERATING ROOM	3, 763, 977	243, 729	297, 269		4, 731, 509	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	4, 724, 742 0	298, 080 0	363, 561 0		5, 640, 827 0	54.00 55.00
55.00	05501 ULTRA SOUND	640, 972	0	0	-	708, 803	•
57.00	05700 CT SCAN	921, 059	0	0	31, 032	952, 091	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	1,032,622	25, 572	31, 189		1, 146, 636	
60.00	06000 LABORATORY	1, 451, 122 8, 118, 442	21, 555 139, 012	26, 290 169, 549		1, 567, 470 8, 939, 483	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	182, 144	0	0	0	182, 144	63.00
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0 1, 798, 646	0 134, 545	0 164, 101	-	0 2, 340, 927	64.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	551, 339	134, 545	04, 101	74, 669	626, 008	•
67.01	06701 AUDI OLOGY	173, 183	0	0		206, 408	•
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	201, 017 0	0	0	25, 942 0	226, 959 0	68.00 69.00
69.00	06901 CARDI OLOGY	1, 686, 443	13, 865	16, 911	-	1, 925, 698	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 630, 139	0	0	Ű	2, 630, 147	
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	3, 838, 343 7, 263, 502	0	0		3, 838, 343 7, 263, 502	
73.00	OUTPATIENT SERVICE COST CENTERS	7,203,302	0	0	0	7,203,302	73.00
90.00	09000 CLINIC	0	0	0		0	90.00
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	220, 980	57, 290 0	69, 875	22, 478	370, 623 0	90.01 90.02
90.02 90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	1
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0	0	0	0	90.05 90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	658	658	
90.11	09011 NEUROLOGY CLINIC	7, 129	0	0	0	7, 129	90.11
90. 12 90. 13	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	0 100, 002	0	0	0 11, 065	0 111, 067	90.12 90.13
90.14	09014 WOUND CARE	576, 050	52, 523	64, 061		734, 566	•
	09100 EMERGENCY	5, 466, 214	368, 231	449, 121	404, 981	6, 688, 547	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
95.00	09500 AMBULANCE SERVI CES	2, 746, 595	71, 350	87, 023	371, 242	3, 276, 210	95.00
118.00		102, 330, 686	2, 847, 712	3, 473, 276	6, 090, 906	94, 533, 110	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9, 353	11, 408	0	20, 761	190 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	40, 679, 866	993, 473	1, 211, 712		47, 658, 111	•
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194.00
	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB	0 114, 441	21, 225 307, 943	25, 888 375, 590		47, 113 809, 082	
	07953 RETAIL PHARMACY	2, 268, 139	5, 996	7, 313		2, 324, 955	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

Health Financial Systems		WI THAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOC	ATION - GENERAL SERVICE COSTS				Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 8/2/2021 1:50 pm		
			CAPITAL RELATED 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)	145, 393, 132	4, 185, 702	5, 105, 187	10, 918, 581	145, 393, 132	202.00	

Heal th	Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2020	Worksheet B Part I	
					o 12/31/2020	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	8/2/2021 1:50 DI ETARY	pm
		E & GENERAL	PLANT	LINEN SERVICE			
	OFNEDAL OFDILLOF OOST OFNEDO	5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 288, 201	4 554 005				5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	510, 495 77, 668	4, 556, 805 0		,		7.00
9.00	00900 HOUSEKEEPI NG	142, 101	69, 562				9.00
10.00	01000 DI ETARY	151, 246	155, 709			1, 595, 057	
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	115, 431 99, 284	0	1		0	
15.00	01500 PHARMACY	210, 765	48, 069			0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	259, 833	75, 933	1		0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	705 700		00.546	450.070	0(0.001	1 00 00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	735, 793 367, 583	505, 056 138, 703			963, 321 0	1
40.00	04000 SUBPROVI DER – I PF	168, 429	158, 808			162, 638	
41.00	04100 SUBPROVI DER – I RF	0	0	C	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	-	0	1
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	7, 160 198, 417	0 120, 258	3, 327 4, 375		0 469, 098	43.00
11.00	ANCI LLARY SERVICE COST CENTERS	170, 117	120, 200	1,070		107,070	1 11.00
50.00	05000 OPERATING ROOM	596, 941	403, 093			0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	711, 664	492, 983			0	
55.00 55.01	05500 RADIOLOGY-THERAPEUTIC	0 89, 425	0			0 0	
57.00	05700 CT SCAN	120, 119	0			0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	144, 663	42, 292			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	197, 757	35, 649			0	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	1, 127, 832 22, 980	229, 907 0			0	
64.00	06400 I NTRAVENOUS THERAPY	0	0			0	1
66.00	06600 PHYSI CAL THERAPY	295, 338	222, 519			0	
67.00	06700 OCCUPATI ONAL THERAPY	78, 979	0			0	
67.01 68.00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	26, 041 28, 634	0			0	67.01 68.00
69.00	06900 ELECTROCARDI OLOGY	20,004	0			0	1
69.01	06901 CARDI OLOGY	242, 952	22, 931			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	331,827	0			0	
72.00 73.00	07200 TMPL. DEV. CHARGED TO PATTENT	484, 257 916, 385	0			0	
10100	OUTPATIENT SERVICE COST CENTERS	, 10, 000		11/2/0	. 20, 210	0	1 101 00
90.00		0	C			0	
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	46, 759 0	94, 749 0		0,,0,0	0 0	
90.02 90.03	09002 CETNIC 09003 DERMATOLOGY CLINIC	0	0			0	
90.04	09004 ENT CLINIC	0	0	C	0	0	1
90.05	09005 SURGERY CLINIC	0	0	(0	
90. 07 90. 09	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	0 83	0	185 C		0	1
90.09 90.11	09011 NEUROLOGY CLINIC	899	0			0	1
90.12	09012 OPTHAMOLOGY CLINIC	0	0	C		0	1
90.13		14, 013	0	564		0	
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	92, 675 843, 847	86, 866			0	90.14 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	043, 047	609, 002	50, 180	, 0	0	91.00
	OTHER REIMBURSABLE COST CENTERS	г – т					
95.00	09500 AMBULANCE SERVICES	413, 336	43, 631	6, 992	2 0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS D SUBTOTALS (SUM OF LINES 1 through 117)	9, 871, 611	3, 555, 720	693, 287	1, 337, 994	1, 595, 057	110 00
110.00	NONREIMBURSABLE COST CENTERS	7,071,011	3, 333, 720	073,207	1, 337, 774	1, 373, 037	1.10.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2, 619	15, 469				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 012, 628	940, 597	0	0		192.00
	07950 THORNTOWN OFFICE BUILDING 107951 CAFE/BOUTIQUE	0 5, 944	0 35, 103				194.00 194.01
	207952 OTHER NONRELIMB	102, 076	35, 103		Ó		194.01
194.03	3 07953 RETAIL PHARMACY	293, 323	9, 916		0		194.03
200.00		_	-	-		-	200.00
201.00 202.00		0 16, 288, 201	0 4, 556, 805	693, 287	0 7 1, 337, 994		201.00
202.00			1, 000, 000	1 070,207	1,007,774	1, 5, 5, 657	1-02.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	WI THAM MEMORI	AL HOSPITAL Provider CC	CN: 15-0104 Pe	In Lieu eriod: om 01/01/2020	of Form CMS-: Worksheet B Part I	2552-10
			To	12/31/2020	Date/Time Pre 8/2/2021 1:50	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
	11.00	13.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS						1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						2.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	1,060,134					10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	20, 512					13.00
15.00 01500 PHARMACY	41, 024		1, 997, 612			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	83, 127	0	0	2, 537, 929		16.00
30. 00 03000 ADULTS & PEDIATRICS	279, 606	194, 294	231	623, 676	9, 624, 855	30.00
31.00 03100 INTENSIVE CARE UNIT	22, 671	86, 779	14	129, 675	3, 792, 538	
40.00 04000 SUBPROVIDER - IPF	35, 626		22	154, 375	2, 212, 857	40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	67, 239	
44.00 04400 SKILLED NURSING FACILITY	0	64, 335	30	0	2, 429, 214	•
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	24, 830	144 205	E 404	223, 844	6, 244, 011	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	30, 228		5, 494 5, 295	598, 976	7, 676, 759	50.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
55. 01 05501 ULTRA SOUND	3, 239		423	64, 838	889, 236	•
57.00 05700 CT_SCAN 58.00 05800 MAGNETI C_RESONANCE_I MAGI NG_(MRI)	4, 318 10, 796		8, 983 5, 311	74, 100 40, 138	1, 254, 597 1, 430, 690	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0,790		0, 311	40, 138	1, 862, 385	•
60. 00 06000 LABORATORY	88, 524	0	11	61, 750	10, 609, 690	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	207, 114	
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 44, 262	0 65, 884	601 0	0 120, 413	6, 677 3, 119, 737	
67. 00 06700 OCCUPATI ONAL THERAPY	18, 353		0	52, 488	813, 645	•
67. 01 06701 AUDI OLOGY	19, 432		0	0	271, 959	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	20, 512		0	0	291, 836 0	68.00 69.00
69. 01 06901 CARDI OLOGY	44, 262	-	935	115, 781	2, 485, 383	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 671	0	0	0	3, 000, 617	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0		0	0	4, 344, 791	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	8, 252, 315	73.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	36, 705	3, 718	5	259, 350	881, 282	
90. 02 09002 CLINIC 90. 03 09003 DERMATOLOGY CLINIC	0	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	0	0	0	185	•
90. 11 09011 NEUROLOGY CLINIC	0	7, 221	2, 025	0	7, 962 10, 053	•
90. 12 09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	
90. 13 09013 ALLERGY CLINIC	0	3, 536	0	0	129, 180	•
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	69, 092	14, 753 101, 474	4, 603 687, 686	0	942, 856 9, 049, 828	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	07,072	101, 171	007,000	Ű	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	92.00
OTHER REIMBURSABLE COST CENTERS		-		-		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	140, 344	0	3, 433	0	3, 883, 946	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1,060,134	889, 246	725, 102	2, 519, 404	85, 793, 437	118.00
NONREI MBURSABLE COST CENTERS]
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0		0 737, 376	0 18, 525	38, 849 55, 394, 739	190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 194. 00 07950 THORNTOWN OFFICE BUILDING	0	27, 502	131, 370	10, 525		192.00
194. 01 07951 CAFE/BOUTI QUE	0	o o	0	o	88, 160	194.01
194. 02 07952 OTHER NONREI MB	0	3, 461	0	0	914, 619	
194.03 07953 RETAIL_PHARMACY 200.00 Cross Foot_Adjustments	0	0	535, 134	0	3, 163, 328 0	194.03 200.00
201.00 Negative Cost Centers	0	о	0	о		200.00
202.00 TOTAL (sum lines 118 through 201)	1, 060, 134	920, 209	1, 997, 612	2, 537, 929	145, 393, 132	202.00

Health Financial Systems	WITHAM MEMORIAL		In Lieu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0104	Period: Worksheet B From 01/01/2020 Part I	
			To 12/31/2020 Date/Time Prep 8/2/2021 1:50	pared:
Cost Center Description	Intern &	Total	0/2/2021 1.30	pin
	Residents			
	Cost & Post Stepdown			
	Adjustments			
	25.00	26.00		
1. 00 OO100 NEW CAP REL COSTS-BLDG & FLXT				1 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 ADMI NI STRATI VE & GENERAL				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 9.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
15. 00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY				16.00
30. 00 03000 ADULTS & PEDIATRICS	0	9, 624, 855		30.00
31.00 03100 I NTENSI VE CARE UNI T	0	3, 792, 538		31.00
40. 00 04000 SUBPROVI DER – I PF	0	2, 212, 857		40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0		42.00 43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	67, 239 2, 429, 214		43.00
ANCI LLARY SERVICE COST CENTERS		2, 127, 211		11.00
50. 00 05000 OPERATI NG ROOM	0	6, 244, 011		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 676, 759		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 ULTRA_SOUND	0	0 889, 236		55.00
57. 00 05700 CT_SCAN	0	1, 254, 597		55.01 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 430, 690		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 862, 385		59.00
	0	10, 609, 690		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	207, 114 6, 677		63.00 64.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 119, 737		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	813, 645		67.00
67. 01 06701 AUDI OLOGY	0	271, 959		67.01
68. 00 06800 SPEECH PATHOLOGY	0	291, 836		68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI OLOGY	0	0 2, 485, 383		69.00 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 000, 617		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 344, 791		72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	8, 252, 315		73.00
90. 00 09000 CLINIC	0	0		90.00
90. 01 09000 OTHER OUTPATIENT SERVICE COST CENTER	0	881, 282		90.00
90. 02 09002 CLI NI C	0	0		90.02
90. 03 09003 DERMATOLOGY CLINIC	0	0		90.03
90. 04 09004 ENT CLINIC	0	0		90.04
90. 05 09005 SURGERY CLINIC 90. 07 09007 UROLOGY CLINIC	0	185		90.05 90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	7, 962		90.07
90. 11 09011 NEUROLOGY CLINIC	Ő	10, 053		90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0	0		90.12
90. 13 09013 ALLERGY CLINIC	0	129, 180		90.13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0	942, 856 9, 049, 828		90.14 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	, 07, 020		91.00
OTHER REIMBURSABLE COST CENTERS	-			
95.00 09500 AMBULANCE SERVICES	0	3, 883, 946		95.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	85, 793, 437		118.00
NONREI MBURSABLE COST CENTERS		20 010		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	38, 849 55, 394, 739		190.00 192.00
194. 00 07950 THORNTOWN OFFICE BUILDING	0	0		194.00
194. 01 07951 CAFE/BOUTI QUE	0	88, 160		194.01
194. 02 07952 OTHER NONREI MB	0	914, 619		194.02
194. 03 07953 RETAIL PHARMACY	0	3, 163, 328		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		200.00 201.00
202.00 TOTAL (sum lines 118 through 201)	0	145, 393, 132		201.00
202.00 IVIAL (Sum LINES ITS Enrough 201)	ן טן	140, 393, 132	I	∠U.

Heal th	Financial Systems	WI THAM MEMORI	AL_HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CO	F	eriod: rom 01/01/2020 o 12/31/2020		pared:
			CAPI TAL REL	ATED COSTS		8/2/2021 1:50	pm
	Cost 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	
	GENERAL SERVICE COST CENTERS	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	0	8, 724	10, 640	19, 364	19, 364	
5.00	00500 ADMI NI STRATI VE & GENERAL	0	278, 804	340, 050		2, 185	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	365, 263 0	445, 502 C		192 10	
9.00	00900 HOUSEKEEPI NG	0	42, 060	51, 300	93, 360	146	
10.00		0	94, 149 0	114, 831	208, 980	165	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	0		0	101 172	11.00 13.00
15.00	01500 PHARMACY	0	29, 065	35, 449		191	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	45, 913	55, 998	101, 911	406	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	305, 380	372, 464	677, 844	1,076	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	83, 866	102, 289	186, 155	559	31.00
40.00	04000 SUBPROVIDER - IPF	0	96, 022	117, 116	213, 138	240	1
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0		0	0	41.00
43.00	04300 NURSERY	0	0	C	0	0	43.00
44.00		0	72, 714	88, 687	161, 401	287	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	243, 729	297, 269	540, 998	755	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	298, 080	363, 561		451	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	
55.01 57.00	05501 ULTRA SOUND 05700 CT SCAN	0	0		0	120 55	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	25, 572	31, 189	56, 761	101	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	21, 555	26, 290		121	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	139, 012 0	169, 549 C		908 0	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0	134, 545	164, 101		431	
67.00 67.01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	0	0		0	132 59	•
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	46	
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	0	13, 865 0	16, 911	30, 776 0	369 0	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	C	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	57, 290	69, 875	-	40	1
90.02		0	0	C	0	0	90.02
90. 03 90. 04	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	0		0	0	90.03 90.04
90.05	09005 SURGERY CLINIC	0	0	C	0	0	90.05
	09007 UROLOGY CLINIC	0	0	C	0	0	90.07
90. 09 90. 11	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	0	0		0	1	90.09 90.11
	09012 OPTHAMOLOGY CLINIC	0	0	C	Ő	0	90.12
90.13	09013 ALLERGY CLINIC	0		C	0	20	90.13
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	0	52, 523 368, 231	64, 061 449, 121		74 717	90.14 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			,	0		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	71, 350	87, 023	158, 373	657	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0				10 797	118.00
	NONREIMBURSABLE COST CENTERS		2,047,712	3,4/3,2/0	0, 320, 988	10, 787	110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9, 353	11, 408			190.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 THORNTOWN OFFICE BUILDING	0	993, 473 0	1, 211, 712	2, 205, 185		192.00 194.00
	107951 CAFE/BOUTI QUE	0	21, 225	25, 888	47, 113		194.00
194.02	207952 OTHER NONREI MB	0	307, 943	375, 590	683, 533	20	194.02
194.03 200.00	307953 RETAIL PHARMACY Cross Foot Adjustments	0	5, 996	7, 313	13, 309		194.03 200.00
200.00			0	c	0		200.00
202.00		0	4, 185, 702	5, 105, 187	9, 290, 889		202.00

Heal th	Financial Systems	WI THAM MEMORI	ΑΙ ΗΩSPITAI		Inlie	u of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS		Provi der C		eriod:	Worksheet B Part II	
				T	rom 01/01/2020 0 12/31/2020	Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	8/2/2021 1:50 DI ETARY	pm
		E & GENERAL	PLANT	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	621, 039					4.00 5.00
7.00	00700 OPERATION OF PLANT	19, 463	830, 420				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2, 961 5, 418	0 12, 677	_,	111, 601		8.00 9.00
10.00	01000 DI ETARY	5, 766	28, 376	1	7, 447	250, 734	10.00
11.00		4,401	0		2,483	0	11.00
13.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY	3, 785 8, 035	0 8, 760	-	1, 123 2, 267	0	13.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	9, 906	13, 838	1	4, 966	0	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	28, 052	92,040	170	37, 725	151, 428	30.00
30.00	03100 I NTENSI VE CARE UNI T	14, 014	92, 040 25, 277		10, 018	151, 420	30.00
40.00	04000 SUBPROVI DER – I PF	6, 421	28, 941		11, 913	25, 566	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	-	0	0	41.00 42.00
43.00	04300 NURSERY	273	0	15	0	0	43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	7, 565	21, 916	19	0	73, 740	44.00
50.00	ANCI LLARY SERVI CE COST CENTERS	22, 759	73, 459	376	2, 224	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 132	89, 840	255	10, 061	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	-	0	0	55.00 55.01
55.01 57.00	05501 ULTRA SOUND 05700 CT SCAN	3, 409 4, 580	0		648 993	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 515	7, 707		950	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	7, 540 42, 999	6, 497 41, 898		0 4, 253	0	59.00 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	42, 999	41, 898	1	4, 200	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	= -	0	0	64.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	11, 260 3, 011	40, 551 0		1, 533 734	0	66.00 67.00
67.01	06701 AUDI OLOGY	993	0		540	0	67.01
68.00	06800 SPEECH PATHOLOGY	1, 092	0	7	324	0	68.00
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	0 9, 263	0 4, 179		0 3, 260	0	69.00 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 651	0	70	0	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	18, 462 34, 937	0		0 2, 353	0	72.00 73.00
73.00	OUTPATIENT SERVICE COST CENTERS	34, 937	0	195	2, 303	0	73.00
	09000 CLINIC	0	0	-	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	1, 783 0	17, 267 0		5, 786 0	0	90.01 90.02
90.03	09003 DERMATOLOGY CLINIC	0	0		0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0	1	0	0	90. 05 90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	3	0	0	0	0	90.09
90. 11 90. 12	09011 NEUROLOGY CLINIC	34	0	0	0	0	90. 11 90. 12
90. 12 90. 13	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	534	0	2	0	0	90.12 90.13
90.14	09014 WOUND CARE	3, 533	15, 830		0	0	90.14
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	32, 172	110, 983	221	0	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	15, 759	7, 951	31	0	0	95.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	376, 357	647, 987	2, 971	111, 601	250, 734	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	100 229, 280	2, 819 171, 410		0		190.00 192.00
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		192.00 194.00
		227	6, 397	0	0		194.01
	2 07952 OTHER NONREI MB 3 07953 RETAIL PHARMACY	3, 892 11, 183	0 1, 807		0		194.02 194.03
200.00	Cross Foot Adjustments	,	., 507		U.		200. 00
201.00 202.00		0 621, 039	0 830, 420	0 2, 971	0 111, 601	0 250, 734	201.00
202.00		1 021,039	030, 420	2,7/1	111,001	200,734	202.00

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2020	Worksheet B	
					To 12/31/2020	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	8/2/2021 1:50 Subtotal	
			ADMI NI STRATI O N		RECORDS & LI BRARY		
		11.00	13.00	15.00	16.00	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	[1	[1		1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00 5.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A	6, 985					11.00
13.00 15.00	01300 NURSING ADMINISTRATION 01500 PHARMACY	135 270			7		13.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	548			131, 575		16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 042	1 100	1(22.222	1 022 421	30,00
30.00	03100 INTENSIVE CARE UNIT	1, 843 149				1, 023, 621 243, 447	31.00
40.00	04000 SUBPROVI DER - I PF	235				294, 767	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0				0	41.00
43.00	04300 NURSERY	0	0		0 0	288	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	365		1 0	265, 294	44.00
50.00	05000 OPERATING ROOM	164	829	23	1 11, 605	653, 400	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	199				820, 958	54.00
55.00 55.01	05500 RADI OLOGY-THERAPEUTI C 05501 ULTRA SOUND	21	0	18	,	0 7,642	55.00 55.01
57.00	05700 CT SCAN	28				10, 242	•
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	71	0		3 2,081 0 0	73, 539 62, 299	•
60.00	06000 LABORATORY	583	0		3, 201	402, 809	60.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0 5 0	885 52	63.00 64.00
66.00	06600 PHYSI CAL THERAPY	292			6, 243	359, 382	
67.00	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	121			2,721 0 0	6, 876	•
67.01 68.00	06800 SPEECH PATHOLOGY	128 135			0 0 0 0	1, 796 1, 662	•
69.00	06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
69. 01 71. 00	06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	292 149			9 6,003 0 0	54, 676 12, 870	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	18, 560	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	(0 0	37, 485	73.00
90.00	09000 CLINIC	0	0	(0 0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	242			13, 446	165, 750	
90. 02 90. 03	09002 CLINIC 09003 DERMATOLOGY CLINIC	0				0	90.02 90.03
90.04	09004 ENT CLINIC	0			0 0	0	90.04
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0			0	90.05 90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	41	(0 0	45	90.09
90. 11 90. 12	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC	0	0			119 0	•
	09012 OPTHAMOLOGY CLINIC	0	20			576	
	09014 WOUND CARE	0		194		136, 340	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	455	575	28, 93	0	991, 406	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS		-		-		
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	925	0	144	4 0	183, 840	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 985	5, 039	30, 504	130, 615	5, 830, 627	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	23 680	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	156	31, 020		2, 646, 491	192.00
	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	0	0				194.00 194.01
	07951 CAFE/ BOUTI QUE 07952 OTHER NONREI MB	0	20			53, 737 687, 465	•
194.03	07953 RETAIL PHARMACY	0	0		3 0	48, 889	194.03
200.00 201.00		0	0		0 0		200.00 201.00
202.00		6, 985	5, 215	84, 03	131, 575		

Health Financial Systems	WI THAM MEMORI A	AL_HOSPITAL	In Lieu of	Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0104 Period: Wor From 01/01/2020 Par	ksheet B t II
			To 12/31/2020 Dat	e/Time Prepared: /2021 1:50 pm
Cost Center Description	Intern &	Total	0/2	72021 1.30 pill
	Residents Cost & Post			
	Stepdown			
	Adjustments		-	
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL				4.00
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
11. 00 01100 CAFETERIA				10.00
13.00 01300 NURSING ADMINISTRATION				13.00
15.00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY I NPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS				16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	1,023,621		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	243, 447		31.00
40. 00 04000 SUBPROVIDER - IPF	0	294, 767		40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	0		41.00
43. 00 04300 NURSERY	0	288		43.00
44.00 04400 SKILLED NURSING FACILITY	0	265, 294		44.00
ANCI LLARY SERVI CE COST CENTERS	0	653, 400		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	820, 958		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
55. 01 05501 ULTRA SOUND	0	7,642		55.01
57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0	10, 242 73, 539		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	62, 299		59.00
60. 00 06000 LABORATORY	0	402, 809		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	885	•	63.00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	52 359, 382		64.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 876		67.00
67. 01 06701 AUDI OLOGY	0	1, 796	1	67.01
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	1, 662 0		68.00 69.00
69. 01 06901 CARDI OLOGY	0	54,676		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 870		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	18, 560		72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	37, 485		73.00
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	165, 750		90.01
90. 02 09002 CLI NI C 90. 03 09003 DERMATOLOGY CLI NI C	0	0		90. 02 90. 03
90. 04 09004 ENT CLINIC	0	0		90.03
90. 05 09005 SURGERY CLINIC	0	0		90.05
90. 07 09007 UROLOGY CLINIC	0	1		90.07
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC	0	45 119		90. 09 90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0	0		90.12
90. 13 09013 ALLERGY CLINIC	0	576	1	90. 13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0	136, 340 991, 406		90. 14 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	771,400		92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0	183, 840		95.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 830, 627		118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	0	23, 680		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 646, 491		192.00
194. 00 07950 THORNTOWN OFFICE BUILDING	0	0		194.00
194. 01 07951 CAFE/BOUTI QUE 194. 02 07952 OTHER NONREI MB	0	53, 737 687, 465		194.01 194.02
194. 03 07953 RETALL PHARMACY	0	48, 889		194.02
200.00 Cross Foot Adjustments	0	0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	0 9, 290, 889		201.00 202.00
	, O	7, 270, 009	1	1202.00

ST AL	Financial Systems LOCATION - STATISTICAL BASIS	WITHAM MEMORIA	Provider CC		Period:	u of Form CMS-2 Worksheet B-1	
	· · · · ·			F	From 01/01/2020		
					12, 01, 2020	8/2/2021 1:50	
		CAPI TAL REL	ATED CUSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio		
		FI XT (SQUARE	EQUI P (SQUARE	BENEFI TS DEPARTMENT	n	E & GENERAL (ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		,		SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
_	ENERAL SERVICE COST CENTERS	279, 243					1.0
	00200 NEW CAP REL COSTS-MVBLE EQUIP	2777210	279, 243				2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	582	582	70, 827, 203			4.0
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	18,600	18,600	8,002,832		129, 104, 931	5. C
	0800 LAUNDRY & LINEN SERVICE	24, 368 0	24, 368 0	701, 484 35, 360		4, 046, 310 615, 619	
	00900 HOUSEKEEPI NG	2, 806	2, 806	534, 093		1, 126, 331	9.0
	1000 DI ETARY	6, 281	6, 281	605, 124		1, 198, 818	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	0	371, 105 629, 812		914, 935	
	1500 PHARMACY	1, 939	1, 939	697, 882		786, 953 1, 670, 574	
	1600 MEDICAL RECORDS & LIBRARY	3, 063	3, 063	1, 486, 466		2, 059, 500	
-	NPATIENT ROUTINE SERVICE COST CENTERS				-	E 005 50	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	20, 373 5, 595	20, 373 5, 595	3, 940, 085 2, 048, 730		5, 832, 086 2, 913, 560	
	04000 SUBPROVI DER – I PF	6, 406	6, 406	877, 789		1, 335, 015	
	04100 SUBPROVI DER – I RF	0	0	(0	41.0
	4200 SUBPROVI DER	0	0	(0	0	
	04300 NURSERY 04400 SKILLED NURSING FACILITY	0 4, 851	0 4, 851	(1, 051, 044	0	56, 752	
	NCILLARY SERVICE COST CENTERS	4, 001	4, 651	1, 051, 044	+ 0	1, 572, 701	44.0
. oo 🖸	5000 OPERATING ROOM	16, 260	16, 260	2, 766, 862	2 0	4, 731, 509	50.0
	5400 RADI OLOGY-DI AGNOSTI C	19, 886	19, 886	1, 650, 539		5, 640, 827	
	95500 RADI OLOGY-THERAPEUTI C 95501 ULTRA SOUND	0	0	(440, 007	-	0 708, 803	55.0 55.0
	05700 CT SCAN	0	0	201, 297		952,091	57.0
	55800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706	371, 389		1, 146, 636	
	05900 CARDI AC CATHETERI ZATI ON	1, 438	1, 438	444, 371		1, 567, 470	
)6000 LABORATORY)6300 BLOOD STORI NG, PROCESSI NG & TRANS.	9, 274 0	9, 274 0	3, 324, 382 (8, 939, 483 182, 144	
	6400 I NTRAVENOUS THERAPY	0	0	(0	
	06600 PHYSI CAL THERAPY	8, 976	8, 976	1, 580, 425		2, 340, 927	
	06700 OCCUPATIONAL THERAPY	0	0	484, 364		626,008	
	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	0	0	215, 523 168, 285		206, 408 226, 959	
	6900 ELECTROCARDI OLOGY	0	0	(00,200	0 0	0	69.0
	06901 CARDI OLOGY	925	925	1, 352, 375		1, 925, 698	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	52		2, 630, 147	
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	(3, 838, 343 7, 263, 502	
0	UTPATIENT SERVICE COST CENTERS					.,	1
	99000 CLINIC	0	0	(0	
	09001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822	145, 813	3 0	370, 623 0	90. 90.
	09003 DERMATOLOGY CLINIC	0	0	(0	90. 90.
	99004 ENT CLINIC	0	0	(0	0	90.
	99005 SURGERY CLINIC	0	0	(0 0	0	90.
		0	0	(0	0	90.
	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	0	0	4, 268		658 7, 129	
	09012 OPTHAMOLOGY CLINIC	0	0	(0 0	0	90.
13 0	99013 ALLERGY CLINIC	0	0	71, 778		111, 067	90. ⁻
	09014 WOUND CARE	3, 504	3, 504	272,006		734, 566	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 566	24, 566	2, 627, 053		6, 688, 547	91. 92.
-	THER REIMBURSABLE COST CENTERS						, 2.
00 0	9500 AMBULANCE SERVI CES	4, 760	4, 760	2, 408, 193	3 0	3, 276, 210	95.0
S. 00	SUBTOTALS (SUM OF LINES 1 through 117)	189, 981	189, 981	39, 510, 788	3 -16, 288, 201	78, 244, 909	118. (
N	ONREI MBURSABLE COST CENTERS				2, 230, 201		
	9000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	(0 0	20, 761	
	9200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	66, 278	66, 278	30, 962, 139	0	47, 658, 111	
	17950 THORNTOWN OFFICE BUILDING 17951 CAFE/BOUTIQUE	1, 416	0 1, 416	(47, 113	194. (194. (
	07952 OTHER NONRELMB	20, 544	20, 544	72, 055	5 0	809, 082	
+. UZIU			400	282, 221		2, 324, 955	
4. 03 0	07953 RETAIL PHARMACY	400	400	202, 22		2, 324, 733	
	7953 RETAIL PHARMACY Cross Foot Adjustments Negative Cost Centers	400	400	202, 22			200. (201. (

Health Fi	nancial Systems	WITHAM MEMORIA	AL HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 185, 702	5, 105, 187	10, 918, 58	1	16, 288, 201	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14. 989461	18. 282238	0. 15415	3	0. 126163	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			19, 36	4	621, 039	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.00027	3	0. 004810	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 HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2020	Worksheet B-1	
			Te		Date/Time Pre 8/2/2021 1:50	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
	PLANT (SQUARE	LINEN SERVICE (GROSS	(HOURS OF SERVICE)	(MEALS SERVED)	(MEALS SERVED)	
	FEET)	CHARGES)		,		
GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	183, 813					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	0 2, 806	381, 815, 298 0	129, 223			8.00 9.00
10. 00 01000 DI ETARY	6, 281	0	8, 623	41, 201		10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	0	2, 875 1, 300	0	982 19	11.00 13.00
15. 00 01500 PHARMACY	1, 939	0	2, 625	0	38	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 063	0	5, 750	0	77	16.00
30. 00 03000 ADULTS & PEDIATRICS	20, 373		43, 681	24, 883	259	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	5, 595 6, 406		11, 600 13, 794	0 4, 201	21 33	31.00 40.00
41. 00 04100 SUBPROVI DER - I RF	0,400	0	0	4, 201	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0	0	0	0	42.00 43.00
44.00 04400 SKILLED NURSING FACILITY	4, 851	1, 831, 818 2, 409, 282	0	12, 117	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1(2(0	47 044 440	0.575			
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 260 19, 886			0	23 28	50.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55.00
55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN	0	8, 117, 740 45, 748, 168		0	3	55.01 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	16, 224, 511	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	1, 095, 920	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 8, 976	3, 345, 949		0 0	0	64.00 66.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0,970	6, 616, 141 3, 165, 281	1, 775 850	0	41 17	67.00
67. 01 06701 AUDI OLOGY	0	714, 269		0	18	67.01
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	840, 897 0	375	0	19 0	68.00 69.00
69. 01 06901 CARDI OLOGY	925	15, 724, 680	3, 775	0	41	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 795, 355 12, 219, 567	0	0	21 0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	24, 346, 119		0	0	
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	0	6, 700	О	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	101, 957 0	0	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	0 310, 424	0	0	0	90.12 90.13
90. 14 09014 WOUND CARE	3, 504	5, 172, 180	0	Ő	0	90.14
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	24, 566	27, 632, 063	0	0	64	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 760	3, 850, 418	0	0	130	95.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	143, 431	381, 815, 298	129, 223	41, 201	982	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624		0	0		190.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 THORNTOWN OFFICE BUILDING	37, 942	0	0	0		192.00 194.00
194. 01 07951 CAFE/BOUTI QUE	1, 416	0	0	Ő	0	194.01
194. 02 07952 0THER_NONREIMB 194. 03 07953 RETAIL_PHARMACY	0 400	0	0	0		194.02 194.03
200.00 Cross Foot Adjustments				0	0	200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	4, 556, 805	693, 287	1, 337, 994	1, 595, 057	1, 060, 134	201.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	24. 790439	0. 001816	10. 354147	38. 714036	1, 079. 566191	203.00

Heal th	inancial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G 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, Part II)	830, 420	2, 971	111, 60	250, 734	6, 985	204.00
205.00	Unit cost multiplier (Wkst. B, Part	4. 517744	0. 000008	0. 86363	6. 085629	7. 113035	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	WITHAM MEMORIA	L HOSPITAL Provider CC	N· 15-0104	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
0001 /				F	From 01/01/2020	
			DUADMA OV		12/31/2020	8/2/2021 1:50 pm
	Cost Center Description	NURSI NG ADMI NI STRATI O	PHARMACY (COSTED	MEDI CAL RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DI RECT		(TIME		
		NRSING HRS) 13.00	15.00	SPENT) 16.00	_	
	GENERAL SERVICE COST CENTERS	13.00	13.00	10.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					4.00 5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	490, 747				11.00
	01500 PHARMACY	470,747	7,034,265			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	41, 100	D	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	103, 616	815	10, 100		30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	46, 279 27, 626	48 77	2, 100 2, 500		31.00 40.00
	04100 SUBPROVI DER – I RF	0	0	2, 500		40.00
42.00	04200 SUBPROVI DER	0	0	(42.00
	04300 NURSERY	0	0	(-	43.00
44.00	04400 SKILLED NURSING FACILITY	34, 310	104	()	44.00
50.00	ANCILLARY SERVICE COST CENTERS	77, 971	19, 346	3, 625	5	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 692	18, 645	9, 700		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	()	55.00
	05501 ULTRA SOUND	0	1, 489	1,050		55.01
	05700 CT SCAN	0	31, 632	1, 200		57.00
	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	10, 661	18, 702 0	650		58.00 59.00
	06000 LABORATORY	0	39	1,000	-	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	()	63.00
	06400 I NTRAVENOUS THERAPY	0	2, 117	(64.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	35, 136 12, 409	0	1, 950 850		66.00 67.00
	06701 AUDI OLOGY	6, 565	0	(67.01
	06800 SPEECH PATHOLOGY	5, 504	0	(68.00
	06900 ELECTROCARDI OLOGY	0	0	(-	69.00
	06901 CARDI OLOGY	34, 761	3, 293	1, 875		69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(-	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
	OUTPATIENT SERVICE COST CENTERS				1	
90.00		0	0	(-	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	1, 983	16	4, 200		90.01 90.02
	09003 DERMATOLOGY CLINIC	0	0	(90.03
	09004 ENT CLINIC	0	0	()	90.04
	09005 SURGERY CLINIC	0	0	()	90.05
	09007 UROLOGY CLINIC	2 951	0	()	90.07
	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	3, 851	7, 129	(90. 09 90. 11
	09012 OPTHAMOLOGY CLINIC	0	, , , , , , , , , , , , , , , , , , , ,	(þ	90.12
90.13	09013 ALLERGY CLINIC	1, 886	0	(D	90.13
	09014 WOUND CARE	7, 868	16, 209	(90.14
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	54, 116	2, 421, 576	(ו	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS					92.00
95.00	09500 AMBULANCE SERVICES	0	12, 090	()	95.00
	SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	474, 234	2, 553, 327	40, 800)	118.00
190, 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	ol	(190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	14, 667	2, 596, 551	300		192.00
	07950 THORNTOWN OFFICE BUILDING	0	0	(D	194.00
		0	0	(194.01
	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	1, 846	0 1, 884, 387	(194.02 194.03
200.00			1, 004, 387	C		200.00
201.00						201.00
202.00	Cost to be allocated (per Wkst. B,	920, 209	1, 997, 612	2, 537, 929	2	202.00
	Part I)	1			1	

Health Fir	ancial Systems	WI THAM MEMORIA	AL HOSPITAL		In Lieu	u of Form CMS-2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2020	Worksheet B-1
					To 12/31/2020	Date/Time Prepared: 8/2/2021 1:50 pm
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	(COSTED	RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DI RECT		(TIME		
		NRSING HRS)		SPENT)		
		13.00	15.00	16.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	1.875119	0. 283983	61.75009	7	203.00
204.00	Cost to be allocated (per Wkst. B,	5, 215	84, 037	131, 57	5	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 010627	0. 011947	3. 20133	8	205.00
206.00	NAHE adjustment amount to be allocated					206.00
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D,					207.00
	Parts III and IV)					

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod
				10 12/31/2020	8/2/2021 1:50	pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	9, 624, 855		9, 624, 85	5 0	9, 624, 855	30.00
31. 00 03100 I NTENSI VE CARE UNI T	3, 792, 538		3, 792, 53		3, 792, 538	
40. 00 04000 SUBPROVIDER - IPF	2, 212, 857		2, 212, 85	7 0	2, 212, 857	1
41.00 04100 SUBPROVIDER – IRF	0			0 C	0	41.00
42. 00 04200 SUBPROVI DER	0			0 C	0	42.00
43.00 04300 NURSERY	67, 239		67,23		67, 239	43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY	2, 429, 214		2, 429, 21	4 0	2, 429, 214	44.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	6, 244, 011		6, 244, 01		6, 244, 011	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 676, 759		7, 676, 75		7, 676, 759	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	
55. 01 05501 ULTRA SOUND	889, 236 1, 254, 597		889, 23		889, 236	1
57.00 05700 CT SCAN			1, 254, 59		1, 254, 597	1
58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON	1, 430, 690 1, 862, 385		1, 430, 69		1, 430, 690 1, 862, 385	
60. 00 06000 LABORATORY	10, 609, 690		1, 862, 38 10, 609, 69		10, 609, 690	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	207, 114		207, 11		207, 114	
64. 00 06400 I NTRAVENOUS THERAPY	6, 677		6, 67		6, 677	
66. 00 06600 PHYSI CAL THERAPY	3, 119, 737	0			3, 119, 737	1
67. 00 06700 OCCUPATI ONAL THERAPY	813, 645	0			813, 645	1
67. 01 06701 AUDI OLOGY	271, 959	0			271, 959	1
68.00 06800 SPEECH PATHOLOGY	291, 836	0			291,836	1
69. 00 06900 ELECTROCARDI OLOGY	271,000	0		0 0	0	
69. 01 06901 CARDI OLOGY	2, 485, 383		2, 485, 38	-	2, 485, 383	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,000,617		3, 000, 61		3,000,617	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	4, 344, 791		4, 344, 79		4, 344, 791	1
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 252, 315		8, 252, 31		8, 252, 315	1
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
90. 00 09000 CLI NI C	0			0 C	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	881, 282		881, 28	2 0	881, 282	90.01
90. 02 09002 CLI NI C	0			0 0	0	90.02
90. 03 09003 DERMATOLOGY CLINIC	0			0 0	0	90.03
90. 04 09004 ENT CLINIC	0			0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0			0 0	0	
90. 07 09007 UROLOGY CLINIC	185		18		185	1
90. 09 09009 GASTROENTEROLOGY CLINIC	7, 962		7, 96		7, 962	
90. 11 09011 NEUROLOGY CLINIC	10, 053		10, 05		10, 053	
90. 12 09012 OPTHAMOLOGY CLINIC	0			0 0	0	
90. 13 09013 ALLERGY CLINIC	129, 180		129, 18		129, 180	1
90. 14 09014 WOUND CARE	942, 856		942, 85			
91.00 09100 EMERGENCY	9, 049, 828		9,049,82		9, 049, 828	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	3, 029, 926		3, 029, 92		3, 029, 926	92.00
95. 00 09500 AMBULANCE SERVICES	3, 883, 946		3, 883, 94	6 0	3, 883, 946	95 00
200.00 Subtotal (see instructions)	88, 823, 363	0			88, 823, 363	
201.00 Less Observation Beds	3, 029, 926	0	3, 029, 92		3, 029, 926	
202.00 Total (see instructions)	85, 793, 437	0				
	00, 1, 0, 107	0	1 00, 0, 10		00, 7, 0, 107	

Heal th	Financial Systems	WI THAM MEMORIA	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPU	TATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet C Part I	
					To 12/31/2020	Date/Time Pre 8/2/2021 1:50	epared:
			Title	e XVIII	Hospi tal	PPS	<u>, piii</u>
			Charges				
	Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			T			
30.00	03000 ADULTS & PEDIATRICS	15, 374, 575		15, 374, 57			30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 403, 536		7, 403, 53			31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 826, 667 0		1, 826, 66	0		40.00
41.00	04200 SUBPROVI DER	0			0		41.00
43.00	04300 NURSERY	1, 831, 818		1, 831, 81			43.00
44.00	04400 SKILLED NURSING FACILITY	2, 409, 282		2, 409, 28			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	7, 569, 747	39, 474, 702			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 694, 536	30, 235, 878			0.00000	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	7 572 252		0 0.000000	0.00000	1
55.01 57.00	05501 ULTRA SOUND 05700 CT SCAN	544, 387 5, 469, 210	7, 573, 353 40, 278, 958			0. 000000 0. 000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	797, 436	40, 278, 938			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 752, 693	17, 109, 387			0. 000000	
60.00	06000 LABORATORY	10, 689, 162	50, 588, 526			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	555, 199	540, 721			0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	1, 489, 630	1, 856, 319			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	2, 256, 532	4, 359, 609			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	2, 150, 403	1, 014, 878			0.00000	
67.01 68.00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	398 175, 668	713, 871 665, 229			0. 000000 0. 000000	
69.00	06900 ELECTROCARDI OLOGY	175,008	005, 229		0. 000000	0. 000000	1
69.01	06901 CARDI OLOGY	5, 698, 406	10, 026, 274			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 449, 995	5, 345, 360			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 218, 589	9,000,978			0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	9, 544, 936	14, 801, 183	24, 346, 11	9 0. 338958	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS	Т		1			
90.00	09000 CLINIC	0	0		0 0.000000	0.00000	
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0	0		0 0.000000 0 0.000000	0. 000000 0. 000000	
90.02 90.03	09002 CEINIC 09003 DERMATOLOGY CLINIC	0	0		0 0.000000	0. 000000	
90.03	09004 ENT CLINIC	0	0		0 0.000000	0. 000000	
90.05	09005 SURGERY CLINIC	0	Ő		0 0.000000	0. 000000	1
90.07	09007 UROLOGY CLINIC	1, 267	100, 690	101, 95	0. 001814	0. 000000	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0 0. 000000	0. 000000	
90. 11	09011 NEUROLOGY CLINIC	0	0		0 0. 000000	0. 000000	
90.12	09012 OPTHAMOLOGY CLINIC	0	0		0 0.000000	0.00000	
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	0	310, 424			0. 000000 0. 000000	
90.14	09100 EMERGENCY	22, 593 3, 566, 773	5, 149, 587 24, 065, 290			0. 000000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	407, 724	5, 425, 426			0. 000000	
00	OTHER REIMBURSABLE COST CENTERS	107,724	3, 120, 120	1 0,000, Te	5.017702	0.00000	1
95.00		1, 057	3, 849, 361	3, 850, 41	8 1.008708	0. 000000	95.00
200.0		93, 902, 219	287, 913, 079	381, 815, 29	8		200.00
201.0		00.000.015	007 010 5	001 015			201.00
202.0) Total (see instructions)	93, 902, 219	287, 913, 079	381, 815, 29	'δ 		202.00

Health Fina	ncial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-25	552-10
	I OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0104	Peri od:	Worksheet C	
				From 01/01/2020		
				To 12/31/2020	Date/Time Prep 8/2/2021 1:50	ared:
			Title XVIII	Hospi tal	PPS	piii
	Cost Center Description	PPS Inpatient	In the Avrill	nospi tai	115	
	cost center bescription	Ratio				
		11.00				
I NPA	TIENT ROUTINE SERVICE COST CENTERS	11100				
	O ADULTS & PEDIATRICS					30.00
	DINTENSIVE CARE UNIT					31.00
	SUBPROVIDER - IPF					40.00
41.00 04100	SUBPROVIDER - IRF					41.00
	O SUBPROVI DER					42.00
	O NURSERY					43.00
	SKILLED NURSING FACILITY					44.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM	0. 132726				50.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 240422				54.00
	RADI OLOGY-THERAPEUTI C	0. 000000				55.00
55.01 0550	1 ULTRA SOUND	0. 109542				55.01
57.00 05700	D CT SCAN	0. 027424				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0. 088181				58.00
	O CARDI AC CATHETERI ZATI ON	0. 081462				59.00
	DLABORATORY	0. 173141				60.00
	D BLOOD STORING, PROCESSING & TRANS.	0. 188986				63.00
	O I NTRAVENOUS THERAPY	0.001996				64.00
	D PHYSI CAL THERAPY	0. 471534				66.00
	O OCCUPATIONAL THERAPY	0. 257053				67.00
	1 AUDI OLOGY	0. 380752				67.01
68.00 06800	SPEECH PATHOLOGY	0. 347053				68.00
69.00 06900	ELECTROCARDI OLOGY	0. 000000				69.00
	1 CARDI OLOGY	0. 158056				69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341159				71.00
	IMPL. DEV. CHARGED TO PATIENT	0. 355560				72.00
73.00 07300	D DRUGS CHARGED TO PATIENTS	0. 338958				73.00
	ATIENT SERVICE COST CENTERS					
90.00 09000	D CLINIC	0. 000000				90.00
90.01 0900	1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				90.01
90.02 09002	2 CLINIC	0. 000000				90.02
90.03 09003	3 DERMATOLOGY CLINIC	0. 000000				90.03
90.04 09004	4 ENT CLINIC	0. 000000				90.04
90.05 09005	5 SURGERY CLINIC	0. 000000				90.05
90.07 0900	7 UROLOGY CLINIC	0. 001814				90.07
90.09 09009	9 GASTROENTEROLOGY CLINIC	0. 000000				90.09
90.11 0901	1 NEUROLOGY CLINIC	0. 000000				90.11
90.12 09012	2 OPTHAMOLOGY CLINIC	0. 000000				90.12
	3 ALLERGY CLINIC	0. 416141				90.13
90.14 09014	4 WOUND CARE	0. 182294				90.14
91.00 09100	DEMERGENCY	0. 327512				91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0. 519432				92.00
	R REIMBURSABLE COST CENTERS					
95.00 09500	D AMBULANCE SERVI CES	1.008708				95.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)				2	202.00
					·	

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	pared:
				llaani tal	8/2/2021 1:50	pm
		1111	e XIX	<u>Hospi tal</u> Costs	Cost	
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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 624, 855		9, 624, 855		9, 624, 855	
31.00 03100 INTENSIVE CARE UNIT	3, 792, 538		3, 792, 538		3, 792, 538	
40.00 04000 SUBPROVIDER - IPF	2, 212, 857		2, 212, 857		2, 212, 857	40.00
41.00 04100 SUBPROVIDER - IRF	0		(-	0	41.00
42. 00 04200 SUBPROVI DER	0		(-	0	42.00
43.00 04300 NURSERY	67, 239		67, 239		67, 239	
44. 00 04400 SKI LLED NURSI NG FACI LI TY	2, 429, 214		2, 429, 214	0	2, 429, 214	44.00
ANCI LLARY SERVI CE COST CENTERS	6 244 011		6 244 011	0	6 244 011	
	6, 244, 011		6, 244, 011		6, 244, 011 7, 676, 759	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	7, 676, 759 0		7, 676, 759			54.00 55.00
55. 01 05501 ULTRA_SOUND	889, 236		889, 236		0 889, 236	55.00
57. 00 05700 CT SCAN	1, 254, 597		1, 254, 597		1, 254, 597	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 430, 690		1, 430, 690		1, 430, 690	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 862, 385		1, 862, 385		1, 862, 385	
60. 00 06000 LABORATORY	10, 609, 690		10, 609, 690		10, 609, 690	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	207, 114		207, 114		207, 114	
64. 00 06400 I NTRAVENOUS THERAPY	6, 677		6, 677		6, 677	64.00
66. 00 06600 PHYSI CAL THERAPY	3, 119, 737	0	3, 119, 737		3, 119, 737	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	813, 645	0	813, 645		813, 645	67.00
67. 01 06701 AUDI OLOGY	271, 959	0	271, 959		271, 959	67.01
68. 00 06800 SPEECH PATHOLOGY	291,836	0	291, 836		291,836	68.00
69. 00 06900 ELECTROCARDI OLOGY	271,000	0	271,000	o o	0	69.00
69. 01 06901 CARDI OLOGY	2, 485, 383		2, 485, 383		2, 485, 383	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,000,617		3,000,617		3,000,617	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 344, 791		4, 344, 791		4, 344, 791	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 252, 315		8, 252, 315		8, 252, 315	
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLINIC	0		() 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	881, 282		881, 282	0	881, 282	90.01
90. 02 09002 CLINIC	0				0	90.02
90. 03 09003 DERMATOLOGY CLINIC	0		(0 0	0	90.03
90. 04 09004 ENT CLINIC	0		(0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0		(0 0	0	90.05
90. 07 09007 UROLOGY CLINIC	185		185	5 0	185	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	7, 962		7, 962	2 0	7, 962	90.09
90. 11 09011 NEUROLOGY CLINIC	10, 053		10, 053	8 0	10, 053	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0		C		0	90.12
90. 13 09013 ALLERGY CLINIC	129, 180		129, 180		129, 180	
90.14 09014 WOUND CARE	942, 856		942, 856			
91. 00 09100 EMERGENCY	9, 049, 828		9, 049, 828		9, 049, 828	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 029, 926		3, 029, 926		3, 029, 926	92.00
OTHER REIMBURSABLE COST CENTERS		-		1		
95.00 09500 AMBULANCE SERVICES	3, 883, 946		3, 883, 946		3, 883, 946	
200.00 Subtotal (see instructions)	88, 823, 363				88, 823, 363	
201.00 Less Observation Beds	3, 029, 926		3, 029, 926		3, 029, 926	
202.00 Total (see instructions)	85, 793, 437	0	85, 793, 437	0	85, 793, 437	202.00

Heal th Financial		WI THAM MEMORI A	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF F	RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	epared:
						8/2/2021 1:50) pm
				e XIX	Hospi tal	Cost	
			Charges	1			
Cost	t Center Description	I npati ent	Outpati ent	Total (col.		TEFRA	
				+ col. 7)	Ratio	Inpatient	
		6.00	7.00	8.00	9.00	Rati o 10.00	
ΙΝΡΔΤΙΕΝΤ	ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
	TS & PEDIATRICS	15, 374, 575		15, 374, 57	5		30.00
	ENSIVE CARE UNIT	7, 403, 536		7, 403, 53			31.00
	PROVIDER - IPF	1, 826, 667		1, 826, 66			40.00
	PROVIDER - IRF	0			0		41.00
42.00 04200 SUBF		0			0		42.00
43.00 04300 NURS	SERY	1, 831, 818		1, 831, 81	8		43.00
44.00 04400 SKIL	LED NURSING FACILITY	2, 409, 282		2, 409, 28	2		44.00
	SERVICE COST CENTERS						
	RATING ROOM	7, 569, 747	39, 474, 702			0. 000000	
	OLOGY-DI AGNOSTI C	1, 694, 536	30, 235, 878			0. 000000	
	OLOGY-THERAPEUTI C	0	C		0 0. 000000	0.00000	
55.01 05501 ULTF		544, 387	7, 573, 353			0.00000	
57.00 05700 CT S		5, 469, 210	40, 278, 958			0.00000	
	NETIC RESONANCE IMAGING (MRI)	797, 436	15, 427, 075			0.00000	
	DI AC CATHETERI ZATI ON	5, 752, 693	17, 109, 387			0.00000	
60.00 06000 LAB		10, 689, 162	50, 588, 526			0.00000	
	DD STORING, PROCESSING & TRANS. RAVENOUS THERAPY	555, 199 1, 489, 630	540, 721			0. 000000 0. 000000	
	SI CAL THERAPY	2, 256, 532	1, 856, 319 4, 359, 609			0. 000000	
	JPATIONAL THERAPY	2, 256, 552	1, 014, 878			0.000000	
67.01 06701 AUDI		2, 130, 403	713, 871			0. 000000	
	ECH PATHOLOGY	175, 668	665, 229			0. 000000	
	CTROCARDI OLOGY	0	000, 227		0.000000	0. 000000	
69.01 06901 CARE		5, 698, 406	10, 026, 274			0. 000000	
	CAL SUPPLIES CHARGED TO PATIENTS	3, 449, 995	5, 345, 360			0. 000000	•
	DEV. CHARGED TO PATIENT	3, 218, 589	9,000,978			0. 000000	
	GS CHARGED TO PATIENTS	9, 544, 936	14, 801, 183			0.000000	•
	T SERVICE COST CENTERS						
90.00 09000 CLIN	VI C	0	C		0 0.000000	0. 000000	90.00
90. 01 09001 OTHE	ER OUTPATIENT SERVICE COST CENTER	0	C		0 0.000000	0. 000000	90.01
90.02 09002 CLIN		0	C		0 0. 000000	0.000000	
	MATOLOGY CLINIC	0	C		0 0. 000000	0.00000	
90.04 09004 ENT		0	C		0 0. 000000	0. 000000	
	GERY CLINIC	0	C		0 0. 000000	0. 000000	
	LOGY CLINIC	1, 267	100, 690			0. 000000	
	FROENTEROLOGY CLINIC	0	C		0 0. 000000	0. 000000	
	ROLOGY CLINIC	0	C		0 0. 000000	0.00000	
	HAMOLOGY CLINIC	0	C		0 0.000000	0.00000	
	ERGY CLINIC	0	310, 424			0.00000	
90.14 09014 WOUN		22, 593	5, 149, 587			0.00000	
91.00 09100 EMER		3, 566, 773	24,065,290			0.00000	
	ERVATION BEDS (NON-DISTINCT PART)	407, 724	5, 425, 426	5, 833, 15	0 0. 519432	0. 000000	92.00
	MBURSABLE COST CENTERS JLANCE SERVI CES	1,057	3, 849, 361	3, 850, 41	8 1.008708	0. 000000	95.00
	total (see instructions)	93, 902, 219	3, 849, 361 287, 913, 079			0.000000	200.00
	s Observation Beds	73, 902, 219	201, 913, 019	301,010,29	0		200.00
4 4	al (see instructions)	93, 902, 219	287, 913, 079	381, 815, 29	8		201.00
_02.001 1000		, , , , , , , , , , , , , , , , , , , ,	20., , 10, 07 /	1 00.,010,27	-1	I	

Health Fina	ncial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lieu	」of Form CMS-255	52-10
	I OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0104	Peri od:	Worksheet C	
				From 01/01/2020	Part I	
				To 12/31/2020	Date/Time Prepar 8/2/2021 1:50 pr	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient	ПЦЕЛІХ	nospi tai	0031	
	cost center bescription	Ratio				
		11.00				
I NPA	TIENT ROUTINE SERVICE COST CENTERS	11100				
	O ADULTS & PEDIATRICS				31	30.00
	DINTENSIVE CARE UNIT					31.00
	SUBPROVIDER - IPF					10.00
41.00 04100	SUBPROVIDER – IRF				4	1.00
42.00 04200	SUBPROVI DER				4	12.00
43.00 04300	NURSERY				4	13.00
44.00 04400	SKILLED NURSING FACILITY				4	4.00
	LARY SERVICE COST CENTERS	· · · · ·				
	O OPERATING ROOM	0. 000000			5	50.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 000000			5	54.00
55.00 05500	RADI OLOGY-THERAPEUTI C	0. 000000			5	5.00
55.01 0550	1 ULTRA SOUND	0. 000000			5	5.01
57.00 05700	DCT SCAN	0. 000000			5	57.00
58.00 05800	D MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			5	58.00
	CARDI AC CATHETERI ZATI ON	0. 000000			5	59.00
	LABORATORY	0. 000000			6	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0. 000000			6	53.00
	INTRAVENOUS THERAPY	0. 000000			6	64.00
	PHYSI CAL THERAPY	0. 000000			6	6.00
67.00 06700	OCCUPATIONAL THERAPY	0. 000000			6	57.00
	1 AUDI OLOGY	0. 000000			6	57.01
68.00 06800	SPEECH PATHOLOGY	0. 000000			6	68.00
69.00 06900	ELECTROCARDI OLOGY	0. 000000			6	69.00
69.01 0690 ⁻	1 CARDI OLOGY	0. 000000			6	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7	1.00
	IMPL. DEV. CHARGED TO PATIENT	0. 000000			7	2.00
73.00 07300	D DRUGS CHARGED TO PATIENTS	0. 000000			7	73.00
OUTPA	ATIENT SERVICE COST CENTERS	· · · · · ·				
90.00 09000	D CLINIC	0. 000000			9	90.00
90.01 0900	1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			9	90.01
90.02 09002	2 CLINIC	0. 000000			9	90.02
90.03 09003	3 DERMATOLOGY CLINIC	0. 000000			9	90.03
90.04 09004	4 ENT CLINIC	0. 000000			9	90.04
90.05 09005	5 SURGERY CLINIC	0. 000000			9	90.05
90.07 0900	7 UROLOGY CLINIC	0. 000000			9	90.07
90.09 09009	9 GASTROENTEROLOGY CLINIC	0. 000000			9	90.09
90. 11 0901	1 NEUROLOGY CLINIC	0. 000000			9	90.11
90.12 09012	2 OPTHAMOLOGY CLINIC	0. 000000			9	90.12
90.13 09013	3 ALLERGY CLINIC	0. 000000			9	90.13
90.14 09014	4 WOUND CARE	0. 000000			9	90.14
91.00 09100	DEMERGENCY	0. 000000			9	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			9	92.00
	R REIMBURSABLE COST CENTERS					
	D AMBULANCE SERVI CES	0. 000000			9	95.00
200.00	Subtotal (see instructions)					00.00
201.00	Less Observation Beds					01.00
202.00	Total (see instructions)				20	02.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provider C	-	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 1:50	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adj ustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 023, 621	0	1, 023, 62	1 7, 465	137.12	30.00
31.00 INTENSIVE CARE UNIT	243, 447		243, 44	7 2, 815	86.48	31.00
40.00 SUBPROVIDER - IPF	294, 767	0	294, 76	7 1,400	210. 55	40.00
41.00 SUBPROVIDER - IRF	0	0) (0 C	0.00	41.00
42.00 SUBPROVI DER	0	0) (0 C	0.00	42.00
43.00 NURSERY	288		28	B 962	0.30	43.00
44.00 SKILLED NURSING FACILITY	265, 294		265, 29	4 4, 039	65.68	44.00
200.00 Total (lines 30 through 199)	1, 827, 417		1, 827, 41	7 16, 681		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2,060					30.00
31.00 INTENSIVE CARE UNIT	1, 046		•			31.00
40. 00 SUBPROVIDER – IPF	1, 001	210, 761				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, 342					44.00
200.00 Total (lines 30 through 199)	6, 449	737, 509	9			200.00

Health Financial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part II	narodi
				10 12/31/2020	Date/Time Pre 8/2/2021 1:50	nm
		Title	XVIII	Hospi tal	PPS	piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	51121 955		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		•	•		•	
50.00 05000 OPERATI NG ROOM	653, 400	47,044,449	0.01388	3, 092, 957	42, 958	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	820, 958	31, 930, 414	0. 02572	1, 009, 855	25, 964	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000		0	55.00
55. 01 05501 ULTRA SOUND	7,642	8, 117, 740			40	55.01
57. 00 05700 CT SCAN	10, 242					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	73, 539		0.00453			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	62, 299					59.00
60. 00 06000 LABORATORY	402, 809					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	885					63.00
64.00 06400 INTRAVENOUS THERAPY	52				6	64.00
66. 00 06600 PHYSI CAL THERAPY	359, 382					66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 876		0.00217			67.00
67. 01 06701 AUDI OLOGY	1, 796					67.01
68.00 06800 SPEECH PATHOLOGY	1, 662				-	68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
69. 01 06901 CARDI OLOGY	54, 676	15, 724, 680				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 870					
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	18, 560					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	37, 485				3, 682	73.00
OUTPATIENT SERVICE COST CENTERS		,				1
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	165, 750	-				90.01
90. 02 09002 CLINIC	0					90.02
90. 03 09003 DERMATOLOGY CLINIC	0	-				90.03
90.04 09004 ENT CLINIC	0					90.04
90. 05 09005 SURGERY CLINIC	0					90.05
90. 07 09007 UROLOGY CLINIC	1	101, 957			-	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	45					90.09
90. 11 09011 NEUROLOGY CLINIC	119	-			-	90.11
90. 12 09012 0PTHAMOLOGY CLINIC	0	-			-	90.12
90. 13 09013 ALLERGY CLINIC	576				-	90.13
90. 14 09014 WOUND CARE	136, 340				-	90.14
91. 00 09100 EMERGENCY	991, 406					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	322, 239					92.00
OTHER REIMBURSABLE COST CENTERS	022,207	, , , , , , , , , , , , , , , , , , , ,	0.0002			1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	4, 141, 609	349, 119, 002		19, 032, 034	175, 361	
	.,,,.,	,,	1	,		1

Health Financial Systems	WI THAM MEMORI			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	STS Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
		T: +1 -	e XVIII	llaani tal	8/2/2021 1:50 PPS	pm
Cost Conton Description	Nuncing			Hospital h Allied Health	All Other	
Cost Center Description	Nursi ng School	Nursi ng School	Post-Stepdow		Medical	
		SCHOOL				
	Post-Stepdown		Adjustments	5	Education	
	Adjustments 1A	1.00	2A	2.00	Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	C	1	0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			0 0		
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	
41. 00 04100 SUBPROVI DER – I RF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	
43. 00 04400 SKI LLED NURSI NG FACI LI TY	0			0 0	0	43.00
	0					200.00
200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed	Total Costs	Total Patier		Inpatient	200.00
cost center bescription	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col. 6)	Frogram Days	
		minus col. 4)		COI. 0)		
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	C	7,4	65 0.00	2,060	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					
40. 00 04000 SUBPROVI DER – I PF	0	-	-/ -			
41. 00 04100 SUBPROVI DER – I RF	0	-		0 0.00		
42. 00 04200 SUBPROVI DER	0			0 0.00		
43. 00 04300 NURSERY	0		9	62 0.00		
44.00 04400 SKILLED NURSING FACILITY					-	
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	I npati ent		10,0		0, 117	200.00
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					İ
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41.00 04100 SUBPROVI DER - I RF	0					41.00
42.00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
200.00 Total (lines 30 through 199)	0					200.00
· · · · · · · · · · · · · · · · · · ·		1				

	Financial Systems	WI THAM MEMORI			In Li	eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI GH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		epared:) pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing	Nursi ng		Allied Health	
		Anestheti st	School	School	Post-Stepdowr		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0 0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	55.00
55.01	05501 ULTRA SOUND	0	0		0	o l	55.01
57.00	05700 CT SCAN	0	0		0	o l	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	o l	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	o l	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		
66.00	06600 PHYSI CAL THERAPY	0	0		0		
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0		
67.01	06701 AUDI OLOGY	0	0		0		
68.00	06800 SPEECH PATHOLOGY	0	0		0		
69.00	06900 ELECTROCARDI OLOGY	0	0		0		1
69.01	06901 CARDI OLOGY	0	0		0		1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		-		
73.00		0	0				
75.00	OUTPATIENT SERVICE COST CENTERS	U 0	0		0	51 0	/ / 3. 00
90.00	09000 CLINIC	0	0		0	0 10	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0				
90.02	09002 CLINIC	0	0		0		
90.02	09003 DERMATOLOGY CLINIC	0	0		0		
90.03 90.04	09004 ENT CLINIC	0	0		0		
90.04 90.05	09005 SURGERY CLINIC	0	0		0		1
90.03 90.07	09007 UROLOGY CLINIC	0	0		0		
90.07	09009 GASTROENTEROLOGY CLINIC	0	0		0		
		0	0				
90.11	09011 NEUROLOGY CLINIC	0	0		0	-	
90.12		0	0		0	0	
90.13	09013 ALLERGY CLINIC	0	0				
90.14	09014 WOUND CARE	0	0		0		
91.00	09100 EMERGENCY	0	0			0 0	
92.00		0		l	0	0	92.00
05 00	OTHER REIMBURSABLE COST CENTERS	1				1	05 00
95.00			~		0		95.00
200.00) Total (lines 50 through 199)	0	0	I	0	0 0	200.00

Health Financial Systems		WI THAM MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTF THROUGH COSTS	PATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0104	Period: From 01/01/2020		norodi
					To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
			Title	XVIII	Hospi tal	PPS	
Cost Center Descrip	otion	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	f C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST C	ENTERS						
50.00 05000 OPERATING ROOM		0	0		0 47, 044, 449		
54.00 05400 RADI OLOGY-DI AGNOSTI	С	0	0		0 31, 930, 414	0.00000	54.00
55.00 05500 RADI OLOGY-THERAPEU	FIC	0	0		0 0	0.00000	55.00
55.01 05501 ULTRA SOUND		0	0		0 8, 117, 740	0.00000	
57.00 05700 CT SCAN		0	0		0 45, 748, 168	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE	IMAGING (MRI)	0	0		0 16, 224, 511	0.00000	58.00
59.00 05900 CARDI AC CATHETERI ZA	ATI ON	0	0		0 22, 862, 080	0.00000	59.00
60.00 06000 LABORATORY		0	0		0 61, 277, 688	0.00000	60.00
63.00 06300 BLOOD STORING, PRO		0	0		0 1,095,920	0.00000	63.00
64.00 06400 INTRAVENOUS THERAPY	(0	0		0 3, 345, 949	0.00000	64.00
66.00 06600 PHYSI CAL THERAPY		0	0		0 6, 616, 141	0.00000	66.00
67.00 06700 OCCUPATIONAL THERAF	рү	0	0		0 3, 165, 281	0.00000	67.00
67. 01 06701 AUDI OLOGY		0	0		0 714, 269	0.00000	67.01
68.00 06800 SPEECH PATHOLOGY		0	0		0 840, 897	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY		0	0		0 0	0.00000	69.00
69. 01 06901 CARDI OLOGY		0	0		0 15, 724, 680	0.00000	69.01
71.00 07100 MEDICAL SUPPLIES CH		0	0		0 8, 795, 355	0.00000	71.00
72.00 07200 I MPL. DEV. CHARGED		0	0		0 12, 219, 567	0.00000	•
73.00 07300 DRUGS CHARGED TO PA		0	0		0 24, 346, 119	0. 000000	73.00
OUTPATIENT SERVICE COST	CENTERS						
90. 00 09000 CLINIC		0	0		0 0	0.00000	
90. 01 09001 OTHER OUTPATIENT SE	ERVICE COST CENTER	0	0		0 0	0. 000000	
90. 02 09002 CLI NI C		0	0		0 0	0. 000000	
90. 03 09003 DERMATOLOGY CLINIC		0	0		0 0	0.00000	
90.04 09004 ENT CLINIC		0	0		0 0	0.00000	
90. 05 09005 SURGERY CLINIC		0	0		0 0	0.00000	
90.07 09007 UROLOGY CLINIC		0	0		0 101, 957	0.00000	•
90.09 09009 GASTROENTEROLOGY CI	_I NI C	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		0 310, 424	0.00000	•
90.14 09014 WOUND CARE		0	0		0 5, 172, 180	0. 000000	•
91.00 09100 EMERGENCY		0	0		0 27, 632, 063	0. 000000	•
92.00 09200 OBSERVATION BEDS (1		0	0		0 5, 833, 150	0. 000000	92.00
OTHER REIMBURSABLE COST	CENTERS						
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 thr		0	0		0 349, 119, 002		95.00 200.00

Health Financial Systems	WI THAM MEMORI AI			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	T		1			
50.00 05000 OPERATING ROOM	0. 000000	3, 092, 957		0 12, 405, 947	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1,009,855		0 9, 847, 585	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	-	55.00
55.01 05501 ULTRA SOUND	0. 000000	42, 334		0 825, 606		55.01
57.00 05700 CT SCAN	0. 000000	1, 732, 141		0 9, 765, 359		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	288, 272		0 4, 969, 547	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	401, 701		0 2, 019, 049		59.00
60.00 06000 LABORATORY	0. 000000	3, 275, 552		0 5, 197, 901	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	105, 683		0 237, 129		63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	385, 974		0 435, 367	0	64.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	315, 861		0 37,726		66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	248, 795		0 18, 185	0	67.00
67. 01 06701 AUDI OLOGY	0. 000000	0		0 0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0.000000	50, 179		0 73, 737		68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	69.00
69. 01 06901 CARDI OLOGY	0.000000	3, 525, 246		0 7, 660, 551	0	69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000	856, 125		0 935, 740	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0 2 200 005		0 19, 620 0 10, 148, 756	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0. 000000	2, 390, 895		0 10, 148, 756	0	73.00
90. 00 09000 CLINIC	0, 000000	0		0 0	0	90.00
90. 01 09000 CETNIC 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0		0 0		90.00
90. 02 109002 CLINIC	0. 000000	0				90.01
90. 03 09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	-	90.02
90. 04 09004 ENT CLINIC	0. 000000	0		0 0		90.03
90. 05 09005 SURGERY CLINIC	0. 000000	0		0 0		90.04
90. 07 09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90.03
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0		90.07
90. 11 09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	90.12
90. 13 09013 ALLERGY CLINIC	0. 000000	0		0 0	0	90.12
90. 14 09014 WOUND CARE	0. 000000	2, 220		0 1, 792, 477	0	90.14
91. 00 09100 EMERGENCY	0, 000000	1, 308, 244		0 3, 949, 080		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 300, 244		0 2, 644, 316		92.00
OTHER REIMBURSABLE COST CENTERS	0.000000	0		2, 511, 510	. 0	1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		19,032,034		0 72, 983, 678	0	200.00
	1				-	

Health Financial Systems	WI THAM MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		pared:
		Title	e XVIII	Hospi tal	PPS	_p
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9	0.00	(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0 10070/	10 105 017			1 (1(500	1 50 00
50. 00 O5000 OPERATING ROOM	0. 132726			0 0	.,	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240422		38		2, 367, 576	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
55. 01 05501 ULTRA SOUND	0. 109542			0 0	90, 439	•
57.00 05700 CT SCAN	0. 027424			0 6, 623	267,805	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 088181			0 8	438, 220	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 081462			0 0	164, 476	•
	0. 173141				899, 970	•
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 188986			0 0	44, 814	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.001996			0 0	869	•
66. 00 06600 PHYSI CAL THERAPY	0. 471534			0 0	17, 789	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 257053			0 0	4, 675	•
	0. 380752			°	0	67.01
68. 00 06800 SPEECH PATHOLOGY	0. 347053		1	0 0	25, 591	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI OLOGY	0.00000			0 107		
	0. 158056				1, 210, 796	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 341159 0. 355560			0 0	319, 236	
73. 00 07200 TMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 338958			0 39, 881	3, 440, 002	•
OUTPATIENT SERVICE COST CENTERS	0. 338958	10, 148, 750	4	0 39,881	3, 440, 002	/3.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0 0	0	90.00
90. 02 09002 CLINIC	0. 000000			0 0	0	90.01
90. 03 09003 DERMATOLOGY CLINIC	0. 000000			0 0	0	90.02
90. 04 09004 ENT CLINIC	0. 000000			0 0	0	90.03
90. 05 09005 SURGERY CLINIC	0. 000000			0 0	0	90.05
90. 07 09007 UROLOGY CLINIC	0. 001814			0 0	0	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000			0 0	0	90.09
90. 11 09011 NEUROLOGY CLINIC	0. 000000			0 0	0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 000000			0 0	0	90.12
90. 13 09013 ALLERGY CLINIC	0. 416141			0 0	0	90.12
90. 14 09014 WOUND CARE	0. 182294			0 6,959	326, 758	
91. 00 09100 EMERGENCY	0. 327512			0 0	1, 293, 371	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 519432			0 0	1, 373, 542	•
OTHER REIMBURSABLE COST CENTERS	0.017432	2,011,010	1	<u> </u>	1,070,042	1 2.00
95. 00 09500 AMBULANCE SERVICES	1. 008708			0		95.00
200.00 Subtotal (see instructions)	1.000700	72, 983, 678	14, 30	8	13, 939, 497	
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		72, 983, 678	14, 30	53, 952	13, 939, 497	202.00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi de	r CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020		
			Ti	tle XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimburse	d			
		Servi ces	Servi ces M	lot			
		Subject To	Subject T	ō			
		Ded. & Coins.	Ded. & Coi	ns.			
		(see inst.)	(see inst	.)			
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0		0			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	92		90			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0			55.00
55.01	05501 ULTRA SOUND	0		0			55.01
57.00	05700 CT SCAN	0		182			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		1			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0			59.00
60.00	06000 LABORATORY	2, 421		o			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		o			63.00
64.00	06400 I NTRAVENOUS THERAPY	0		o			64.00
66.00	06600 PHYSI CAL THERAPY	0		o			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		o			67.00
67.01	06701 AUDI OLOGY	0		0			67.01
68.00	06800 SPEECH PATHOLOGY	0		0			68.00
69.00	06900 ELECTROCARDI OLOGY	0		0			69.00
		0		17			
69.01 71.00	06901 CARDI OLOGY	0		0			69.01
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		0			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	10				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,	518			73.00
~ ~ ~	OUTPATIENT SERVICE COST CENTERS	0		0			
90.00	09000 CLINIC	0		0			90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0		0			90.01
90.02	09002 CLINIC	0		0			90.02
90.03	09003 DERMATOLOGY CLINIC	0		0			90.03
90.04	09004 ENT CLINIC	0		0			90.04
90.05	09005 SURGERY CLINIC	0		0			90.05
90.07	09007 UROLOGY CLINIC	0		0			90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0		0			90.09
90. 11	09011 NEUROLOGY CLINIC	0		0			90.11
	09012 OPTHAMOLOGY CLINIC	0		0			90.12
90.13	09013 ALLERGY CLINIC	0		0			90.13
90.14	09014 WOUND CARE	0	1,	269			90.14
	09100 EMERGENCY	0		0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0			92.00
	OTHER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVI CES	0					95.00
200.00		2, 513	15,	077			200.00
201.00		0					201.00
	Only Charges						
	Net Charges (line 200 - line 201)	2, 513		077			202.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0104	Peri od:	Worksheet D	
		Component	CCN: 15-S104	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 8/2/2021 1:50	pareo
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	Č, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	0	, , , , , , , , , , , , , , , , , , ,	
	col. 26)		,			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	653, 400	47,044,449	0. 01388	4, 555	63	50.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	820, 958	31, 930, 414	0. 02571	1 19, 214	494	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0 0	0	55.
5.01 05501 ULTRA SOUND	7,642	8, 117, 740	0. 00094	1, 310	1	55.
7.00 05700 CT SCAN	10, 242	45, 748, 168	0. 00022	43, 948	10	57.
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	73, 539	16, 224, 511	0.00453	33 7, 941	36	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON	62, 299	22, 862, 080	0.00272		8	59.
D. 00 06000 LABORATORY	402, 809	61, 277, 688	0. 00657	275, 406	1, 811	60.
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	885	1, 095, 920	0. 00080	0 8	0	63.
4.00 06400 INTRAVENOUS THERAPY	52	3, 345, 949	0.00001	6 3, 017	0	64.
6. 00 06600 PHYSI CAL THERAPY	359, 382	6, 616, 141	0. 05431	9 16, 124	876	66.
7.00 06700 OCCUPATI ONAL THERAPY	6, 876	3, 165, 281	0.00217	2 268	1	67.
7. 01 06701 AUDI OLOGY	1, 796	714, 269	0. 00251	4 0	0	67.
B. 00 06800 SPEECH PATHOLOGY	1, 662	840, 897	0.00197	76 874	2	68.
9. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69.
9. 01 06901 CARDI OLOGY	54, 676	15, 724, 680	0.00347	26, 375	92	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 870	8, 795, 355	0.00146	53 16, 124	24	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	18, 560	12, 219, 567	0.00151	9 0	0	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	37, 485	24, 346, 119	0. 00154	0 280, 392	432	73.
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	0	0				90.
D. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	165, 750	0				90.
D. 02 09002 CLINIC	0	0	0.00000			90.
D. 03 09003 DERMATOLOGY CLINIC	0	0				90.
D. 04 09004 ENT CLINIC	0	0	0.00000		0	90.
D. 05 09005 SURGERY CLINIC	0	0	0. 00000		0	90.
D. 07 09007 UROLOGY CLINIC	1	101, 957	0. 00001		0	90.
D. 09 09009 GASTROENTEROLOGY CLINIC	45	0			0	90.
D. 11 09011 NEUROLOGY CLINIC	119	0			0	90.
D. 12 09012 OPTHAMOLOGY CLINIC	0	0	0.0000		0	90.
D. 13 09013 ALLERGY CLINIC	576	310, 424	0. 00185		0	90.
D. 14 09014 WOUND CARE	136, 340	5, 172, 180			1	90.
1.00 09100 EMERGENCY	991, 406	27, 632, 063				
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 833, 150	0.0000	0 0	0	92.
OTHER REIMBURSABLE COST CENTERS	1					0.5
5. 00 09500 AMBULANCE SERVICES	2 010 070	240 110 000		710 (05	4 570	95.
00.00 Total (lines 50 through 199)	3, 819, 370	349, 119, 002		718, 625	4, 570	1200.

ealth Financial Systems	WI THAM MEMORI			In Lie	u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet D Part IV	
'HROUGH COSTS		Component	CCN: 15-S104	To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title	xVIII	Subprovider -	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		0	1		0	50.00
	0			0 0 0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	54.00 55.00
	0	0		0 0		
55.01 05501 ULTRA SOUND 57.00 05700 CT SCAN	0			0 0	0	55.01 57.00
	0			0 0	0	57.00
	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 50. 00 06000 LABORATORY	0			0 0	0	60.00
33. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.00
4. 00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.0
6. 00 06600 PHYSI CAL THERAPY	0			0 0	0	66.0
07. 00 06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.0
57.00 06700 00004110NAL THERAPT	0			0 0	0	67.0
57. 01 06701 ADD 0L0G1	0			0 0	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
9. 01 06901 CARDI OLOGY	0			0 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.0
22.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	l o		0 0	0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS			1	0 0		/0.0
0. 00 09000 CLINIC	0	0		0 0	0	90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	90.0
20, 02 09002 CLINIC	0	0		0 0	0	90.0
0. 03 09003 DERMATOLOGY CLINIC	0	0		0 0	0	90.0
0. 04 09004 ENT CLINIC	0	0		0 0	0	90.0
20. 05 09005 SURGERY CLINIC	0	0		0 0	0	90.0
0. 07 09007 UROLOGY CLINIC	0	0		0 0	0	90.0
0. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	90.0
0. 11 09011 NEUROLOGY CLINIC	0	0		0 0	0	90.1
0. 12 09012 OPTHAMOLOGY CLINIC	0	0		0 0	0	90.1
0. 13 09013 ALLERGY CLINIC	0	0		0 0	0	90.1
20. 14 09014 WOUND CARE	0	0		0 0	0	90.1
01.00 09100 EMERGENCY	0	0		0 0	0	91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.0
OTHER REIMBURSABLE COST CENTERS						
25. 00 09500 AMBULANCE SERVICES						95.0
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	RVICE OTHER PAS	S Provider C	CN: 15-0104	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020	Part IV	
		Component	CCN: 15-S104	To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title	e XVIII	Subprovider -	PPS	-1
Cost Center Description	All Other	Total Cost	Total	IPF Total Charges	Patio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum o		(col. 5 ÷	
	Cost	4)	col s. 2, 3,		col. 7)	
	0031		and 4)	001.0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 47, 044, 449	0. 000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 31, 930, 414	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	55.00
55. 01 05501 ULTRA SOUND	0	0		0 8, 117, 740	0. 000000	55.01
57. 00 05700 CT SCAN	0	0		0 45, 748, 168	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 16, 224, 511	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 22, 862, 080	0. 000000	59.00
50. 00 06000 LABORATORY	0	0		0 61, 277, 688	0. 000000	60.00
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 095, 920	0. 000000	63.00
54.00 06400 INTRAVENOUS THERAPY	0	0		0 3, 345, 949	0. 000000	64.00
56. 00 06600 PHYSI CAL THERAPY	0	0		0 6, 616, 141	0. 000000	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 165, 281	0. 000000	67.00
57. 01 06701 AUDI OLOGY	0	0		0 714, 269	0. 000000	67.0 [°]
58.00 06800 SPEECH PATHOLOGY	0	0		0 840, 897	0. 000000	68.00
59. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	69.00
59. 01 06901 CARDI OLOGY	0	0		0 15, 724, 680	0. 000000	69. 0 ⁻
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 795, 355	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 12, 219, 567	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 24, 346, 119	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS		1		E		
90. 00 09000 CLINIC	0	0		0 0	0. 000000	90.00
PO. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	-	1	0 0	0. 000000	
20. 02 09002 CLINIC	0	0	1	0 0	0. 000000	
20. 03 09003 DERMATOLOGY CLINIC	0	0		0 0	0. 000000	
20. 04 09004 ENT CLINIC	0	0	1	0 0	0. 000000	
20. 05 09005 SURGERY CLINIC	0	0		0 0	0. 000000	
0. 07 09007 UROLOGY CLINIC	0	0		0 101, 957	0. 000000	
20. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0. 000000	
PO. 11 09011 NEUROLOGY CLINIC	0	0		0 0	0. 000000	
PO. 12 09012 OPTHAMOLOGY CLINIC	0	0		0 0	0. 000000	
PO. 13 09013 ALLERGY CLINIC	0	0		0 310, 424	0. 000000	
20. 14 09014 WOUND CARE	0	0		0 5, 172, 180	0. 000000	
91.00 09100 EMERGENCY	0	-		0 27, 632, 063		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 5, 833, 150	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
25. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	1	0 349, 119, 002		200.0

Health Financial Systems	WI THAM MEMORI AL				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0104	Period:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-S104	From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title	XVIII	Subprovider -	8/2/2021 1:50 PPS	рш
		in the		IPF	115	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	h Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS				_	-	
50. 00 05000 OPERATING ROOM	0.000000	4, 555		0 0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	19, 214		0 50	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	55.00
55. 01 05501 ULTRA SOUND	0.000000	1, 310		0 0	0	55.01
57.00 05700 CT SCAN	0.000000	43, 948		0 0	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	7, 941		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	3,006		0 0	0	59.00
60. 00 06000 LABORATORY	0.000000	275, 406		0 0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0			0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	3,017			0	64.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0. 000000	16, 124 268			-	66.00 67.00
	0. 000000 0. 000000	268			0	67.00
67. 01 06701 AUDI OLOGY 68. 00 06800 SPEECH PATHOLOGY	0. 000000	874			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0/4			0	69.00
69. 01 06901 CARDI OLOGY	0. 000000	26, 375			0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	16, 124		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	10, 124				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	280, 392		0 0		73.00
OUTPATI ENT SERVI CE COST CENTERS	0.000000	200, 372		0 0	0	/ 3.00
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0		90.01
90. 02 09002 CLINIC	0. 000000	0		0 0	0	90.02
90. 03 09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 ENT CLINIC	0. 000000	0		0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0. 000000	0		0 0	0	90.05
90. 07 09007 UROLOGY CLINIC	0. 000000	0		0 0	0	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90.09
90. 11 09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 000000	0	1	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	31		0 0	0	90.14
91.00 09100 EMERGENCY	0. 000000	20, 040		0 951	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
	1		1			
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		718, 625		0 1,001		95.00 200.00

	ncial Systems	WI THAM MEMORI				u of Form CMS-2	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet D Part V	
			Component	CCN: 15-S104	To 12/31/2020		epared:) pm
			Title	e XVIII	Subprovider -	PPS	-
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9	0.00	(see inst.)	(see inst.)	F 00	
		1.00	2.00	3.00	4.00	5.00	-
	LARY SERVICE COST CENTERS	0. 132726	0		0 0	0	50.00
	RADI OLOGY-DI AGNOSTI C	0. 132720	50		0 39	12	
	RADI OLOGY-THERAPEUTI C	0. 240422	0		0 0	0	
	ULTRA SOUND	0. 109542	0		0 0	0	
	CT SCAN	0. 027424	0		0 698	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0. 088181	0		0 1	0	
	CARDIAC CATHETERIZATION	0. 081462	0		0 0	0	
	LABORATORY	0. 173141	Ő		0 0	0	
	BLOOD STORING, PROCESSING & TRANS.	0. 188986	0		0 0	0	
	INTRAVENOUS THERAPY	0. 001996	0		0 0	0	
	PHYSICAL THERAPY	0. 471534	0		0 0	0	
	OCCUPATIONAL THERAPY	0. 257053	0		0 0	0	
	AUDI OLOGY	0. 380752	0		0 0	0	
	SPEECH PATHOLOGY	0. 347053	0		0 0	0	
	ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
	I CARDI OLOGY	0. 158056	0		0 11	0	69.0
1.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341159	0		0 0	0	71.0
2.00 07200	IMPL. DEV. CHARGED TO PATIENT	0. 355560	0)	0 0	0	72.0
3.00 07300	DRUGS CHARGED TO PATIENTS	0. 338958	0		0 4, 206	0	73.0
OUTPA	ATIENT SERVICE COST CENTERS						
0.00 09000	CLINIC	0. 000000	0		0 0	0	90.0
	OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	90.0
	2 CLINIC	0. 000000	0		0 0	0	
	B DERMATOLOGY CLINIC	0. 000000	0		0 0	0	
	4 ENT CLINIC	0. 000000	0		0 0	0	
	5 SURGERY CLINIC	0. 000000	0		0 0	0	
	VIROLOGY CLINIC	0. 001814	0		0 0	0	
	GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	
	NEUROLOGY CLINIC	0. 000000	0		0 0	0	
	2 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	
	ALLERGY CLINIC	0. 416141	0		0 0	0	90.1
	WOUND CARE	0. 182294	0		0 734	0	
	EMERGENCY	0. 327512	951		0 0	311	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 519432	0	1	0 0	0	92.00
	REIMBURSABLE COST CENTERS	1 000700		1	0		
		1.008708		1	0		95.00
95.00 09500			1 001		0 5 4 0 0	200	200 00
95.00 09500 200.00	Subtotal (see instructions)		1, 001		0 5,689	323	
			1, 001		0 5,689 0 0	323	200. 00 201. 00

	incial Systems	WI THAM MEMORI		<u></u>		J OF FORM CMS-	-2552-1
APPORITONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet D Part V	
			Component	CCN: 15-S104	To 12/31/2020	Date/Time Pr 8/2/2021 1:5	epared: 0 pm
			Title	e XVIII	Subprovider - IPF	PPS	0 011
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. (see inst.)	Ded. & Coins. (see inst.)				
		6.00	7.00	-			
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00	<u> </u>			
	O OPERATING ROOM	0	0				50.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	9				54.00
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0	0				55.00
55.01 0550	1 ULTRA SOUND	0	0				55.0
57.00 0570	O CT SCAN	0	19				57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
59.00 0590	O CARDI AC CATHETERI ZATI ON	0	0				59.0
	0 LABORATORY	0	0				60.0
	O BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
	O INTRAVENOUS THERAPY	0	0				64.0
	O PHYSI CAL THERAPY	0	0				66.0
	O OCCUPATIONAL THERAPY	0	0				67.0
	1 AUDI OLOGY	0	0				67.0
	O SPEECH PATHOLOGY	0	0				68.00
		0	0				69.00
	1 CARDI OLOGY 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2 0				69.0
	OIMPL. DEV. CHARGED TO PATIENTS	0	0				71.0
	O DRUGS CHARGED TO PATIENTS	0	1, 426	•			73.0
	ATIENT SERVICE COST CENTERS		1, 420	1			- / 0. 0
	O CLINIC	0	0				90.0
	1 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90.0
	2 CLINIC	0	0				90.0
0. 03 0900	3 DERMATOLOGY CLINIC	0	0				90.0
90.04 0900	4 ENT CLINIC	0	0				90.0
90.05 0900	5 SURGERY CLINIC	0	0				90.0
	7 UROLOGY CLINIC	0	0				90.0
	9 GASTROENTEROLOGY CLINIC	0	0				90.0
	1 NEUROLOGY CLINIC	0	0				90.1
	2 OPTHAMOLOGY CLINIC	0	0				90.1
	3 ALLERGY CLINIC	0	0				90.13
	4 WOUND CARE	0	134				90.14
	O EMERGENCY	0	0				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	R REIMBURSABLE COST CENTERS	0					
95.00 0950 200.00	Subtotal (see instructions)	0	1, 590				95.00 200.00
200.00	Less PBP Clinic Lab. Services-Program	0	1, 590				200.00
201.00	Only Charges	0					201.00
				1			

Image: construction of		ncial Systems	WI THAM MEMORI				u of Form CMS-	2552-10
Component CCN: 15-832 To 12/31/2020 DeterTime Prepared President Cost Center Description Cost to From Ion Program Cost to Cost to Charge Ratio Program Charges Ratio Program Skilled Nursing Program Program Oosts MCILLARY SERVICE COST CENTERS 0.132726 0 O 0	APPORTI ONME	INT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0104	Peri od: From 01/01/2020	Worksheet D	
Cost Center Description Cost to Charge Ratio From Worksheet C, Prot Worksheet C,				Component	CCN: 15-5832		Date/Time Pre	epared:) pm
Rest Cost Center Description Cost Cost Charge Ratio From Worksheet C, 9 o Cost S (see inst.) Cost S Cost Subject To Ded. & Coins. Cost S Subject To Ded. & Coins. PPS Services (see inst.) 50:00 00000 (PERATING ROM Subject TO Ded. & Coins.) 1.000 2.00 3.00 4.000 5.00 50:00 00000 (PERATING ROM Subject TO Ded. & Coins.) 0 0 0 0 5.00 50:00 00000 (PERATING ROM Subject TA DED. & Coins.) 0.122726 0 0 0 0 5.00 50:00 005000 (PERATING ROM Subject TA DED. Coins TO DED. & Coins TO DED.				Title	e XVIII	0	PPS	_
Image: Services and the service of the services of the					Charges	- doiling	Costs	
From Darksheet L (Part 1, col.) 9 Services (see 1.st.) Subject To Subject T		Cost Center Description						
Worksheet C, Part I, col. inst.) Bud, & Colins. (see inst.) Subject To Ded, & Colins. 50.00 650000 (PERATING ROM 0.32726 0 0 0 0 0 50.00 050000 (PERATING ROM 0.132726 0 0 0 0 0 0 0 0 0 5.00 50.00 0550000 (PERATING ROM 0.132726 0 0 0 0 0 5.00 55.00 0 0 0 5.00 55.00 0 0 0 5.01 0 0 0 0 5.01 0 5.01 0 0 0 0 5.01 0 5.01 0 5.01 0 5.01 0 5.01 0 5.01 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>(see inst.)</td> <td></td>							(see inst.)	
Part I, col. Ded. % Coins. Ded. % Coins. Ded. % Coins. 05:000 05:000 07:000 2:00 3:00 4:00 5:00 05:000 05:000 07:000 0 0 0 0 5:00 05:000 05:000 00000 0 0 0 0 5:00 0 5:00 0 0 0 0 5:00 0 0 0 5:00 0 0 0 5:00 0 0 0 5:00 0 0 0 5:00 0 0 0 0 5:00 0 0 0 0 5:00 0 0 0 0 0 5:00 0								
9 (see inst.) (see inst.) 4.00 5.00 MACILLARY SERVICE COST CENTERS 0 2.00 3.00 4.00 50.00 60.00 [05:000 (PERATIN (B ROM 0.132726) 0 0 0 0 0 0 0 0 50.00 50.00 [05:000 (CV PLARAPEUTIC) 0.240422 0 0 0 55.00 0 55.00 0 55.00 0 55.00 0.55.00 0 55.00 0.55.00 0 55.00 55.00 55.00 0.55.00 55.00 55.00 0.55.00 0.55.00 55.00 0.55.00 55.00 55.00 55.00 0.55.00 55.0				inst.)				
ANCLLARY SERVICE COST CENTERS 0 2.00 2.00 0.000 0.000 0.000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.00								
ANCILLARY SERVICE COST CENTERS Image: Control of Control On				2.00			F 00	
50.00 05000 0PERATI NG ROOM 0.132726 0 0 0 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 0 0 55.00 0 55.00 0 55.00 0 56.00 0 0 0 0 58.00 0 58.00 0 58.00 0 59.00 0 0 0 0 63.00 0 0 0 63.00 0 0 0 63.00 0 0 0 0 64.00 0 0 0 64.00 0 0 0 64.00 0 0 0 64.00 0 0 0	ANCLI	LADY SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
64.00 05400 RADIOLOGY-DIAGNOSTIC 0.240422 0 0 30 0 54.00 05500 05500 05500 0 0.00000 0 0 0 55.01 05501 ULTR SOUND 0.027424 0 0 744 0 57.00 05700 CRADIALOCY-THERAPEUTIC 0.00000 0 0 0 58.00 05700 CRADIALCACTHETERIZATION 0.08181 0 0 0 68.00 05000 CARDIALCACTHETERIZATION 0.08181 0 0 0 68.00 06000 CARDIALOCY-THETERIZATION 0.08181 0 0 0 64.00 05000 CARDIALOCY-THERAPEUTIC 0.01996 0 0 0 64.00 064000 OCCUPATIONAL THERAPY 0.257053 0 0 0 64.00 06400 OCCUPATIONAL THERAPY 0.257053 0 0 0 67.01 07100 OTOONO OCCUPATIONAL THERAPY 0.380			0 132726		1	0 0	0	50 00
55:00 05500 RADIOLOGY-THERAPUTIC 0.000000 0 0 0 55:00 55:00 05501 <							-	
55.01 05501 ULTRA SOUND 0.109542 0 0 744 0.55.01 05700 00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
57:00 05700 CT SCAN 0.027424 0 0 744 0 57.00 58:00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.081462 0 0 0 58.00 05000 LABORATORY 0.173141 0 0 0 60.00 60.00 60.00 0 0 60.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
58:00 0 (S800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.08181 0 0 0 59:00 0 (S900 CARDI AC CATHETERIZATI ON 0.081462 0 0 0 59:00 0 (S900 CARDI AC CATHETERIZATI ON 0.01713141 0 0 0 60:00 0 (S400 DI LROD STORI NG, PROCESSI NG & TRANS. 0.183986 0 0 0 60:00 0 (S400 OCCUPATI NUME THERAPY 0.01796 0 0 0 64:00 0 (S400 OCCUPATI ONAL THERAPY 0.257053 0 0 0 66:00 0 (S400 OCCUPATI ONAL THERAPY 0.347053 0 0 0 66:00 0 (S400 OECLECTROCARDI OLOGY 0.380752 0 0 0 66:00 0 (S400 OECLECTROCARDI OLOGY 0.380752 0 0 0 0 67:01 0 (S400 ORGE CARDI OLOGY 0.380752 0 0 0 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00							-	
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60:00 06000 LABORATORY 0.173141 0 0 0 60:00 66:00 06:00 BLODD STORING, PROCESSING & TRANS. 0.188986 0 0 0 66:00 0 66:00 0 0 66:00 0 0 66:00 0 0 0 66:00 0 0 0 66:00 0 0 0 66:00 0 0 0 66:00 0 0 0 66:00 0 0 0 67:01 0				-			-	
63.00 643.00 663.00 Second BLOOD STORING, PROCESSING & TRANS. 0.188986 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0.001996 0 0 0 64.00 65.00 06600 PHYSICAL THERAPY 0.27753 0 0 0 67.00 67.01 06701 AUDIOLOGY 0.380752 0 0 0 68.00 68.00 06900 ELECTROCARDIOLOGY 0.380752 0 0 0 68.00 69.01 06901 CARDIOLOGY 0.380752 0 0 0 68.00 69.01 06901 IARDIOLOGY 0.314159 0 0 0 0 71.00 71.00 07300 IRUES CHARGED TO PATIENTS 0.338958 0 5,220 0 73.00 0010900 CLINIC 0.000000 0 0 0 0 0 0 0 0 0 0 0				-			-	
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66.00 0 06600 PHYSICAL THERAPY 0.471534 0 0 0 0 66.00 67.00 06700 OCUPATIONAL THERAPY 0.257053 0 0 0 67.00 0 67.01 06700 0 0 0 67.01 06701 AUDIOLOGY 0.347053 0 0 0 0 68.00 0 0 0 0 68.00 0 0 0 0 0 68.00 0 0 0 0 69.01 68.00 0 0 0 0 0 0 0 0 69.01 69.01 0				-			-	
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69:00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69:00 69:01 06901 CARDI OLOGY 0.000000 0 0.158056 0 0.11 0 69:01 69:00 69:00 69:00 69:00 69:00 0 0 0 69:00 69:00 0 0 0 0 69:00 69:00 69:00 0 0 0 71:00				-				
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73.00 07300 DRUGS CHARGED TO PATIENTS 0.338958 0 0 5,220 0 73.00 0010 OUTPATIENT SERVICE COST CENTERS 0.00000 0				-			-	
OUTPATI ENT SERVICE COST CENTERS 0.00000 0							-	
90.00 09000 CLINIC 0.00000 0			0. 330930	<u> </u>	<u>и</u>	0 5,220	0	/3.00
90.01 09001 OTHER OUTPATI ENT SERVICE COST CENTER 0.000000 0			0,00000	0		0 0	0	
90.02 09002 CLINIC 0.00000 0								
90.03 DERMATOLOGY CLINIC 0.000000 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 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 90.07 90.11 09011 NEUROLOGY CLINIC 0.000000 0 0 0 90.19 90.12 09714 OPTHAMOLOGY CLINIC 0.000000 0 0 0 90.12 90.13 09013 ALLERGY CLINIC 0.182294 0 0 0 90.14 91.00 09100 EMERGENCY 0.327512 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92.00 01HER REIMBURANCE SERVICES 1.008708 0 0 0 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td>				-			-	
90.04 09004 ENT CLINIC 0.000000 0<							-	
90.05 09005 SURGERY CLINIC 0.000000 0 0 0 90.05 90.07 90.07 09007 UROLOGY CLINIC 0.001814 0 0 0 90.07 90.09 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 90.09 90.11 09011 NEUROLOGY CLINIC 0.000000 0 0 90.09 90.12 09012 OPTHAMOLOGY CLINIC 0.000000 0 0 0 90.12 90.13 ALLERGY CLINIC 0.000000 0 0 0 90.12 90.14 09014 WOUND CARE 0.182294 0 0 0 90.14 91.00 09100 EMERGENCY 0.327512 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92.00 01HER REIMBURSABLE COST CENTERS 1.008708 0 0 0 20.00 20.00 20.00 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td>-</td><td></td></t<>				-			-	
90.07 09007 UROLOGY CLINIC 0.001814 0 0 0 90.07 90.07 90.09 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 0 90.09 90.11 09011 NEUROLOGY CLINIC 0.000000 0 0 0 90.07 90.12 09012 OPTHAMOLOGY CLINIC 0.000000 0 0 0 90.12 90.13 09013 ALLERGY CLINIC 0.000000 0 0 0 90.12 90.14 09014 WOUND CARE 0.182294 0 0 0 90.14 91.00 09100 EMERGENCY 0.327512 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92.00 09500 AMBULANCE SERVICES 1.008708 0 0 200.00 201.00 201.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00				-			-	
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90.11 09011 NEUROLOGY CLINIC 0.000000 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 90.12 90.14 09014 WOUND CARE 0.416141 0 0 0 90.13 90.14 0914 WOUND CARE 0.182294 0 0 0 90.14 91.00 EMERGENCY 0.327512 0 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 1.008708 0 95.00 95.00 95.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00								
90.12 09714 09714 09714 09714 09714 09714 09714 09714 09714 09714 09714 09714 09714 00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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91.00 09100 EMERGENCY 0.327512 0 0 0 91.00 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92.00 92.00 0THER REIMBUSABLE COST CENTERS 0 0 0 0 92.00 92.00 0500 AMBULANCE SERVICES 1.008708 0 95.00 95.00 95.00 0 0 0 200.00 200.00 200.00 0 0 0 200.00 201.00 0 0 0 200.00 201.00 0 0 201.00 0 0 201.00 0 0 201.00 201.00 0 0 201.00 0 201.00 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td>				-			-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.519432 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 0 0 0 95. 00 09500 AMBULANCE SERVICES 1.008708 0 95. 00 95. 00 200. 00 Subtotal (see instructions) 0 0 6,025 0 200. 00 201. 00 0 0 0 201. 00 0 0 0 201. 00 201. 00 201. 00 0 0 0 0 201. 00 201. 00 201. 00 0 0 0 0 201. 00 201. 00 201. 00 0 0 0 0 201. 00 <				-			-	
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1.008708 0 95.00 200.00 Subtotal (see instructions) 0 0 6,025 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00								
95.00 09500 AMBULANCE SERVICES 1.008708 0 95.00 200.00 Subtotal (see instructions) 0 0 6,025 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 0 201.00			0. 317432		1	<u> </u>	0	/2.00
200.00 Subtotal (see instructions) 0 0 6,025 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00			1 008708		1	0		95 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges			1.000700				n –	
Only Charges								
		5						
	202.00			c	þ	0 6, 025	о	202.00

	ancial Systems	WI THAM MEMORI				J of Form CMS-25	552-1
IPPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2020	Worksheet D Part V	
			Component	CCN: 15-5832	To 12/31/2020	Date/Time Prep 8/2/2021 1:50	
			Title	e XVIII	Skilled Nursing	PPS	<u></u>
		Cos	sts		Facility		
	Cost Center Description	Cost	Cost	1			
	•	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00	-			
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00				
	O OPERATING ROOM	0	0				50. C
	0 RADI OLOGY-DI AGNOSTI C	0					54.0
5.00 0550	0 RADI OLOGY-THERAPEUTI C	0	0				55.0
5.01 0550	1 ULTRA SOUND	0	0				55.0
7.00 0570	O CT SCAN	0	20				57.0
	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
	O CARDI AC CATHETERI ZATI ON	0	0	1			59. (
	0 LABORATORY	0	0	•			60.0
	O BLOOD STORING, PROCESSING & TRANS.	0	0	•			63.
	O INTRAVENOUS THERAPY	0	0				64.
	0 PHYSI CAL THERAPY 0 OCCUPATI ONAL THERAPY	0					66. 67.
	1 AUDI OLOGY	0					67.
	O SPEECH PATHOLOGY	0					68.0
	0 ELECTROCARDI OLOGY	0	0				69.0
	1 CARDI OLOGY	0	5				69.0
1.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. (
2.00 0720	OIMPL. DEV. CHARGED TO PATIENT	0	C				72.0
	O DRUGS CHARGED TO PATIENTS	0	1, 769				73.
	ATIENT SERVICE COST CENTERS	1		1			
		0					90.
	1 OTHER OUTPATIENT SERVICE COST CENTER 2 CLINIC	0					90. 90.
	3 DERMATOLOGY CLINIC	0		1			90. 90.
	4 ENT CLINIC	0					90. 90.
	5 SURGERY CLINIC	0	l o				90.
	7 UROLOGY CLINIC	0					90.
	9 GASTROENTEROLOGY CLINIC	0	0				90.
0901	1 NEUROLOGY CLINIC	0	0				90.
0901	2 OPTHAMOLOGY CLINIC	0	0				90.
	3 ALLERGY CLINIC	0	0	1			90.
	4 WOUND CARE	0	0	•			90.
	0 EMERGENCY	0					91. (
	0 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. (
	R REIMBURSABLE COST CENTERS						OF 1
5.00 0950 00.00	0 AMBULANCE SERVICES Subtotal (see instructions)	0					95. (200. (
00.00	Less PBP Clinic Lab. Services-Program	0					200. (201. (
	Only Charges	0				2	
02.00	Net Charges (line 200 - line 201)	0	1, 801			2	202.0

	Financial Systems WITHAM MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
		Title XVIII	To 12/31/2020 Hospi tal	Date/Time Pre 8/2/2021 1:50 PPS	
	Cost Center Description		- Hospi tui	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		7, 465	1 1.
00	Inpatient days (including private room days, excluding swing-			7,465	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b			5, 115	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	Join days) through beceind	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
20	reporting period	m dava) ofter December	21 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 OF the cost	0	8
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excludin	g swing-bed and	2,060	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc		room days) after	0	11
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) arter	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	year, enter 0 on this li	ne)	0	14
	Total nursery days (title V or XIX only)	alli (excluding swing-bed	uays)	0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
	reporting period				
	Medicaid rate for swing-bed NF services applicable to service reporting period	U U		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
	Total general inpatient routine service cost (see instruction			9, 624, 855	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)		g por ou (i no o		
. 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, 624, 855	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		1		
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷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)			0.00	
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	9, 624, 855	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see		I	1, 289. 33	38
	Program general inpatient routine service cost per drem (see	•		2, 656, 020	
	Medically necessary private room cost applicable to the Progr			2,000,020	
. 00					

	Financial Systems	WITHAM MEMORIA		011 15 0101		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	veriod: rom 01/01/2020 o 12/31/2020	Worksheet D-1 Date/Time Pre	pared:
			Title	e XVIII	Hospi tal	8/2/2021 1:50 PPS	рш
	Cost Center Description	Total I npati ent Cost	Total Inpatient 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	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
42.00	Intensive Care Type Inpatient Hospital Units	2 702 520	2.015	1 047 0/	1.04/	1 400 004	42.00
43.00 44.00 45.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	3, 792, 538	2, 815	1, 347. 26	1, 046	1, 409, 234	44.00 45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description	I					47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wk					3, 670, 317	•
49.00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		7, 735, 571	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpu	ationt routing	sorvicos (fro	m Wkst D sum	of Parts L and	372, 925	50.00
50.00	(111)		Services (IIU	III WKSL. D, SUIII	UI PALLS I AND	572, 925	50.00
51.00	Pass through costs applicable to Program inp. and IV)		y services (f	rom Wkst. D, s	um of Parts II	175, 361	
52.00	Total Program excludable cost (sum of lines					548, 286	
53.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		nated, non-pr	ysician anestro	etist, and	7, 187, 285	53.00
	Program di scharges					0	54.00
	Target amount per discharge					0.00	•
56.00	Target amount (line 54 x line 55)				50)	0	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996	updated and co	mpounded by the		
07100	market basket	por tring por rou	onding 1770,	apuatoa ana oo	inpoundou by the	0.00	
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	•
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected cost				0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	-					
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	ost per diem (l		• •			71.00
72.00	Program routine service cost (line 9 x line			2F)			72.00
73.00 74.00	Medically necessary private room cost application Total Program general inpatient routine serv	0	•	,			73.00
75.00	Capital -related cost allocated to inpatient - 26, line 45)			·	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77.00	Program capital -related costs (line 9 x line	,					77.00
78.00 79.00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess	,	rovi der recor	(sh			78.00 79.00
80.00	Total Program routine service costs for comp	· · ·		,	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi				,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83.00	Reasonable inpatient routine service costs (s)				83.00
84.00 85.00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ins)				84.00 85.00
86.00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1
87.00	Total observation bed days (see instructions	·				2, 350	
88.00 89.00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•				1, 289. 33 3, 029, 926	
57.00						5, 027, 720	1 07.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 023, 621	9, 624, 855	0. 10635	2 3, 029, 926	322, 239	90.00
91.00 Nursing School cost	0	9, 624, 855	0.00000	0 3, 029, 926	0	91.00
92.00 Allied health cost	0	9, 624, 855	0.00000	0 3, 029, 926	0	92.00
93.00 All other Medical Education	0	9, 624, 855	0.00000	0 3, 029, 926	0	93.00

	Financial Systems WI THAM MEMORIAL TATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-S104	From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
		Title XVIII	Subprovider -	8/2/2021 1:50 PPS	pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		· · · · · · · · · · · · · · · · · · ·		
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			1,400	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivato room dave	1, 400 0	
00	do not complete this line.	ays). It you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b	oed days)		1, 400	4.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5.
~ ~	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	am days) through Decembe	r 31 of the cost	0	7
00	reporting period	Sin days) thi dugh becembe		0	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	1, 001	9
~~	newborn days) (see instructions)			0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		room dayoy artor	Ũ	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period		-		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
~~	after December 31 of the cost reporting period (if calendar			0	1.4
. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
. 00	5 5 1			0	
	SWING BED ADJUSTMENT				1.0
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	10
. 00	reporting period	es through becomber of o		0.00	'
. 00		es after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			2, 212, 857	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18)			0	20
. 00		er 31 of the cost report	ing period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
00	x line 20)			0	24
. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 2, 212, 857	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		I	2,212,007	2'
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		-	0	
. 00	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
. 00 . 00	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	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	2, 212, 857	37
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILISTMENTS			-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 580. 61	20
. 00	Program general inpatient routine service cost (line 9 x line	-		1, 582, 191	
. 00	Medically necessary private room cost applicable to the Progr			0	
. 00					

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	WITHAM MEMORIA	AL HOSPITAL Provider C	CN: 15-0104	In Lie Period:	u of Form CMS- Worksheet D-1	
			CCN: 15-S104	From 01/01/2020 To 12/31/2020		
			e XVIII	Subprovider -	8/2/2021 1:50 PPS	
Cost Conton Deconintian	Tatal			I PF		
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	5	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Un	0	C	0.0	0 0	0	9 42.0
3.00 INTENSIVE CARE UNIT	0	C	0.0	0 0	0	
4. 00 CORONARY CARE UNIT 5. 00 BURN INTENSIVE CARE UNIT						44.0
6. 00 SURGICAL INTENSIVE CARE UNIT						46.0
7.00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3	3, line 200)			174, 463	48.
9.00 Total Program inpatient costs (sum of lir	nes 41 through 48)	(see instructi	ons)		1, 756, 654	49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program	inpatient routine	services (fro	m Wkst. D. su	m of Parts I and	210, 761	50.
	•					
1.00 Pass through costs applicable to Program and IV)	inpatient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	4, 570	51.
2.00 Total Program excludable cost (sum of lir	nes 50 and 51)				215, 331	52.
3.00 Total Program inpatient operating cost ex		elated, non-ph	ysician anest	hetist, and	1, 541, 323	53.
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
4.00 Program discharges					0	
5.00 Target amount per discharge					0.00	
5.00 Target amount (line 54 x line 55) 7.00 Difference between adjusted inpatient ope	erating cost and ta	arget amount (line 56 minus	line 53)		
3.00 Bonus payment (see instructions)	Ũ	0			0	
9.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.
D. 00 Lesser of Lines 53/54 or 55 from prior ye	ar cost report, up	dated by the	market basket		0.00	60.
1.00 Ifline 53/54 is less than the lower of I					0	61.
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		s (lines 54 x	60), or 1% o	f the target		
2.00 Relief payment (see instructions)					0	62.
3.00 Allowable Inpatient cost plus incentive p	payment (see instru	uctions)			0	63.
4.00 Medicare swing-bed SNF inpatient routine	costs through Dece	ember 31 of th	e cost report	ing period (See	0	64.
instructions)(title XVIII only)						
5.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decem	ber 31 of the	cost reportin	g period (See	0	65.
6.00 Total Medicare swing-bed SNF inpatient ro	outine costs (line	64 plus line	65)(title XVI	II only). For	0	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient rou	iting costs through	December 31	of the cost r	enorting period	0	67.
(line 12 x line 19)		December 51	of the cost i	epor tring period		07.
8.00 Title V or XIX swing-bed NF inpatient rou	itine costs after [December 31 of	the cost rep	orting period	0	68.
line 13 x line 20) 9.00 Total title V or XIX swing-bed NF inpatie	ent routine costs (íline 67 + lin	e 68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHE	R NURSING FACILITY	, AND ICF/IID	ONLY		-	
0.00 Skilled nursing facility/other nursing fa 1.00 Adjusted general inpatient routine servic	2		•)		70.
2.00 Program routine service cost (line 9 x li		The 70 ÷ The	2)			72.
3.00 Medically necessary private room cost app	, e	•				73.
4.00 Total Program general inpatient routine s 5.00 Capital-related cost allocated to inpatie				Part II column		74.
26, line 45)	ant routine service		Nor Kancet D,			/ 3.
5.00 Per diem capital-related costs (line 75 ÷						76.
7.00 Program capital-related costs (line 9 x 3.00 Inpatient routine service cost (line 74 m						77.
9.00 Aggregate charges to beneficiaries for ex	cess costs (from p		· · ·			79.
0.00 Total Program routine service costs for c 1.00 Inpatient routine service cost per diem I	•	cost limitatio	n (line 78 mi	nus line 79)		80. 81.
1.00 Inpatient routine service cost per diem 2.00 Inpatient routine service cost limitatior)				81.
3.00 Reasonable inpatient routine service cost	s (see instruction					83.
4.00 Program inpatient ancillary services (see 5.00 Utilization review – physician compensati		ns)				84. 85.
6.00 Total Program inpatient operating costs (85.
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST				-	
7.00 Total observation bed days (see instructi 8.00 Adjusted general inpatient routine cost p		line 2)			0 00	87.
,, as as a general input ont routine cost p		· · · · · · · · · · · · · · · · · · ·			0.00	89.

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (CCN: 15-S104	From 01/01/2020 To 12/31/2020		pared: pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		· ·		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	294, 767	2, 212, 857	0. 13320	07 0	0	90.00
91.00 Nursing School cost	0	2, 212, 857	0.0000	0 00	0	91.00
92.00 Allied health cost	0	2, 212, 857	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	2, 212, 857			0	93.00

JIVIPUI	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od:	Worksheet D-1	2552
		Component CCN: 15-5832	From 01/01/2020 To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title XVIII	Skilled Nursing Facility	PPS	<u>, bui</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	INPATIENT DAYS			1.000	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing	J . J . J		4, 039 4, 039	
00	Private room days (excluding private room days, excluding swing Private room days (excluding swing-bed and observation bed d		rivate room days	4,039	
00	do not complete this line.	ays). It you have only p	rivate room days,	0	
00	Semi-private room days (excluding swing-bed and observation			4,039	4
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5
00	reporting period	and dave) ofter December	21 of the east	0	6
00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oolii days) al ter beceiliber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (oveludin	a swing bod and	2, 342	9
50	newborn days) (see instructions)	to the riogram (excluding	g swillig-bed and	2, 342	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
	through December 31 of the cost reporting period (see instru-	ictions)			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
. 00	through December 31 of the cost reporting period			0	
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
~~	after December 31 of the cost reporting period (if calendar				
. 00 . 00	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
00	reporting period		+h+	0.00	1
. 00	Medicare rate for swing-bed SNF services applicable to servi- reporting period	ces al ter beceniber 31 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period	<u> </u>			
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	inc)		2, 429, 214	21
2.00	Swing-bed cost applicable to SNF type services through Decem		ting period (line	2, 429, 214	
	5 x line 17)			-	
8.00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23
00	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost report	ing period (line	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)	•			
b. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		2, 429, 214	27
. 00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	28
. 00	Private room charges (excluding swing-bed charges)		5 /	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diam charge (line 20 ; line 2)	÷line 28)		0.00000	
. 00	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	
. 00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	itterential (líne	2, 429, 214	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (se	e instructions)			38
00	Program general inpatient routine service cost (line 9 x line	e 38)			39
	Medically necessary private room cost applicable to the Prog	(1) and (1) and (1)	1		40

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	WI THAM MEMORI		CN: 15-0104	In Lie Period:	u of Form CMS- Worksheet D-1			
CONTRACTOR OF THEATTENT OPERATING CUST			CN: 15-0104 CCN: 15-5832	From 01/01/2020 To 12/31/2020				
					8/2/2021 1:50			
			e XVIII	Skilled Nursing Facility	PPS			
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00	42.00		
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	ts					42.00		
43.00 INTENSIVE CARE UNIT						43.00		
44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT						44.00		
46.00 SURGICAL INTENSIVE CARE UNIT						46.00		
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00		
· · · · · · · · · · · · · · · · · · ·					1.00			
48.00 Program inpatient ancillary service cost ()			222)			48.00		
49.00 Total Program inpatient costs (sum of line: PASS THROUGH COST ADJUSTMENTS	s 41 through 48)	(see instructi	ons)			49.00		
50.00 Pass through costs applicable to Program in	npatient routine	services (fro	m Wkst. D, su	um of Parts I and		50.00		
) 51.00 Pass through costs applicable to Program in	npatient ancilla	rv services (f	rom Wkst. D.	sum of Parts II		51.00		
and IV)		· · · · · · · · · · · · · · · · · · ·	,					
52.00 Total Program excludable cost (sum of line: 53.00 Total Program inpatient operating cost excl		elated non-ph	vsician anes	thetist and		52.00 53.00		
medical education costs (line 49 minus line								
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program di scharges						54.00		
55.00 Target amount per discharge						55.00		
56.00 Target amount (line 54 x line 55)				1		56.00		
57.00 Difference between adjusted inpatient opera 58.00 Bonus payment (see instructions)	ating cost and t	arget amount (line 56 minus	s line 53)		57.00		
59.00 Lesser of lines 53/54 or 55 from the cost								
market basket 60.00 Lesser of lines 53/54 or 55 from prior yea	r cost report u	ndated by the	market baske	+		60.00		
61.00 If line 53/54 is less than the lower of lin	nes 55, 59 or 60	enter the les	ser of 50% of	f the amount by		61.00		
which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% (of the target				
62.00 Relief payment (see instructions)						62.00		
63.00 Allowable Inpatient cost plus incentive par PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see instr	uctions)				63.00		
64.00 Medicare swing-bed SNF inpatient routine co	osts through Dec	ember 31 of th	e cost repor	ting period (See		64.00		
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine co	asts after Decom	bor 21 of the	cost roportiu	a pariod (Soo		65.00		
instructions) (title XVIII only)		bel 31 01 the	cost reportin	ig period (see		05.00		
66.00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	tine costs (line	64 plus line	65)(title XV	III only). For		66.00		
67.00 Title V or XIX swing-bed NF inpatient rout	ine costs throug	h December 31	of the cost i	reporting period		67.00		
(line 12 x line 19)	na agata aftar	December 21 of	the east rea	osting pariod		40.00		
68.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	The costs after	December 31 of	the cost re	borting period		68.00		
69.00 Total title V or XIX swing-bed NF inpatien						69.00		
70.00 Skilled nursing facility/other nursing fac				7)	2, 429, 214	70.00		
71.00 Adjusted general inpatient routine service	cost per diem (,	601.44	71.00		
72.00 Program routine service cost (line 9 x line 73.00 Medically necessary private room cost appli		m (line 14 v l	ine 35)		1, 408, 572 0	1		
74.00 Total Program general inpatient routine se	0	•	,		1, 408, 572			
75.00 Capital-related cost allocated to inpatien 26, line 45)	t routine servic	e costs (from	Worksheet B,	Part II, column	0	75.00		
76.00 Per diem capital-related costs (line 75 ÷ 1	line 2)				0.00	76.00		
77.00 Program capital-related costs (line 9 x lin					0			
78.00 Inpatient routine service cost (line 74 min 79.00 Aggregate charges to beneficiaries for exc	,	provider recor	ds)		0			
80.00 Total Program routine service costs for co	mparison to the	•		nus line 79)	0	80.00		
81.00 Inpatient routine service cost per diem lin 82.00 Inpatient routine service cost limitation		1)			0.00 0	1		
83.00 Reasonable inpatient routine service cost rimitation					1, 408, 572			
84.00 Program inpatient ancillary services (see i	instructions)				1, 057, 324	84.00		
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su					0 2, 465, 896			
PART IV - COMPUTATION OF OBSERVATION BED PART	ASS THROUGH COST							
						1 07 00		
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost per		÷ line 2)			0 00	87.00 88.00		

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (CCN: 15-5832	From 01/01/2020 To 12/31/2020		pared: pm
		Title	XVIII	Skilled Nursing	PPS	- <u>-</u>
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				. 89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0.0000	0 00	0	90.00
91.00 Nursing School cost	0	0	0. 00000	0 00	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 00	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 00	0	93.00

	Financial Systems WITHAM MEMORIAL HOS ATION OF INPATIENT OPERATING COST Production	ovider CCN: 15-0104	Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
			To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, e	excluding newborn)		7, 465	1 1.
00	Inpatient days (including private room days, excluding swing-bed	and newborn days)		7, 465	2
00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	lf you have only p	rivate room days,	0	3
00 00	Semi-private room days (excluding swing-bed and observation bed of Total swing-bed SNF type inpatient days (including private room of		er 31 of the cost	5, 115 0	
00	reporting period Total swing-bed SNF type inpatient days (including private room of	days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room da			0	7
	reporting period	5, 6			
00	Total swing-bed NF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	ays) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable to the newborn days) (see instructions)	ne Program (excludin	g swing-bed and	141	9
00	Swing-bed SNF type inpatient days applicable to title XVIII only		room days)	0	10
00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, enter	r 0 on this line)	5 ,		
00	Swing-bed NF type inpatient days applicable to titles V or XIX or through December 31 of the cost reporting period	5 . 61	5 /	0	
00	Swing-bed NF type inpatient days applicable to titles V or XIX or after December 31 of the cost reporting period (if calendar year,			0	13
	Medically necessary private room days applicable to the Program	(excl udi ng swi ng-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			962 97	15
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services t	through December 31	of the cost	0.00	 17
	reporting period	0			
00	Medicare rate for swing-bed SNF services applicable to services a reporting period	after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to services th reporting period	nrough December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services at reporting period	fter December 31 of	the cost	0.00	20
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 3	21 of the cost repor	ting ported (ling	9, 624, 855 0	
	5 x line 17)		31 1		
00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reporti	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December 37	1 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of	of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (lin	ne 21 minus line 26)		9, 624, 855	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed ar	nd observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)	(ma. 20)		0	
00 00	General inpatient routine service cost/charge ratio (line 27 ÷ li Average private room per diem charge (line 29 ÷ line 3)	ne 20)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average per diem private room charge differential (line 32 minus	line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x line 3			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost and 27 minus line 36)	private room cost d	ifferential (line	9, 624, 855	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			1.000.05	1 ~~
00	Adjusted general inpatient routine service cost per diem (see ins	STRUCTLODE)		1, 289. 33	1 38
		-			
. 00 . 00 . 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program)		181, 796 0	39

46. DO SURGE CAL LARTERSIVE CARE UNIT 46. DO 47. DO COST CENTER DESCRIPTION 100 47. DO COST CENTER DESCRIPTION 100 48. DO Program inpatient any service cost (West, D.S. col. 3, Line 200) 220, 273 48. DO 49. DO Program inpatient costs (sum of Lines 41 through 48) (see instructions) 942, 271 49. DO 50. DO Pass through costs applicable to Program inpatient routine services (from West, D. sum of Parts I and III) 05. DO 51. DO Program inpatient operating cost excluding capt tal related, non-physician anesthetist, and one decatal on costs (line 47 min usi Line 52) 05. DO 51. DO Drage through costs applicable cost (sum inpatient operating cost and target amount (line 56 minus line 55) 05. 400 52. DO Diarpet amount per discharge 05. 400 05. 400 53. DD Diarpet amount per discharge 05. 400 05. 400 50. DD Diarpet amount per discharge 05. 400 06. 400 06. 400 50. DD Diarpet amount per discharge 05. 400 06. 400 00. 400 06. 400 06. 400 06. 400 06. 400 06. 400 06. 400 06. 400 06. 400 06. 400 06. 400 <		Financial Systems	WI THAM MEMORI		01 45 0404		u of Form CMS-		
Cost Contor Description Test in transform Test into transform <td>COMPUT</td> <td>ATTON OF INPATIENT OPERATING COST</td> <td></td> <td>Provider C</td> <td>F</td> <td>rom 01/01/2020</td> <td>Date/Time Pre</td> <td>epared:</td>	COMPUT	ATTON OF INPATIENT OPERATING COST		Provider C	F	rom 01/01/2020	Date/Time Pre	epared:	
Impart intImpart intTurnat int				Ti tl	e XIX	Hospi tal		, piii	
1.00 2.00 3.00 4.00 5.00 4.00 10 INDERFY (11 Ls V & XLX ent y) 67.23 9.62 67.90 97 6.780 42.00 10 INDERFY (11 Ls V & XLX ent y) 67.23 9.62 67.90 97 6.780 43.00 10 CROMAN CARE UNIT 3.792.538 2.810 1.347.26 67 90.266 43.00 40.00 CROMAN CARE UNIT 3.792.538 2.810 1.347.26 67 90.266 43.00 47.00 ORDER ANDE (2001114) 1.100 2.8.728 44.00 40.00 Frogram Inpatter to act: (sum of 11 lines 41 through db) (see Instructions) 52.4.757 40 50.00		Cost Center Description	Inpati ent	I npati ent	Diem (col. 1	Program Days	(col. 3 x		
Interastive Care: Type Inguitient Weight all Units: 3, 7/2, 538 2, 815 1, 347.26 67 90, 264 44.00 BURNINTERSIVE Cake: UNIT 3, 7/2, 538 2, 815 1, 347.26 67 90, 264 45.00 BURNINTERSIVE Cake: UNIT 1 1 67 67 67 45.00 SUBJECLE CARE:			1.00	2.00	3.00		5.00		
41.00 INTERSIVE CARE UNIT 3.792.538 2.815 1.347.20 67 90.264 34.00 45.00 BURN INTERSIVE CARE UNIT 3.792.538 2.815 1.347.20 67 90.264 34.00 45.00 BURN INTERSIVE CARE UNIT 3.792.538 2.815 1.347.20 67 90.264 34.00 45.00 BURN INTERSIVE CARE UNIT 3.792.538 2.815 1.347.20 67 90.264 34.00 45.00 BURN INTERSIVE CARE UNIT 3.792.538 2.815 1.347.20 67 90.264 35.00 45.00 Total Program Inpatient costs (sum of lines 41 through 48) (see instructions) 263.728 48.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 52.00 51.00 50.00 51.00 52.00 50.00 <td>42.00</td> <td></td> <td>67, 239</td> <td>962</td> <td>69.90</td> <td>97</td> <td>6, 780</td> <td>42.00</td>	42.00		67, 239	962	69.90	97	6, 780	42.00	
41.00 COROMARY CARE UNIT 44.00 44.00 COROMARY CARE UNIT 44.00 45.00 BURD CAL INTERSIVE CARE UNIT 44.00 45.00 SURCICAL INTERSIVE CARE UNIT 47.00 45.00 SURCICAL INTERSIVE CARE UNIT 47.00 45.00 FORGENERING DESCRIPTION 100 45.01 SURCICAL INTERSIVE CARE UNIT 47.00 45.01 SURCICAL INTERSIVE CARE UNIT 47.00 45.00 FORGENERING DESCRIPTION 254.270 46.00 Program Inpatient and Linary services (sem of Fines AI through costs applicable to Program Inpatient routine services (from Wist. D. sum of Parts II and IV) 51.00 50.00 Total Program Inpatient and Inpati Inpatient operating cost and ling applical related, non-physician anesthetist, and end al V 51.00 51.00 Tasker Moort AND LINIT COMPTAND MAN 054.00 55.00 52.00 Tasker Moort AND LINIT COMPTAND MAN 054.00 55.00 53.00 Tasker Moort AND LINIT COMPTAND MAN 054.00 55.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00 055.00	43 00		3 702 538	2 815	1 347 26	67	00.266	1 13 00	
45. OB BURN INTENSIVE CABE UNIT 45.00 45. OB SUBRICLALINTENSIVE CABE UNIT 45.00 47. 00 OTHER SPECIAL CABE (SPECIFY) 1.00 48. 00 Program Inpattion Costs (sum of Tines 41 Introduct AB) (see instructions) 524.570 50. 00 Prost Introduct Costs (sum of Tines 50 and 51) 0 51.00 51. 00 Prost Introduct Costs (sum of Tines 50 and 51) 0 52.00 52. 00 Total Program Inpattion operating cost and target anount (line 53 0 54.00 50. 00 Target amount (per di Scharge 0 54.00 56.00 57.00 50. 00 Target amount (line 54 for 55 from the cost report in geride anount (line 53) 0 6.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00			3, 192, 550	2,015	1, 347.20	07	90, 200	1	
42.00 Differ SPECIAL CARE (SPECIPY) 47.00 46.00 Program Inpatient ancillary service cost (West, D-3, col. 3, line 200) 263, 724 48.00 46.00 Program Inpatient ancillary service cost (West, D-3, col. 3, line 200) 263, 724 48.00 47.00 Distribution of the cost reporting the program Inpatient routine services (from West, D, sum of Parts I and IV) 512, 721 48.00 10.00 Distribution of the cost reporting provide costs applicable cost (sum of ince 30 and 51) 512, 500 5100 510								45.00	
Cost Center Description 1.00 46.00 Program inpatient ancillary service cost (West D-3, col. 3, line 200) 763,724 48.00 46.01 Tetal Program inpatient costs (sum of lines 41 through 48)(see instructions) 763,724 48.00 46.01 Tetal Program inpatient costs (sum of lines 41 through 48)(see instructions) 763,724 48.00 50.00 Tetal Program inpatient costs (sum of lines 41 through 48)(see instructions) 624,257 49.00 51.00 Peas through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and II) 0 50.00 52.00 Total Program inpatient operating cost excluding capital related. non-physician anesthetist, and III and and compounded by the S1.00 0 53.00 53.00 Target amount (ne 4 × 1 line 50) 0 0.00 55.00 10 Frogram inpatient costs (sim of lines 55.5 % or 60 enter the lesser of 50% or 16 mag and compounded by the 0.00 58.00 0 0.00								46.00	
40.00 Program inpatient ancillary service cost (Wst. D-3. col. 3, line 200) 203, 722 48.00 40.00 Program inpatient costs (sum of lines 51 through 48) (see instructions) 524, 727 48.00 50.00 PASS. Through costs applicable to Program inpatient routine services (from Wst. D., sum of Parts I and Oland V) 50.00 10.00 Prost. Through costs applicable to Program inpatient ancillary services (from Wst. D., sum of Parts II on and V) 0 20.00 Total Program excludable cost (sum of lines 50 and 51) 0.52.00 30.00 Total Program excludable cost (sum of lines 50 and 51) 0.52.00 30.00 Torget amount per discharge 0.00 50.00 Target amount (line 54 x line 55) 0.00 50.00 Target amount (line 54 x line 55) 0.00 50.00 Target amount (line 54 x line 55) 0.00 50.00 Difficience between and/s of strom the cost report, updated by the market basket 0.00 00.01 Instructions) 0.01 01.01 Hermiski senter zone (see instructions) 0.01 02.01 0.01 Hermiski senter zone (see instructions) 0.01 02.01 Diffine 52/34 is 168 from the cost rep	47.00							47.00	
48.00 Program Inpatient ancillery service cost (wist. D-3, col. 3, line 200) 263,728 48.00 49.00 Total Program Inpatient costs (sum of Lines 41 through 48)(see instructions) 542,570 49.00 50.00 Pass ThROUGH COST ADJUSTIVIN'S 55.00 55.00 50.00 Pass ThROUGH COST ADJUSTIVIN'S 55.00 51.00 Physic Through costs applicable to Program inpatient nuclilary services (from Wist. D, sum of Parts II and IV) 51.00 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52) 51.00 54.00 Torget amount (line 54 x line 55) 55.00 50.00 Difference between adjusted Inpatient operating cost and target amount (line 56 minus line 53) 55.00 50.00 Difference between adjusted Inpatient operating cost and target amount (line 56 minus line 53) 56.00 50.00 Difference between adjusted Inpatient operating cost and target amount (line 56 minus line 50), or 16 or 57.00 57.00 50.00 Difference between adjusted Inpatient could pust matrix based tabokt 0.00 61.00 Difference between adjusted Inpatient could pust matrix based tabokt 0.00 62.00 Col Total Hanyment (see instructions) 0.62.00		Cost Center Description					1 00		
Dess through cost ADJUSTMENTS Intervent 0.0 PAss through cost applicable to Program inpatient nucli lesevices (from West. 0, sum of Parts I and IV) 51.00 110 Priss through cost applicable to Program inpatient ancillary services (from West. 0, sum of Parts I and IV) 51.00 2.00 Press through costs applicable to Program inpatient ancillary services (from West. 0, sum of Parts I and IV) 51.00 2.00 Program excludable cost (sum of lines 50 and 51) 52.00 3.00 Tradet Advoit Adv IVI CoMPUTATION 52.00 7.00 Program discharge 0 5.00 Target amount per discharge 0 5.00 Diarget amount (line 54 x line 55) 0.00 St.00 5.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 St.00 0.00 St.00 0.01 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 0.00 St.00 0.01 IFIER St.01 FAT MOTHER St.01 From the cost report ing beried (costs (lines 54 x 60), or 1% of the target amount period (see instructions) 0 0.01 IFIER St.01 FAT MOTHER St.01 From the costs through December 31 of the cost reporting period (See instructions) 0 0.01 Misto and co	48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)				48.00	
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and II. 0 50.00 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II. and IV.) 0 51.00 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 0 0 52.00 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 0 0 0 53.00 Total Program inpatient operating cost excluding capital related. non-physician anesthetist, and 0 0 53.00 64.00 Program discharges 0 64.00 0 55.00 Target amount (line 54 x line 55) 0 55.00 0 0 0 50.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 0	49.00		41 through 48)	(see instructi	ons)		542, 570	49.00	
111) 111	50.00							1 50 00	
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73.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital-related costs (line 75 ÷ line 2)76.0077.00Program capital-related costs (line 74 minus line 77)77.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service cost per diem limitation81.0081.00Inpatient routine service costs (see instructions)81.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,35087.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33				ine /u - line	<u>~)</u>				
75.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost per diem limitation81.0081.00Inpatient routine service cost s (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)87.0070.01Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,289.33				m (line 14 x l	ine 35)			73.00	
26, line 45)76.0076.00Per diem capital -related costs (line 75 + line 2)77.00Program capital -related costs (line 9 x line 76)77.00Inpatient routine service cost (line 74 minus line 77)79.00Aggregate charges to beneficiaries for excess costs (from provider records)80.00Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)80.00Inpatient routine service cost per diem limitation82.00Inpatient routine service cost s (see instructions)83.00Reasonable inpatient routine services (see instructions)84.00Program inpatient ancillary services (see instructions)85.00Utilization review - physician compensation (see instructions)86.00Total Program inpatient operating costs (sum of lines 83 through 85)PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.00Total observation bed days (see instructions)88.00Adjusted general inpatient routine cost per diem (line 27 + line 2)88.00Adjusted general inpatient routine cost per diem (line 27 + line 2)			•					74.00	
76.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost per diem limitation81.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service costs (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.0070.00Total observation bed days (see instructions)2, 35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 289.3388.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 289.33	75.00		routine service	e costs (from	Worksheet B, Pa	art II, column		75.00	
77.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service costs (see instructions)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.0077.00Total observation bed days (see instructions)2,35087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33	76.00		ne 2)					76.00	
79.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)82.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST2,35087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33								77.00	
80.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.0087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33								78.00	
81.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00700Total observation bed days (see instructions)2,35087.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33		55 5 5	· · ·		,	ic Line 70)		1	
82.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST2,35087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33				cost rimitatio		13 IIIIe /9)			
84.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST2,35087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33				1)				82.00	
85.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST2,35087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33	83.00	Reasonable inpatient routine service costs (see instruction					83.00	
86.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.0087.00Total observation bed days (see instructions)2,35088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,289.33								84.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 289.33			•						
87.00 Total observation bed days (see instructions) 2,350 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,289.33 88.00	00.00			in ough 00)			1	00.00	
		Total observation bed days (see instructions)						
os. upuservation bed cost (The s/ x The ss) (see Instructions) [3,029,926] 89.00			•						
	07. UU	UNSELVATION DEG COST (TIME &/ X TIME &8) (Se	e instructions,)			3, 029, 926	07.UU	

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 01/01/2020 To 12/31/2020		pared: pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 023, 621	9, 624, 855	0. 10635	2 3, 029, 926	322, 239	90.00
91.00 Nursing School cost	0	9, 624, 855	0.00000	0 3, 029, 926	0	91.00
92.00 Allied health cost	0	9, 624, 855	0.00000	0 3, 029, 926	0	92.00
93.00 All other Medical Education	0	9, 624, 855	0.00000	0 3, 029, 926	0	93.00

INDATIENT /	ancial Systems WITHAM MEMORIAI ANCILLARY SERVICE COST APPORTIONMENT	- HOSPITAL	CN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAILUT A	ANCIELARI SERVICE COST AFFORITONMENT	FIOVICEIC	GN. 15-0104	From 01/01/2020	WULKSHEEL D-3)
				To 12/31/2020		
				11	8/2/2021 1:50) pm
	Cast Canton Description	litle	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs	
			10 charges	Charges	(col. 1 x	
				charges	col. 2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
	0 ADULTS & PEDIATRICS			1, 918, 242		30.00
	O INTENSIVE CARE UNIT			1, 878, 341		31.00
	0 SUBPROVI DER – I PF			2, 562		40.00
	0 SUBPROVI DER – I RF			0		41.00
	O SUBPROVI DER			0		42.00
	O NURSERY					43.00
	LLARY SERVICE COST CENTERS		0 1007	2/ 2.002.057	410 51(50.00
	O OPERATI NG ROOM O RADI OLOGY-DI AGNOSTI C		0. 1327		410, 516 242, 791	
	0 RADI OLOGY-DI AGNOSTI C		0.2404		242, 791	
	1 ULTRA SOUND		0. 0000		4, 637	
	O CT SCAN		0. 0274		47, 502	
	O MAGNETIC RESONANCE I MAGING (MRI)		0.0881		25, 420	
	O CARDI AC CATHETERI ZATI ON		0.0814		32, 723	
	0 LABORATORY		0. 1731		567, 132	
	0 BLOOD STORING, PROCESSING & TRANS.		0. 1889		19,973	
	O I NTRAVENOUS THERAPY		0.0019		770	
	0 PHYSI CAL THERAPY		0. 4715		148, 939	
67.00 0670	O OCCUPATI ONAL THERAPY		0. 2570		63, 954	67.00
67.01 0670	1 AUDI OLOGY		0. 3807	52 0	0	67.01
	O SPEECH PATHOLOGY		0.3470	53 50, 179	17, 415	68.00
	0 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
	1 CARDI OLOGY		0. 1580	56 3, 525, 246	557, 186	69.01
	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3411		292, 075	
	O I MPL. DEV. CHARGED TO PATIENT		0. 3555		0	
	O DRUGS CHARGED TO PATIENTS		0. 3389	58 2, 390, 895	810, 413	73.00
	ATIENT SERVICE COST CENTERS		0.0000	20		
			0.0000		0	
	1 OTHER OUTPATI ENT SERVICE COST CENTER 2 CLINIC		0.0000		0	
	3 DERMATOLOGY CLINIC		0.0000		0	
	4 ENT CLINIC		0.0000		0	
	5 SURGERY CLINIC		0.0000		0	
	7 UROLOGY CLINIC		0.0018		0	
	9 GASTROENTEROLOGY CLINIC		0.0000		0	
	1 NEUROLOGY CLINIC		0.0000		0	
	2 OPTHAMOLOGY CLINIC		0.0000		0	
	3 ALLERGY CLINIC		0. 4161		0	
	4 WOUND CARE		0. 1822		405	90.14
91.00 0910	0 EMERGENCY		0. 3275	12 1, 308, 244	428, 466	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 5194	32 0	0	92.00
	R REIMBURSABLE COST CENTERS					
	O AMBULANCE SERVI CES					95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			19, 032, 034	3, 670, 317	
201.00	Less PBP Clinic Laboratory Services-Program only charge Net charges (line 200 minus line 201)	es (line 61)		0 19, 032, 034		201.00
202.00						

NPATIENT A	ncial Systems WITHAM MEMORIAL	Provi der C	CN: 15-0104	Peri od:	u of Form CMS-: Worksheet D-3	
NIATENT /	NOTEENIN SERVICE COST ALLONNENT	in ovraci o	011. 13 0104	From 01/01/2020		
		Component	CCN: 15-S104	To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title	e XVIII	Subprovider -	PPS	, pii
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	col. 2) 3.00	
INPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			0		30.00
	INTENSIVE CARE UNIT			0		31.00
0.00 0400	SUBPROVIDER - IPF			1, 314, 398		40.00
1.00 0410	SUBPROVIDER - IRF			0		41.00
	D SUBPROVI DER			0		42.00
	D NURSERY					43.00
	LARY SERVICE COST CENTERS		1		L	
	DOPERATING ROOM		0. 1327			
	D RADI OLOGY-DI AGNOSTI C		0. 2404			
	D RADI OLOGY-THERAPEUTI C		0.0000		-	
	ULTRA SOUND		0. 1095			
	D CT SCAN		0.0274			
	D MAGNETI C RESONANCE I MAGI NG (MRI) D CARDI AC CATHETERI ZATI ON		0. 0881 0. 0814		700 245	
	DLABORATORY		0. 1731			
	D BLOOD STORING, PROCESSING & TRANS.		0. 1889			
	I NTRAVENOUS THERAPY		0.0019		6	
	OPHYSICAL THERAPY		0. 4715			
7.00 0670	OCCUPATIONAL THERAPY		0. 2570			
7.01 0670 ⁻	1 AUDI OLOGY		0. 3807	52 0	0	67.0
	D SPEECH PATHOLOGY		0. 3470		303	68.0
	D ELECTROCARDI OLOGY		0.0000		, s	1
	1 CARDI OLOGY		0. 1580			
	D MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 3411			
	DIMPL. DEV. CHARGED TO PATIENT		0. 3555		0	
	D D D D D D D D D D D D D D D D D D D		0. 3389	58 280, 392	95, 041	73.0
	ATIENT SERVICE COST CENTERS		0.0000	00 0	0	90.0
	OTHER OUTPATIENT SERVICE COST CENTER		0.0000			
	2 CLINIC		0.0000			
	3 DERMATOLOGY CLINIC		0.0000			
	4 ENT CLINIC		0.0000			
0. 05 0900!	5 SURGERY CLINIC		0.0000	00 0	0	90.0
0. 07 0900	7 UROLOGY CLINIC		0. 0018	14 0	0	90.0
0.09 0900	9 GASTROENTEROLOGY CLINIC		0.0000	00 0	0	90.0
	1 NEUROLOGY CLINIC		0.0000	00 0	0	90.1
	2 OPTHAMOLOGY CLINIC		0.0000	00 0		
	3 ALLERGY CLINIC		0. 4161			
	4 WOUND CARE		0. 1822		6	
	DEMERGENCY		0.3275			
	D OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS		0. 5194	32 0	0	92.0
	A REIMBURSABLE CUST CENTERS					95.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			718, 625	174, 463	
201.00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		023	1,1,403	200.00
	on the Laber area , ber theos in ogram only charge		1	718, 625	1	202.00

ealth Financial Systems WITHAM MEMORIA NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	L HOSPITAL	CN: 15-0104	Peri od:	u of Form CMS-: Worksheet D-3	
NFATTENT ANGLEART SERVICE COST AFFORTIONMENT	FIOVIDEI C	GN. 15-0104	From 01/01/2020)
	Component	CCN: 15-5832	To 12/31/2020	Date/Time Pre	
	Title	e XVIII	Skilled Nursing	8/2/2021 1:50 PPS	рш
Cost Conton Description			Facility		
Cost Center Description		Ratio of Cos		Inpatient Program Costs	
		To Charges	Charges	(col. 1 x	
			onar ges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
10. 00 04000 SUBPROVI DER – I PF			0		40.00
11.00 04100 SUBPROVIDER - IRF			0		41.00
12.00 04200 SUBPROVI DER			0		42.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 1327	26 40, 851	5, 422	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2404			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			
55. 01 05501 ULTRA SOUND		0. 1095			
57. 00 05700 CT SCAN		0.0274			
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0881			58.0
9.00 05900 CARDI AC CATHETERI ZATI ON		0. 0814	62 29, 528	2, 405	59.0
0. 00 06000 LABORATORY		0. 1731	41 235, 155	40, 715	60.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1889		-	
04.00 06400 INTRAVENOUS THERAPY		0.0019		34	
56. 00 06600 PHYSI CAL THERAPY		0. 4715			
7.00 06700 OCCUPATI ONAL THERAPY		0. 2570		249, 506	
7. 01 06701 AUDI OLOGY		0. 3807		, s	
8. 00 06800 SPEECH PATHOLOGY		0.3470		9, 860	
99. 00 06900 ELECTROCARDI OLOGY 99. 01 06901 CARDI OLOGY		0.0000		0 33, 717	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1580		36, 912	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3411			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3389		-	
OUTPATI ENT SERVICE COST CENTERS			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	200,100	1 / 0.1 0
0. 00 09000 CLINIC		0.0000	00 0	0	90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000	00 0	0	90.0
0. 02 09002 CLINIC		0.0000		0	90.0
0. 03 09003 DERMATOLOGY CLINIC		0.0000		-	
0. 04 09004 ENT CLINIC		0.0000		-	1
0. 05 09005 SURGERY CLINIC		0.0000			
0. 07 09007 UROLOGY CLINIC		0.0018		-	1
0. 09 09009 GASTROENTEROLOGY CLINIC		0.0000			
0. 11 09011 NEUROLOGY CLINIC 0. 12 09012 OPTHAMOLOGY CLINIC		0.0000		, s	
0. 12 09012 OPTHAMOLOGY CLINIC 0. 13 09013 ALLERGY CLINIC		0. 0000			
0. 13 09013 ALLERGY CLINIC 0. 14 09014 WOUND CARE		0. 4181		-	
01. 00 09100 EMERGENCY		0. 1822			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5194			
OTHER REI MBURSABLE COST CENTERS				0	10
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 322, 007	1, 057, 324	200.0
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			3, 322, 007		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0104	In Lie Period:	Worksheet D-3	
			From 01/01/2020		
			To 12/31/2020		
		e XIX	Hospi tal	8/2/2021 1:50 Cost	pm
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
				col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		1	1, 071, 168		30.0
31. 00 03100 I NTENSI VE CARE UNI T			83, 194		31.0
40. 00 04000 SUBPROVI DER - I PF			4, 252		40.0
11. 00 04100 SUBPROVI DER - I RF			0		41.0
12. 00 04200 SUBPROVI DER			0		42.0
43. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS		1		1	
50.00 OSOOO OPERATING ROOM		0. 1327			
54.00 05400 RADI OLOGY-DI AGNOSTI C		0.2404			
55. 00 O5500 RADI OLOGY-THERAPEUTI C		0.0000			
55.01 05501 ULTRA SOUND		0. 1095			
77.00 05700 CT SCAN		0.0274		-	
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0881			
9. 00 05900 CARDIAC CATHETERIZATION 0. 00 06000 LABORATORY		0. 0814 0. 1731			
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1731			1
54. 00 06400 INTRAVENOUS THERAPY		0. 1889			
56. 00 06600 PHYSI CAL THERAPY		0. 4715		-	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 2570			
57. 01 06701 AUDI OLOGY		0. 3807			
58.00 06800 SPEECH PATHOLOGY		0. 3470			
59. 00 06900 ELECTROCARDI OLOGY		0.0000		0	69.0
59. 01 06901 CARDI OLOGY		0. 1580	56 0	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3411	59 118, 173	40, 316	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3555	60 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3389	58 255, 240	86, 516	73.0
OUTPATIENT SERVICE COST CENTERS		1			
		0.0000			
00.01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000			
0. 02 09002 CLINIC		0.0000			
0. 03 09003 DERMATOLOGY CLINIC 0. 04 09004 ENT CLINIC		0.0000			
0. 04 09004 ENT CLINIC 0. 05 09005 SURGERY CLINIC		0. 0000 0. 0000			
0. 05 09005 SURGERY CEINIC 0. 07 09007 UROLOGY CLINIC		0.0000			
0. 07 09007 0R0L0GY CLINIC 0. 09 09009 GASTROENTEROLOGY CLINIC		0.0018			
0. 09 109009 GASTROENTEROLOGT CLINIC 0. 11 09011 NEUROLOGY CLINIC		0.0000		-	
0. 12 09012 OPTHAMOLOGY CLINIC		0.0000		-	
0. 13 09013 ALLERGY CLINIC		0. 4161			
0. 14 09014 WOUND CARE		0. 1822			
1. 00 09100 EMERGENCY		0. 3275			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5194			
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 143, 777	263, 728	
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)		1	1, 143, 777	1	202.0

ALCUL	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Period: From 01/01/2020	ı of Form CMS-: Worksheet E Part A	
			To 12/31/2020	Date/Time Pre 8/2/2021 1:50	
		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	0 4, 681, 954	
02	DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	1, 566, 393	1.
03	DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for discharges occurring	prior to October	0	1.
04	DRG for federal specific operating payment for Model 4 BPCI 1 October 1 (see instructions)	for discharges occurring	on or after	0	
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 2.
02	Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	
03	Outlier payments for discharges occurring prior to October 1			3, 496	
04	Outlier payments for discharges occurring on or after October	r 1 (see instructions)		6, 116	2.
00	Managed Care Simulated Payments			0	
00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instr	ructions)	62.72	4.
00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.
00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap for	0.00	6.
00 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	
00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	8.
01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl			0.00	8.
02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap sl			0.00	8.
00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir	nes (8, 8,01 and 8,02)	(see	0.00	9.
). 00	instructions) FTE count for allopathic and osteopathic programs in the curr	rent year from your reco	ords	0.00	
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00	
3.00	Total allowable FTE count for the prior year.			0.00	
. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,	0.00	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15
	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital clo	osure		0.00	
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	4)		0.00 0.000000	
	Prior year resident to bed ratio (see instructions)	·)·		0.000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	22
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	22 of the MMA		0	22
. 00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).		CFR 412.105	0.00	23
. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24
. 00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00	
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27
	IME add-on adjustment amount (see instructions)	5)		0	
	Total IME payment (sum of lines 22 and 28)			0	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	
0.00	Disproportionate Share Adjustment	antiont dave (and insta-	uctions)		1 20
). 00 I. 00	Percentage of SSI recipient patient days to Medicare Part A p Percentage of Medicaid patient days (see instructions)	batient days (see instru	ictions)	3. 37 23. 98	
2.00	Sum of lines 30 and 31			23.98	
3.00	Allowable disproportionate share percentage (see instructions	s)		11.78	
		-			

Heal th	Financial Systems WITHAM MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
25 00	Uncompensated Care Adjustment		0	0	25 00
35.00 35.01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0.00000000	0.00000000	35.00 35.01
35.01	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (se		991, 071	35.02
00.02	instructions)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00.02
35.03	Pro rata share of the hospital uncompensated care payment amou	nt (see instructions)	711, 404	249, 804	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		961, 208		36.00
	Additional payment for high percentage of ESRD beneficiary dis				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68	34 and 685. (see	0		40.00
41 00	instructions)				41 00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68 instructions)	33, 684 an 685. (See	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-D	NRGs 652 682 683 684	0		41.01
	an 685. (see instructions)		Ū		
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualif	y for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.		0.00		46.00
47.00	Subtotal (see instructions)	01)	7, 403, 181		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	0		48.00
	only. (see instructions)				
				Amount	
10.00				1.00	10.00
49.00	Total payment for inpatient operating costs (see instructions)			7, 403, 181	49.00
50.00 51.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			483, 405 0	50.00 51.00
52.00	Direct graduate medical education payment (from Wkst. E.4, lir	· · · · · ·		0	52.00
53.00	Nursing and Allied Health Managed Care payment			Ő	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intru			0	56.00
57.00 58.00	Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I		nrougn 35).	0	57.00 58.00
59.00	Total (sum of amounts on lines 49 through 58)	v, col. 11 111e 200)		7, 886, 586	
60.00	Primary payer payments			0,000,000	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		7, 886, 586	61.00
62.00	Deductibles billed to program beneficiaries			727, 584	62.00
63.00	Coinsurance billed to program beneficiaries			3, 872	63.00
64.00	Allowable bad debts (see instructions)			52, 057	
65.00	Adjusted reimbursable bad debts (see instructions)	susti opc)		33, 837	
66.00 67.00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63)	uctions)		52, 057 7, 188, 967	66.00 67.00
68.00	Credits received from manufacturers for replaced devices for a	unnlicable to MS_DRGs (s	ee instructions)	7, 188, 907	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		- /	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see	instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70. 87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)		_	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70.92 70.93	HVBP payment adjustment amount (see instructions)			11, 262	
70.93	HRR adjustment amount (see instructions)			-61, 110	
	Recovery of accel erated depreciation				70.95

	Financial Systems WITHAM MEMORIAL TION OF REIMBURSEMENT SETTLEMENT	Provi der CC	N: 15-0104	Peri od:	u of Form CMS-2 Worksheet E	10
				From 01/01/2020 To 12/31/2020	Part A	
		Title	XVIII	Hospi tal	PPS	pili
				′ (уууу)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		2020	692, 276	70.96
70.07	the corresponding federal year for the period prior to 10/1)			2021	222.021	70.07
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2021	232, 821	70.97
70. 98	Low Volume Payment-3				0	70.98
	HAC adjustment amount (see instructions)				0	70.99
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			8, 064, 216	71.00
71.01	Sequestration adjustment (see instructions)				53, 224	71.01
1	Demonstration payment adjustment amount after sequestration				0	
1	Sequestration adjustment-PARHM pass-throughs				7 740 500	71.03
	Interim payments Interim payments-PARHM				7, 713, 532	72.00
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)				, v	73.01
	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			297, 460	
	73)					
	Balance due provider/program-PARHM (see instructions)					74.01
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			172, 104	75.00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					-
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.00
/01/00	plus 2.04 (see instructions)	01 2100			, i i i i i i i i i i i i i i i i i i i	/
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
1	Operating outlier reconciliation adjustment amount (see instr				0	
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instructions)				0.00	
	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc				0	
/0.00				Prior to 10/1	On/After 10/1	70.00
				1.00	2.00	
	ISP Bonus Payment Amount				L	
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0. 000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0.0000000000000000000000000000000000000		102.00
	IRR Adjustment for HSP Bonus Payment	3)				102.00
	HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructions			0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonst	<u>ration) Adju</u>	stment			
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	riod under t	ne 21st			200.00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
	Medicare discharges (see instructions)					202.00
203.00	Case-mix adjustment factor (see instructions)					203.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curre	ent 5-year demons	strati on	
	beriod) Madi aana tangat amaunt					1204 00
	Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					204.00 205.00
	Medicare inpatient routine cost cap (line 202 times time 204)					205.00
	Adjustment to Medicare Part A Inpatient Reimbursement					200.00
	Program reimbursement under the §410A Demonstration (see inst	ructions)				207.00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208.00
	Adjustment to Medicare IPPS payments (see instructions)					209.00
	Reserved for future use					210.00
	Total adjustment to Medicare IPPS payments (see instructions)					211.00
	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	211)				212.00
		211)				212.00
213.00	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS a	nd cost reim	bursement)			218.00

	Financial Systems LUME CALCULATION EXHIBIT 4		WI THAM MEMORI	Provider C	1	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pre	t 4 pare
				T: +! -	XVIII	Hospi tal	8/2/2021 1:50 PPS	pm
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01		Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	(0 0	0	1.
)1	payments DRG amounts other than outlier payments for discharges	1.01	4, 681, 954	0	4, 681, 954	4	4, 681, 954	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 566, 393	0		1, 566, 393	1, 566, 393	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	0	(כ כ	0	1.
)4	October 1 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						2.
)1	discharges (see instructions) Outlier payments for	2.02	0	0	(0 0	0	2.
)2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	3, 496	0	3, 490	6	3, 496	2.
03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	6, 116	0		6, 116	6, 116	2.
00	instructions) Operating outlier reconciliation	2.01	0	0	(o o	0	3.
00	Managed care simulated payments	3.00	0	0	(0 0	0	4.
	Indirect Medical Education Adju							
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000	0. 000000		5.
00	IME payment adjustment (see instructions)	22.00	0	0	(o o	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0	(0 0	0	6
	Indirect Medical Education Adju	stment for th	e Add-on for Se	ection 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000			0.000000		7
0	IME adjustment (see instructions)	28.00	0	0	(0 0	0	8
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	(0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	(0 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	(0 0	0	9
	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see	33.00	0. 1178	0. 1178	0. 1178	3 0. 1178		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	184, 014	0	137, 884	46, 130	184, 014	11
01	Additional payment for high per	36.00	961,208 RD beneficiary		711, 404	4 249, 804	961, 208	11.
00	Total ESRD additional payment	46.00	0	0	(0 0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	7, 403, 181	0	5, 534, 738	3 1, 868, 443	7, 403, 181	13
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	(0 0	0	14
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	7, 403, 181	0	5, 534, 738	3 1, 868, 443	7, 403, 181	15

	Financial Systems		WITHAM MEMORI	Provider C	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		t 4 epared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4,00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	483, 405	0			483, 405	16.00
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	0	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.01 17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	5, 901, 7	52 1, 984, 834	7, 886, 586	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	482, 768 0	0		34 116, 034 0 0	482, 768 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	637 0	0		30 357 0 0	637 0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000				22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	483, 405	0	367, 01	14 116, 391	483, 405	26.00
		W/S E, Part A						
		line	E, Part A)	0.55				
07.00		0	1.00	2.00	3.00	4.00	5.00	07.00
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 1173(692, 2		692, 276	27.00 28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				232, 821	232, 821	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

Title XVIII Hospit 0 DRG amounts other than outlier payments discharges occurring prior to October 1 Amt. From Wkst. E, Pt. Amt. From Wkst. E, Pt. Period to 10/01 after 2 1.00 DRG amounts other than outlier payments discharges occurring prior to October 1 1.00 2.00 3.0 1.01 DRG amounts other than outlier payments for discharges occurring on or after October 1 1.02 1,566,393 1.5 1.03 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 1.04 0 0 0 1.04 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 0.04 0 0 0 2.00 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.03 3,496 3,496 2.03 Outlier payments for discharges occurring or after October 1 (see instructions) 2.01 0 0 0 3.00 Outlier payment for managed care (see instructions) 2.01 0.00000 0.000000 0.000000 6.01 IME payment adjustment for managed care (see instructions) 22.00 0 0 0	1/2020 Date/Time I 8/2/2021 PPS i on Total (cols 0/01 2 and 3) 0 4.00 66, 393 1, 566, 3 0 3, 4 0 3, 4	ibit 5 Prepare :50 pm S s. 954 1.
West E, Pt. A, LineAnt. From West, E, Pt. A)Period to 10/01Period after 4 A)1.00DRG amounts other than outlier payments discharges occurring prior to 0ctober 1 discharges occurring prior to 0ctober 11.002.003.01.01DRG amounts other than outlier payments for discharges occurring on or after October 1 tor Model 4 BPCI occurring prior to 0ctober1.021.566,3931.51.03DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 11.040001.04DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 11.040001.04DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 12.033,4963,4962.01Outlier payments for discharges (see periot to 0ctober 12.033,4963,4962.02Outlier payments for discharges occurring or after October 1 (see instructions) or after October 1 (see instructions) s.000000Operating outlier reconciliation (see instructions)2.010000Mamaged care simulated payments (see instructions)2.000000Mamaged care simulated payment (see instructions)2.000000Mamaged care simulated payment (see instructions)2.000000Mamaged care simulated payment (see instructions)22.000000 <t< td=""><td>al PPS I on 0/01 Total (cols 2 and 3) 0 4.00 4,681,9 66,393 1,566,3 0 3,4 6,116 6,1 0 3,4</td><td>S. S. 1. 954 1. 393 1. 0 1. 0 1. 2. 0 2. 496 2. 116 2.</td></t<>	al PPS I on 0/01 Total (cols 2 and 3) 0 4.00 4,681,9 66,393 1,566,3 0 3,4 6,116 6,1 0 3,4	S. S. 1. 954 1. 393 1. 0 1. 0 1. 2. 0 2. 496 2. 116 2.
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(see instructions) 1.00 Disproportionate share adjustment (see 34.00 184,014 137,884	0. 1178	10.
instructions)		014 11.
1.01 Uncompensated care payments 36.00 961,208 711,404 2	49, 804 961, 2	208 11.
Additional payment for high percentage of ESRD beneficiary discharges2.00Total ESRD additional payment (see46.0000instructions)0000	0	0 12.
B. 00Subtotal (see instructions)47.007,403,1815,534,7381,8H. 00Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see48.0000	68, 443 7, 403, 1 0	181 13. 0 14.
instructions) 5.00 Total payment for inpatient operating costs 49.00 7,403,181 5,534,738 1,8 (see instructions)	68, 443 7, 403, 1	181 15.
	16 201 402	405 16.
7.00 Special add-on payments for new technologies 54.00 0 0 7.01 Net organ acquisition cost 0 0	16, 391 483, 4	0 17. 17.
7.02 Credits received from manufacturers for 68.00 0 0 replaced devices for applicable MS-DRGs 0 0 0	Ο	0 17. 0 18.
8. 00 Capital outlier reconciliation adjustment amount (see instructions) 93. 00 0 0 9. 00 SUBTOTAL 5, 901, 752 1, 9		

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	WITHAM MEMORI		°N: 15_0104	In Lie Period:	u of Form CMS-: Worksheet E	2552-10
103111	AL ACQUIRED CONDITION (IAC) REDUCTION CALCULA				From 01/01/2020 To 12/31/2020	Part A Exhibi	epared:
			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	482, 768	366, 73		482, 768	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
	Capital DRG outlier payments	2.00	637	28	30 357	637	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	483, 405	367, 01	4 116, 391	483, 405	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1,00	2.00	3.00	4.00	
27.00		0	1.00	2.00	0.00	1.00	27.00
28.00	Low volume adjustment prior to October 1	70, 96	692, 276	692, 27	6	692, 276	
29.00	Low volume adjustment on or after October 1	70, 97	232, 821		232, 821	232, 821	
	HVBP payment adjustment (see instructions)	70. 93	11, 262	17,80			
	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	
31.00	HRR adjustment (see instructions)	70, 94	-61, 110	-36, 98	-24, 123	-61, 110	31.00
	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E. Pt. A.		N				100.00

2.00 Medical and other services reimbursed under OPPS (see instructions) 13,92 3.00 OPPS payments 12,12 4.01 Outlier payment (see instructions) 12,12 4.01 Outlier reconciliation amount (see instructions) 12,12 5.00 Enter the hospital specific payment to cost ratio (see instructions) 12,12 6.00 Transitional corridor payment (see instructions) 14,01 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 16,00 8.00 Transitional corridor payment (see instructions) 16,00 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10,00 10.00 Organ acquisitions 11,01 11.00 Total cost (sum of lines 1 and 10) (see instructions) 11,01 12.00 Ancillary service charges 11,00 12.00 Ancillary service charges 11,00 12.00 Ancillary service charges 11,00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 01 14.00 Total reasonable charges 01 15.00 Aggregate amount actually collected from patients liable for payment for services on	1:50 PPS 7,590 9,497 1,593 4,586 0 0.000 0 0,000 0 0,000 0 0,000 0 0,000 0 0,000 0,00000 8,315 0 0,725 0 7,590 0,7590	pm 1.00 2.00 3.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
Title XVIII Hospital PART B MEDICAL AND OTHER HEALTH SERVICES 1.00 100 Medical and other services (see instructions) 1.3,97 2:00 Medical and other services (see instructions) 13,97 3:00 OPPS payments 12,11 4:00 Outlier payment (see instructions) 12,11 4:00 Outlier recorditation amount (see instructions) 12,11 6:00 Finantitional corridor payment (see instructions) 12,11 6:00 Transitional corridor payment (see instructions) 12,11 7:00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 1000 7:00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 1000 7:00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 1000 7:00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 1000 7:00 Ancillary service cost of CHARGES 1000 101 8:00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a c	PPS 7, 590 9, 497 1, 593 4, 586 0, 00 0 0, 00 0, 0, 00 0, 0000000	1.00 2.00 3.00 4.01 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
PART B MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 13,92 2.00 Medical and other services (see instructions) 13,92 3.00 OPPS payments 12,12 4.01 Outlier payment (see instructions) 12,12 4.00 Outlier payment (see instructions) 12,12 4.00 Outlier payment (see instructions) 12,12 5.00 Enter the hospital specific payment to cost ratio (see instructions) 12,12 6.00 Line 2 times line 5 12,12 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 13,11 8.00 Transitional corridor payment (see instructions) 14,01 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10,00 0.00 Organ acquisition CoAldress 16,00 COMPUTATION OF LESSER OF COST OR CHARGES 12,00 Ancillary service charges 12,01 10.00 Organ acquisition charges (sum of lines 12 and 13) 00 00 00 Customary charges Sum optients liable for payment for services on a charge basis had such paym	7, 590 9, 497 1, 593 4, 586 0 0, 000 0 0 0 0 7, 590 8, 315 0 8, 315 0 0 0 0 0 0 0 0 0 7, 590 0 0 0 0 0 7, 590 0 0 0 0 0 0 7, 590 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 01\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
PART B MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 13,92 2.00 Medical and other services (see instructions) 13,92 3.00 OPPS payments 12,12 4.01 Outlier payment (see instructions) 12,12 4.00 Outlier payment (see instructions) 12,12 4.00 Outlier payment (see instructions) 12,12 4.00 Outlier payment (see instructions) 12,12 5.00 Enter the hospital specific payment to cost ratio (see instructions) 12,12 6.00 Ulie 2 times line 5 12,12 7.00 Sum of lines 3,4, and 4.01, divided by line 6 13,110 8.00 Transitional corridor payment (see instructions) 10,00 0.00 Organ acquisitions 10,01 11.00 Total cost (sum of lines 1 and 10) (see instructions) 10,01 0.00 Ancillary service charges 12,00 12.00 Ancillary service charges 12,00 13.00 Organ acquisition charges (sum of lines 12 and 13) 00 14.01 Total reasonable	7, 590 9, 497 1, 593 4, 586 0 0, 000 0 0 0 0 7, 590 8, 315 0 8, 315 0 0 0 0 0 0 0 0 0 7, 590 0 0 0 0 0 7, 590 0 0 0 0 0 0 7, 590 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 01\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
1.00 Medical and other services (see instructions) 1.3, 92 2.00 Medical and other services reimbursed under OPPS (see instructions) 13, 92 3.00 OPPS payments 13, 92 4.00 Outlier payment (see instructions) 13, 92 4.01 Outlier reconciliation amount (see instructions) 14, 92 5.00 Enter the hospital specific payment to cost ratio (see instructions) 16, 92 6.00 Transitional corridor payment (see instructions) 16, 92 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10, 00 10.00 Organ acquisitions 16, 92 11.00 Total cost (sum of lines 1 and 10) (see instructions) 16, 92 11.00 Total cost (sum of lines 1 and 10) (see instructions) 16, 92 11.00 Total cost (sum of lines 1 and 10) (see instructions) 16, 92 12.00 Ancillary service charges 16, 92 16, 93 16, 93 13.00 Torgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 16, 93 16, 93 13.00 Torgan acquisition charges (from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413, 1	9, 497 1, 593 4, 586 0, 000 0, 000 0, 00 0, 7, 590 0, 7, 590 0, 7, 590 0, 00 0, 00 0, 7, 590 0, 00 0, 00 0, 7, 590 0, 00 0, 00 0, 00 0, 7, 590 0, 00 0, 00 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 01\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
3.00 OPPS payments 12, 11 4.00 Outlier payment (see instructions) 12, 12 4.01 Outlier reconciliation amount (see instructions) 12, 12 5.00 Enter the hospital specific payment to cost ratio (see instructions) 12 6.00 Transitional corridor payment (see instructions) 13, 10 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 14 8.00 Transitional corridor payment (see instructions) 14 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 15 10.00 Organ acquisitions 12 11.00 Total cost (sum of lines 1 and 10) (see instructions) 16 COMPUTATION OF LESSER OF COST OR CHARGES 12 Reasonable charges 12 13 12.00 Ancillary service charges (sum of lines 12 and 13) 16 Customary charges 12 13.00 10 13.00 Total reasonable charges (sum of lines 1.000000) 0.0 0.0 14.00 Total reasonable charges (sum of lines 1.000000) 0.0 0.0 15.00 Aggregate amount actually collected from patients liable for payment for services on a ch	1, 593 4, 586 0 0, 000 0 0 0 0 0 7, 590 8, 315 0 8, 315 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 4.\ 01\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
4.00 Outlier payment (see instructions) 3.3 4.01 Outlier reconciliation amount (see instructions) 5.3 5.00 Enter the hospital specific payment to cost ratio (see instructions) 5.3 6.00 Line 2 times line 5 5.3 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 5.3 8.00 Transitional corridor payment (see instructions) 9.0 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 0.00 Organ acquisitions 7.0 11.00 Tests of COST OR CLARGES 7.0 Reasonable charges 7.0 12.00 Ancillary service charges 7.0 13.00 Organ acquisition charges (sum of lines 12 and 13) 7.0 Customary charges 7.0 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 7.0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.0 0.0 18.00 Lesser of cost or charges (see instructions) 7.0 0.0 19.00 Excess of reasonable cost over customary charges	4, 586 0, 000 0, 000 0, 000 0, 00 0, 00 0, 590 8, 315 0, 725 0 7, 590 0 7, 590 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 4.00\\ 4.01\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$
4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Total cost (sum of lines 12 and 13) Customary charges Customary charges 13.00 Organ acquisition charges (sum of lines 12 and 13) Customary charges Customary charges 10.01 Total reasonable charges (sum of lines 12 and 13) Customary charges Customary charges 10.00 Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 10.00 Reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) 10.00 Excess of customary charges	0.000 0.00 0.00 0 0 0 0 7,590 8,315 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$
6.00 Line 2 times ine 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 01.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 03.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges 12.00 Ancillary service charges 03.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges 04.00 Total reasonable charges (sum of lines 12 and 13) 05.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19.00 Excess of customary charges (see instructions) 20.00 Exce	0 0.00 0 0 7,590 8,315 0 8,315 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 19.00\\ \end{array}$
7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 2.00 Ancillary service charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.0 18.00 Detat customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.0 19.00 Excess of customary charges (see instructions) 0.0 20.01 Interns and residents (see instructions) 0.0 21.00 Interns and residents (see instructions) 0.0 22.00 Interns and residents (see instructions) 0.0 23.00 Co	0.00 0 0 7,590 8,315 0 8,315 0 0 0 0 0 0 0 0 0 0 7,590 0 7,590 0 0 0 0 0 0 0 0 0 0 0 0 0	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
8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 18.00 Total customary charges (see instructions) 0.0 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.0 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.0 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.0 21.00 Lesser of cost or charges (see instructions) 0.0 22.00 Interns and residents (see instructions	0 0 7, 590 8, 315 0 8, 315 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 7, 590 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 7, 590 0 0 7, 590 0 7, 590 0 7, 590 0 8, 315 0 8, 315 0 8, 315 0 8, 315 0 0 8, 315 0 0 8, 315 0 0 0 7, 590 0 0 8, 315 0 0 0 0 0 7, 590 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
10.00 Organ acquisitions	0 7, 590 8, 315 0 8, 315 0 0 0 0 0 0 0 0 0 0 7, 590 0 0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
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COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 17.00 Ratio of line 15 to line 16 (not to exceed 1.00000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 Excess of cost or charges (see instructions) 21.00 Lesseer of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Deductibles and Coinsuranc	8, 315 0 8, 315 0 0 0 0 0 0 0 0 7, 590 0 0 0	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
12.00 Ancillary service charges 0 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 14.00 Total reasonable charges (sum of lines 12 and 13) 0 Customary charges 0 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.0 18.00 Total customary charges (see instructions) 0 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 21.00 Lesser of cost or charges (see instructions) 0 22.00 Interns and residents (see instructions) 12.01 23.00 Cost of physicians' services in a teaching hospital (see instructions) 12.15 23.00 Deductibles and coinsurance amounts (for CAH, see instructions) 12.15 24.00 Deductibles and coinsurance amounts (for CAH, see instructions) 2.14 25.00 Deductibles and coinsurance amounts relating to amount on li	0 8, 315 0 0 0 000000 8, 315 0, 725 0 7, 590 0 0 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) (4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) (6) Customary charges (6) 5.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) (6) 7.00 Ratio of line 15 to line 16 (not to exceed 1.00000) (7) 18.00 Total customary charges (see instructions) (7) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) (7) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) (7) 21.00 Lesser of cost or charges (see instructions) (7) 22.00 Interns and residents (see instructions) (8) 23.00 Cost of physicians' services in a teaching hospital (see instructions) (8) 24.00 Deductibles and coinsurance amounts (for CAH, see instructions) (2) 25.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) (2) 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) (2)<	0 8, 315 0 0 0 000000 8, 315 0, 725 0 7, 590 0 0 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.01 18.00 Total customary charges (see instructions) 0.01 19.00 Excess of customary charges (see instructions) 0.01 19.00 Excess of customary charges (see instructions) 0.01 20.00 Excess of customary charges (see instructions) 0.01 21.00 Lesser of cost or charges (see instructions) 0.02 22.00 Interns and residents (see instructions) 0.02 23.00 Cost of physicians' services in a teaching hospital (see instructions) 12, 15 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 12, 15 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 18 26.00 Deductibles and Coinsurance amounts (for CAH, see instructions) 2, 18 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 2, 18 28	8, 315 0 0 000000 8, 315 0, 725 0 7, 590 0 0	14.00 15.00 16.00 17.00 18.00 19.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.0 18.00 Total customary charges (see instructions) 0 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 21.00 Lesser of cost or charges (see instructions) 0 0 22.00 Interns and residents (see instructions) 0 12, 18 23.00 Cost of physicians' services in a teaching hospital (see instructions) 12, 18 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 12, 18 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 2, 15 26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 15 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 15	0 00000 8, 315 0, 725 0 7, 590 0 0 0	16.00 17.00 18.00 19.00
16.00Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)017.00Ratio of line 15 to line 16 (not to exceed 1.00000)0.018.00Total customary charges (see instructions)0.019.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)0.020.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)9.021.00Lesser of cost or charges (see instructions)0.023.00Interns and residents (see instructions)12, 1524.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)12, 1525.00Deductibles and coinsurance amounts (for CAH, see instructions)2, 1526.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)2, 1527.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)10, 0728.00Direct graduate medical education payments (from Wkst. E-4, line 50)10, 07	0 00000 8, 315 0, 725 0 7, 590 0 0 0	16.00 17.00 18.00 19.00
had such payment been made in accordance with 42 CFR §413.13(e)017.00Ratio of line 15 to line 16 (not to exceed 1.000000)0.018.00Total customary charges (see instructions)019.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)020.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)1121.00Lesser of cost or charges (see instructions)2122.00Interns and residents (see instructions)2223.00Cost of physicians' services in a teaching hospital (see instructions)12,1524.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)12,1525.00Deductibles and Coinsurance amounts (for CAH, see instructions)2,1527.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)2,1528.00Direct graduate medical education payments (from Wkst. E-4, line 50)10,07	00000 8, 315 0, 725 0 7, 590 0 0	17. 00 18. 00 19. 00
18.00 Total customary charges (see instructions) 0 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 21.00 Lesser of cost or charges (see instructions) 0 22.00 Interns and residents (see instructions) 0 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 12,15 COMPUTATION OF REIMBURSEMENT SETLEMENT 0 0 25.00 Deductibles and Coinsurance amounts (for CAH, see instructions) 2, 15 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 15 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 10, 07 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 10, 07	8, 315 0, 725 0 7, 590 0 0	18. 00 19. 00
19.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)20.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)21.00Lesser of cost or charges (see instructions) 22.0022.00Interns and residents (see instructions) 23.0023.00Cost of physicians' services in a teaching hospital (see instructions) 24.0024.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATI ON OF RELIMBURSEMENT SETTLEMENT25.00Deductibles and coinsurance amounts (for CAH, see instructions) 26.0026.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 27.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)28.00Direct graduate medical education payments (from Wkst. E-4, line 50)	0, 725 0 7, 590 0 0	19.00
<pre>instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)</pre>	0 7, 590 0 0	
instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF RELIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	7, 590 0 0	20.00
21.00Lesser of cost or charges (see instructions)22.00Interns and residents (see instructions)23.00Cost of physicians' services in a teaching hospital (see instructions)24.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)25.00Deductibles and coinsurance amounts (for CAH, see instructions)26.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)27.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)28.00Direct graduate medical education payments (from Wkst. E-4, line 50)	0 0	
22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	0 0	21.00
24.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)12,1525.00Deductibles and coinsurance amounts (for CAH, see instructions)26.0026.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)2,1527.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)2,1528.00Direct graduate medical education payments (from Wkst. E-4, line 50)2,16		22.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT25.00Deductibles and coinsurance amounts (for CAH, see instructions)26.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)27.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)28.00Direct graduate medical education payments (from Wkst. E-4, line 50)		23.00
25.00Deductibles and coinsurance amounts (for CAH, see instructions)26.00Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)27.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)28.00Direct graduate medical education payments (from Wkst. E-4, line 50)	0, 179	24.00
 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 	235	25.00
instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)		26.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	7,504	27.00
29 00 ESRD direct medical education costs (from Wkst E-4 line 36)	0	28.00
		29.00
30.00Subtotal (sum of lines 27 through 29)10,0°31.00Primary payer payments10		30.00 31.00
32.00 Subtotal (line 30 minus line 31) 10,07	3, 751	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0	22.00
33.00Composite rate ESRD (from Wkst. I-5, line 11)34.00Allowable bad debts (see instructions)11		33.00 34.00
		35.00
5		36.00
37.00 Subtotal (see instructions) 10,12 38.00 MSP-LCC reconciliation amount from PS&R 10		37.00 38.00
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		39.00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39.50
 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 		39. 97 39. 98
39. 99 RECOVERY OF ACCELERATED DEPRECIATION	o	39.99
		40.00
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration		40. 01 40. 02
40.03 Sequestration adjustment-PARHM pass-throughs	Ŭ	40.02
	8, 668	41.00
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only)	o	41.01 42.00
42.00 Tentative settlement (for contractor use only) 42.01 Tentative settlement-PARHM (for contractor use only)		42.00 42.01
43.00 Balance due provider/program (see instructions)	2, 684	43.00
43.01 Balance due provider/program-PARHM (see instructions)		43.01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
TO BE COMPLETED BY CONTRACTOR		
90.00 Original outlier amount (see instructions)		90.00
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money		91.00 92.00
93.00 Time Value of Money (see instructions)		93.00
94.00 Total (sum of lines 91 and 93)		93.00 94.00

	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Period: From 01/01/2020	u of Form CMS-2 Worksheet E Part B	2002 1
		Component CCN: 15-S104	To 12/31/2020		
		Title XVIII	Subprovider -	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 590	1.0
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		323	2.0
3.00 4.00	OPPS payments Outlier payment (see instructions)			268 0	3.C 4.C
4.01	Outlier reconciliation amount (see instructions)			0	4.0
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0. 000 0	5.0 6.0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.0
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	
10.00	Organ acquisitions	10, 001. 13, 1110 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 590	11.0
	Reasonable charges				
12.00	Ancillary service charges	line (0)		5, 689	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	TTHE 69)		0 5, 689	13.0 14.0
4 - 00	Customary charges				45.0
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
17 00	had such payment been made in accordance with 42 CFR §413.13	(e)	0	0,000000	17.0
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 5, 689	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	4, 099	
20.00	instructions) Excess of reasonable cost over customary charges (complete or	nlvifline 11 exceeds l	ine 18) (see	0	20.0
	instructions)	,		1 500	
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			1, 590 0	
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	23.0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			268	24.0
25.00	Deductibles and coinsurance amounts (for CAH, see instruction			0	25. C
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			0 1, 858	26.0 27.0
	instructions)] (
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			1, 858	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0 1, 858	31.0 32.0
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	ICES)		1,000	32.0
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. C 34. C
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.0
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 858 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	``````````````````````````````````````		0	
39.50 39.97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	ns)		0	39.5 39.9
39. 98	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	39.9
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 858	39.9 40.0
40.00	Sequestration adjustment (see instructions)			1, 030	
40.02	Demonstration payment adjustment amount after sequestration			0	
40.03 41.00	Sequestration adjustment-PARHM pass-throughs Interim payments			1, 397	40.0 41.0
	Interim payments-PARHM				41.0
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.0 42.0
43.00	Balance due provider/program (see instructions)			449	43.0
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2	chapter 1.	0	43.C
	§115. 2		- p		
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.0
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.0
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. C 93. C
	Total (sum of lines 91 and 93)				94.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0104	Period: From 01/01/2020	u of Form CMS-2 Worksheet E Part B		
		Component CCN: 15-5832	To 12/31/2020			
		Title XVIII	Skilled Nursing Facility	PPS	' piii	
			Facility			
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00		
00	Medical and other services (see instructions)			1, 801] 1	
00 00	Medical and other services reimbursed under OPPS (see instru- OPPS payments	ictions)		0		
00	Outlier payment (see instructions)					
01	Outlier reconciliation amount (see instructions)				4	
00 00	Enter the hospital specific payment to cost ratio (see instru- Line 2 times line 5	fuctions)		0		
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00		
00	Transitional corridor payment (see instructions)			0	8	
00	Ancillary service other pass through costs from Wkst. D, Pt.		0			
00 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)		0 1, 801	1 .		
00	COMPUTATION OF LESSER OF COST OR CHARGES			1,001	1'	
00	Reasonable charges Ancillary service charges			6, 025	1 1'	
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0, 025	13	
. 00	Total reasonable charges (sum of lines 12 and 13)			6, 025		
00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis					
00 00	Anounts that would have been realized from patients liable for			0	1	
	had such payment been made in accordance with 42 CFR §413.13	1 3	on a ona gobaoro	0		
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000		
. 00 . 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	nlvifline 18 exceeds l	ine 11) (see	6, 025 4, 224		
. 00	instructions)			7, 227	'	
. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see					
. 00	instructions) Lesser of cost or charges (see instructions)			1, 801	2	
	Interns and residents (see instructions)				2	
. 00	Cost of physicians' services in a teaching hospital (see ins	-		0		
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	2	
. 00	Deductibles and coinsurance amounts (for CAH, see instruction	ons)		0	2	
. 00	Deductibles and Coinsurance amounts relating to amount on li				2	
. 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	1, 801	2	
. 00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	2	
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36	-		0		
. 00	Subtotal (sum of lines 27 through 29)			1, 801		
. 00 . 00	Primary payer payments Subtotal (line 30 minus line 31)			0 1, 801		
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	TCES)		1,001		
. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0		
. 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0		
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0		
. 00	Subtotal (see instructions)			1, 801		
00	MSP-LCC reconciliation amount from PS&R				3	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	30	
. 97	Demonstration payment adjustment amount before sequestration			0		
. 98	Partial or full credits received from manufacturers for repla		ctions)	0		
. 99 . 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 801		
. 00	Sequestration adjustment (see instructions)				40	
. 02	Demonstration payment adjustment amount after sequestration			0	4	
03	Sequestration adjustment-PARHM pass-throughs			1 001	4	
00 01	Interim payments Interim payments-PARHM			1, 201	4	
00	Tentative settlement (for contractors use only)			0		
01	Tentative settlement-PARHM (for contractor use only)				4	
. 00 . 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			588	43	
. 00	Protested amounts (nonallowable cost report items) in accord	lance with CMS Pub. 15-2,	chapter 1,	0		
	\$115.2 TO BE COMPLETED BY CONTRACTOR					
. 00	Original outlier amount (see instructions)				90	
. 00	Outlier reconciliation adjustment amount (see instructions)				9	
. 00	The rate used to calculate the Time Value of Money				9: 9:	
	Time Value of Money (see instructions)					

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	AL HOSPITAL Provider CC	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		pare
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		7, 713, 5		9, 938, 668	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3
02				0	0	3
02				0	0	3
04				0	0	3
05				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)		7 740 5			
00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 713, 5	32	9, 938, 668	4
	(transfer to Wkst. E or Wkst. E-3, line and column as 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)					
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	5
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	5
51 52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
,,	5. 50-5. 98)			0		Ĭ
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		297, 4	60	122, 684	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		8, 010, 9		10, 061, 352	7
				Contractor	NPR Date	
		C		Number	(Mo/Day/Yr) 2.00	
		(1.00	2 ()()	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-0104 CCN: 15-S104	Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Subprovider -	PPS	- piii
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		932,4	0	0	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.
1	ADJUSTMENTS TO PROVI DER			0	0	3
2				0	0	3
)3				0	0	3
)4)5				0	0	3
5	Provider to Program			0	0	3
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
2				0	0	3
3				0	0	3
4				0	0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		932, 4	67	1, 397	4
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
0	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	TENTATI VE TO PROVI DER			0	0	5
2				0	0	5 5
5	Provider to Program			U	0	
0	TENTATI VE TO PROGRAM			0	0	5
1				0	0	5
2				0	0	5
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
)1	SETTLEMENT TO PROVIDER		4,6	84	449	6
)2	SETTLEMENT TO PROGRAM		007 1	0	0	6
00	Total Medicare program liability (see instructions)		937, 1	Contractor	1,846 NPR Date	7
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0104 CCN: 15-5832	Period: From 01/01/2020 To 12/31/2020		pare
		Title	e XVIII	Skilled Nursing Facility		-p
		Inpatien	it Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 156, 7	0	1, 201 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
)1	ADJUSTMENTS TO PROVIDER			0	0	3
2				0	0	3
)3)4				0	0	3
,4)5				0	0	3
	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	0	3
1				0	0	3
52				0	0	3
53 54				0	0	3
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 156, 7	89	1, 201	4
	TO BE COMPLETED BY CONTRACTOR		1			
0	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)2	TENTATI VE TO PROVI DER			0	0	5
)2)3				0	0	
	Provider to Program			-1		
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
2 9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
11	the cost report. (1) SETTLEMENT TO PROVIDER			0	588	,
)1)2	SETTLEMENT TO PROVIDER			0	588	6
00	Total Medicare program liability (see instructions)		1, 156, 7	-	1, 789	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)0	Name of Contractor		2	1.00	2.00	8

Heal th	Financial Systems WI THAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0104	Period: From 01/01/2020	Worksheet E- Part II	-1			
			To 12/31/2020					
		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		2.00					
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2							
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4.00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	line 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			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and I	line 31) (see instructio	ns)		32.00			
	· · · · · · ·		· · ·		•			

alth Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu o					
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2020	Worksheet E-3	
		Component CCN: 15-S104	To 12/31/2020		par
		•		8/2/2021 1:50	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	edical education payments)	1, 020, 905	1
00	Net IPF PPS Outlier Payments			0	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recent 15, 2004. (see instructions)	cost report filed on or	before November	0.00	4
01	Cap increases for the unweighted intern and resident FTE co	unt for residents that we	re displaced by	0.00	4
	program or hospital closure, that would not be counted with				
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs i	n the new program growth	period of a "new	0.00	6
00	teaching program" (see instuctions)			0.00	
00	Current year's unweighted I&R FTE count for residents withi teaching program" (see instuctions)	n the new program growth	period of a "new	0.00	
00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions)	0.00	
00	Average Daily Census (see instructions)			3.825137	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised t	o the power of .5150 -1}.		0.000000	1(
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	1
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11			1, 020, 905	1
. 00	Nursing and Allied Health Managed Care payment (see instruc	ti on)		0	1
. 00	Organ acquisition (DO NOT USE THIS LINE)				1
. 00	Cost of physicians' services in a teaching hospital (see in	structions)		0	
. 00	Subtotal (see instructions)			1, 020, 905	
. 00	Primary payer payments			1 000 005	1
. 00	Subtotal (line 16 less line 17). Deductibles			1,020,905	
00	Subtotal (line 18 minus line 19)			75, 768 945, 137	
00	Coinsurance			1, 760	
00				943, 377	
00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		0	2
00	Adjusted reimbursable bad debts (see instructions)			0	2
00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		0	2
00	5			943, 377	
00	Direct graduate medical education payments (see instruction	s)		0	2
00	Other pass through costs (see instructions)			0	2
00	Outlier payments reconciliation			0	2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50	Pioneer ACO demonstration payment adjustment (see instruction			0	3
. 99	Demonstration payment adjustment amount before sequestratio	n		0	3
00				943, 377	
01	Sequestration adjustment (see instructions)			6, 226	
02	Demonstration payment adjustment amount after sequestration			0 932, 467	3
00	Interim payments Tentative settlement (for contractor use only)			932, 467	32
00	Balance due provider/program (line 31 minus lines 31.01, 31	02 32 and 33		4,684	
. 00	Protested amounts (nonallowable cost report items) in accor		chapter 1,	4,084	35
	§115. 2				
. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			0	50
. 00	Outlier reconciliation adjustment amount (see instructions)			0	
2.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				5

		WITHAM MEMORIAL			u of Form CMS-2		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od:	Worksheet E-3		
			Component CCN: 15-5832	From 01/01/2020 To 12/31/2020	Part VI Date/Time Pre	narod	
			component con. 15-3832	10 12/31/2020	8/2/2021 1:50		
			Title XVIII	Skilled Nursing	PPS		
				Facility			
					1.00		
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEN	MEMENT - ALL OTH	IER HEALTH SERVICES FOR	TITLE XVIII PART	A PPS SNF		
	SERVICES						
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				1 011 00/	1 00	
1.00	Resource Utilization Group Payment (RUGS)		1, 311, 926	1.00			
2.00	Routine service other pass through costs		0	2.00 3.00			
3.00							
4.00	.00 <u>Subtotal (sum of lines 1 through 3)</u> COMPUTATION OF NET COST OF COVERED SERVICES						
5.00							
5.00	Part B. This line is now shaded.)	ne as vaccine c		THE T UT W/3 L,		5.00	
6.00	Deducti bl e				0	6.00	
	Coinsurance		144, 848				
	Allowable bad debts (see instructions)				0	8.00	
	Reimbursable bad debts for dual eligible benef	ficiaries (see i	nstructions)		0	9.00	
	Adjusted reimbursable bad debts (see instructi				0	10.00	
	Utilization review				0	11.00	
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and	7, plus lines 1	0 and 11)(see instruction	ons)	1, 167, 078	12.00	
	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 instructior	is)		0	14.50	
14.99	Demonstration payment adjustment amount before	e sequestration			0	14.99	
	Subtotal (see instructions				1, 167, 078	15.00	
15.01	Sequestration adjustment (see instructions)				10, 289	15.01	
	Demonstration payment adjustment amount after				0	15.02	
	Sequestration for non-claims based amounts (se	ee instructions)			0	15.75	
	Interim payments				1, 156, 789	16.00	
	Tentative settlement (for contractor use only)				0		
	Balance due provider/program (line 15 minus li				0		
	Protested amounts (nonallowable cost report it	tems) in accorda	nce with CMS 19 Pub. 15	-2, chapter 1,	0	19.00	
	§115. 2						

	Financial Systems WITHAM MEMORIAL I ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E-3	
UNECOL			From 01/01/2020 To 12/31/2020	Part VII	pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR .	XIX SERVICES		-
1.00	Inpatient hospital/SNF/NF services	542, 570		1.00	
2.00	Medical and other services		542, 570	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		542, 570	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		5 10 570	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		542, 570	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		1, 143, 777	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 143, 777	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	0	0	13.00	
14.00	basis Amounts that would have been realized from patients liable for	on 0	0	14.00	
14.00	a charge basis had such payment been made in accordance with 4	0	0	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 143, 777	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	601, 207	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18.00
10.00	16) (see instructions)		0	0	10 00
19.00 20.00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	suctions)	0	0	
20.00	Cost of covered services (enter the lesser of line 4 or line 1		542, 570	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00 28.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		542, 570	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		542, 570	0	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	542, 570	0	31.00
32.00	Deductibles		0	0	32.00
	Coinsurance		0	0	00.00
	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	542, 570	0	1	
37.00 38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)	542, 570	0		
39.00	Direct graduate medical education payments (from Wkst. E-4)	042, 570	0	39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)		542, 570	0	1
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		542, 570	0	1
43.00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				1

DI RECT	Financial Systems WITHAM MEMORIAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	HOSPITAL Provider CO	CN: 15-0104	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	8/2/2021 1:50 PPS	рт
					1.00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT			i na mani ada		1 1 00
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	r cost report	ing periods	0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF	ructions)	0.00			
3.00 3.01	Amount of reduction to Direct GME cap under section 422 of MN Direct GME cap reduction amount under ACA §5503 in accordance	. (see	0.00 0.00			
instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicar						4.00
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst stradding 74(2001)		r cost report	ing periods	0.00	4.0
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	tructions for	cost reporting	0.00	4.0
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus	lines 4.01 and	0.00	5.00
6.00 Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)						6.00
7.00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7.00
			1.00	2.00	3.00	
3.00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	oathi c	0.0	0. 00	0.00	8.00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0. 00	0.00	9.0
0.00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		0.00		10.0
0.00	Unweighted dental and podiatric resident FTE count for the cu			0.00		10.0
1.00	Total weighted FTE count		0.0			11.0
2.00	Total weighted resident FTE count for the prior cost reportin instructions)	ig year (see	0.0	0.00		12.0
3.00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)		0.0	0.00		13.0
4.00 5.00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	l by 3).	0. (0. (14.0 15.0
5.00	Unweighted adjustment for residents in initial years of new programs	programs	0.0			15.0
6.00	Adjustment for residents displaced by program or hospital clo		0.0			16.0
6. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0.00		16. C
7.00	closure Adjusted rolling average FTE count		0.0	0. 00		17.0
8.00	Per resident amount		0.0			18.0
9.00	Approved amount for resident costs			0 0	0	19.0
0.00		TE			1.00	
0.00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots re	cei vea under 42	0.00	20.0
1.00	Direct GME FTE unweighted resident count over cap (see instru	ictions)			0.00	21.0
2.00	Allowable additional direct GME FTE Resident Count (see instr				0.00	
3.00	Enter the locality adjustment national average per resident a Multiply line 22 time line 23	imount (see i	nstructions)		0.00	
4.00 5.00					0	
			I npati ent	Managed Care	Total	
			Part A 1.00	2.00	3.00	
6.00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X, line	4, 10			26.0
7.00	3.02, column 2) Total Inpatient Days (see instructions)		9, 47	9,477		27.0
28.00	Ratio of inpatient days to total inpatient days		0. 43336			27.0
29.00	Program direct GME amount			0 0	0	29.0
29.01	Percent reduction for MA DGME					29.0 30.0
30.00	Reduction for direct GME payments for Medicare Advantage			0	0	

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUT	PATIENT DIRECT	Provider CCN: 15-0104	Peri od:	Worksheet E-4		
MEDI CA	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod	
				10 12/31/2020	8/2/2021 1:50		
-			Title XVIII	Hospi tal	PPS		
					1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)						
32.00	Renal dialysis direct medical education cos	nd 23. lines 74	0	32.00			
	and 94)						
33.00	Renal dialysis and home dialysis total char	74 and 94)	0	33.00			
34.00	Ratio of direct medical education costs to		0.00000	34.00			
35.00	Medicare outpatient ESRD charges (see instr		0	35.00			
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)					36.00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE (COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost						
	Reasonable cost (see instructions)		12, 212, 723				
	Organ acquisition costs (Wkst. D-4, Pt. III				0	38.00	
	Cost of physicians' services in a teaching	hospital (see inst	ructions)		0	39.00	
	Primary payer payments (see instructions)				0	40.00	
41.00	Total Part A reasonable cost (sum of lines	37 through 39 minu	is line 40)		12, 212, 723	41.00	
40.00	Part B Reasonable Cost				10.0(0.001	40.00	
	Reasonable cost (see instructions)						
43.00	Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus	1:00 (2)			3, 753		
44.00 45.00	Total reasonable cost (sum of lines 41 and	,			13, 957, 048 26, 169, 771		
45.00	Ratio of Part A reasonable cost to total re		0 41 · Lipo 4E)		0, 466673		
	Ratio of Part B reasonable cost to total re				0. 533327	48.00	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETV				0. 555527	47.00	
48 00	Total program GME payment (line 31)				0	48.00	
	Part A Medicare GME payment (line 46 x 48)	(title XVIII only)	(see instructions)		0		
	Part B Medicare GME payment (line 47 x 48)				0	50.00	

fund-type accounting records, complete the General Fund column nly)				om 01/01/2020 12/31/2020) Date/Time Prep 8/2/2021 1:50	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	50,065,375	0	0	0	1 1.
00	Temporary investments	2, 965, 591	0	0	0	2.
	Notes receivable	0	0	0	0	
	Accounts receivable	26, 869, 530	0	0	0	
	Other receivable	1, 925, 644	0	0	0	5.
	Allowances for uncollectible notes and accounts receivable Inventory	0 3, 662, 369	0	0	0	6
	Prepaid expenses	3,002,30 7 0	0	0	0	
	Other current assets	2, 350, 984	0	0	0	
	Due from other funds	2,000,701	0	Ő	0	10
	Total current assets (sum of lines 1-10)	87, 839, 493	0	0	0	
	FIXED ASSETS					
2.00	Land	0	0	0	0	12
	Land improvements	5, 898, 844	0	0	0	13
	Accumulated depreciation	0	0	0	0	14
	Buildings	3, 704, 163	0	0	0	
	Accumulated depreciation Leasehold improvements	0	0	0	0	16 17
	Accumulated depreciation	0	0	0	0	18
	Fi xed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
2. 00	Accumulated depreciation	0	0	0	0	22
. 00	Major movable equipment	206, 804, 752	0	0	0	23
	Accumulated depreciation	-94, 643, 851	0	0	0	24
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28
	Total fixed assets (sum of lines 12-29)	121, 763, 908	0	0	0	
	OTHER ASSETS	121,703,700	0		0	1 30
	Investments	0	0	0	0	31
2.00	Deposits on Leases	0	0	0	0	32
3.00	Due from owners/officers	0	0	0	0	33
	Other assets	32, 150, 024	0	0	0	34
	Total other assets (sum of lines 31-34)	32, 150, 024	0	0	0	35
	Total assets (sum of lines 11, 30, and 35)	241, 753, 425	0	0	0	36
	CURRENT LIABILITIES Accounts payable	4 500 001	0	0	0	37
	Salaries, wages, and fees payable	4, 508, 821 12, 489, 222	0	0	0	
	Payroll taxes payable	12, 409, 222	0	0	0	
	Notes and Loans payable (short term)	68, 258	0	Ő	0	
	Deferred income	0	0	0	0	
2.00	Accelerated payments	0				42
3.00	Due to other funds	0	0	0	0	
	Other current liabilities	20, 869, 815	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	37, 936, 116	0	0	0	45
	LONG TERM LIABILITIES		0	0		
	Mortgage payable Notes payable	83, 664	0	0	0	
	Unsecured Loans	63, 004 0	0	0	0	
	Other long term liabilities	31, 364, 439	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	31, 448, 103	0	0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	69, 384, 219	0	0	0	51
	CAPITAL ACCOUNTS					
	General fund balance	172, 369, 206				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	0	56
	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
. 00	replacement, and expansion				0	1 26
		170 0/0 00/				59
9.00	Total fund balances (sum of lines 52 thru 58)	172, 369, 206	0	0	0	

Heal th	Financial Systems	WI THAM MEMORIA	L HOSPI TAL			In Lie	u of Form CM	S-2	552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0104		i od: m 01/01/2020 12/31/2020	Worksheet G Date/Time P 8/2/2021 1:	rep	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	165, 849, 096 2, 925, 281 168, 774, 377 0 168, 774, 377 0 168, 774, 377		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 10.\ 00\\ 19.\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ $
		Endowment Fund	PI ant	Fund					
1.00	Fund halances at beginning of pariod	6.00	7.00	8.00	0			_	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0104	Period: From 01/01/2020 To 12/31/2020		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
1 00	General Inpatient Routine Services		12 260 0		12 260 062	1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		13, 369, 0		13, 369, 063	1.00 2.00
2.00	SUBPROVIDER - IRF		-1, 826, 6	0	-1, 826, 667 0	3.00
4.00	SUBPROVI DER			0	0	
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY		-2, 418, 2	22	-2, 418, 222	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)		9, 124, 1	74	9, 124, 174	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		6, 897, 8	77	6, 897, 877	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	E Linco	4 007 0		4 007 077	15.00
16.00	Total intensive care type inpatient hospital services (sum of 11-15)	i i i nes	6, 897, 8	//	6, 897, 877	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 10	6)	16, 022, 0	51	16, 022, 051	17.00
18.00	Ancillary services	5)	75, 892, 8			18.00
19.00	Outpatient services		1, 40			
20.00				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		1, 0	57 3, 868, 371	3, 869, 428	23.00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		01 017 0	0 0	0	27.00
28.00		3 to Wkst.	91, 917, 3	30 371, 573, 808	463, 491, 188	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			164, 125, 146		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00 42.00	Total doductions (sum of lines 27 41)			0		41.00 42.00
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 4	12) (transfor		164, 125, 146		42.00
45.00	to Wkst. G-3, line 4)			104, 123, 140		-3.00
	······································		1	1	1	

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0104	Peri od: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Pre 8/2/2021 1:50	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa	art I, column 3, lir	ne 28)		463, 491, 188	1.00
2.00	Less contractual allowances and discounts	on patients' accour	nts		314, 744, 968	2.00
3.00	Net patient revenues (line 1 minus line 2))			148, 746, 220	3.00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line	43)		164, 125, 146	4.00
5.00	Net income from service to patients (line	3 minus line 4)	-		-15, 378, 926	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscella	aneous communicatior	n servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	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 g	guests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical		than patients		0	16.00
17.00	Revenue from sale of drugs to other than p				0	17.00
18.00	Revenue from sale of medical records and a				0	18.00
19.00					0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING INCOME				4, 030, 965	
24.01	NON-OPERATING INCOME				5, 875, 836	
24.50	COVI D-19 PHE Funding				8, 397, 406	
25.00	Total other income (sum of lines 6-24)				18, 304, 207	
26.00	Total (line 5 plus line 25)				2, 925, 281	
27.00	OTHER EXPENSES (SPECIFY)	···· /			0	27.00
28.00	Total other expenses (sum of line 27 and s				0	28.00
29.00	Net income (or loss) for the period (line	zo minus rine 28)		I	2, 925, 281	29.00

			Parts I-III		
		From 01/01/2020 To 12/31/2020			
	Title XVIII	Hospi tal	PPS		
		-	1.00		
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT 00 Capital DRG other than outlier			482, 768	1.0	
Model 4 BPCI Capital DRG other than outlier			0		
00 Capital DRG outlier payments			637	2.0	
Model 4 BPCI Capital DRG outlier payments			0	2.0	
	Total inpatient days divided by number of days in the cost reporting period (see instructions)				
0 Number of interns & residents (see instructions) 0 Indirect medical education percentage (see instructions)	0.00 0.00				
Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)		0 0. 00			
Percentage of SSI recipient patient days to Medicare Part / 30) (see instructions)	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				
00 Percentage of Medicaid patient days to total days (see ins	Percentage of Medicaid patient days to total days (see instructions)				
00 Sum of lines 7 and 8	Sum of lines 7 and 8				
00 Allowable disproportionate share percentage (see instruction	ons)		0.00		
00 Disproportionate share adjustment (see instructions)			0		
00 Total prospective capital payments (see instructions)			483, 405	12.	
			1.00		
PART II - PAYMENT UNDER REASONABLE COST		T			
0 Program inpatient routine capital cost (see instructions) 0 Program inpatient ancillary capital cost (see instructions)	`		0	1.0	
0 Total inpatient program capital cost (see instructions, 0 Total inpatient program capital cost (line 1 plus line 2))		0	3.	
0 Capital cost payment factor (see instructions)			0	4.	
00 Total inpatient program capital cost (line 3 x line 4)			0		
			1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS					
00 Program inpatient capital costs (see instructions)	• • • • • • •		0		
0 Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0		
00 Net program inpatient capital costs (line 1 minus line 2)			0	3.	
0 Applicable exception percentage (see instructions) 0 Capital cost for comparison to payments (line 3 x line 4)			0.00		
0 Capital cost for comparison to payments (line 3 x line 4) 0 Percentage adjustment for extraordinary circumstances (see	instructions)		0.00		
Adjustment to capital minimum payment level for extraordina		x line 6)	0.00		
00 Capital minimum payment level (line 5 plus line 7)	,		Ő		
00 Current year capital payments (from Part I, line 12, as app	plicable)		0		
00 Current year comparison of capital minimum payment level to	o capital payments (line 8	less line 9)	0	10.	
00 Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	r capital payment (from pri	or year	0	11.	
00 Net comparison of capital minimum payment level to capital	payments (line 10 plus lin	ne 11)	0	12.	
00 Current year exception payment (if line 12 is positive, en		,	0		
00 Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	r capital payment for the r	following period	0	14.	
(If the 12 is negative, enter the amount on this time)					
00 Current year allowable operating and capital payment (see i	instructions)		0	15.	