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 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/27/2022 12:47 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/27/2022 Time: 12:47 pm] Manually prepared cost report use only Ilf 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. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[18] 17. Contractor's Vendor Code:
[18] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date: Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	George Pogas			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	George Pogas			2
3	Signatory Title	SENI OR VP/CFO			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	380, 825	46, 883	0	-115, 740	1.00
2.00 Subprovider - IPF	0	-1	1, 409		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4. 00 SUBPROVI DER 1						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	832		0	7.00
200. 00 Total	0	380, 824	49, 124	0	-115, 740	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.

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

Heal th	Financial Systems	WITHAM MEMORIA	AL HOSPITA	٩L			l I	n Lieu	of For	m CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	der CC	:N: 1		Period: From 01/01/ To 12/31/	′2021 ′2021	Workshe Part I Date/Ti 5/27/20	me Pre	pared:
	1.00	2.00		3. 00			4	4. 00	3/2//20	122 12.	47 piii
	Hospital and Hospital Health Care Co										
1.00	Street: 2605 N. LEBANON STREET	PO Box:	7: - 0	- 4/0	\F-2	0	DOONE				1.00
2. 00	City: LEBANON	State: IN Component Name	Zip Cod CCN	e: 460 CBS		Provi der	y: BOONE Date	Day/mor	nt Syst	om (D	2. 00
		Component Name	Number	Numk		Type	Certified		0, or		
						31		V	XVIII		
	T	1. 00	2.00	3. (00	4. 00	5. 00	6. 00	7. 00	8.00	
2 00	Hospital and Hospital-Based Componer Hospital		150104	2/0	100	1	07/01/10//	NI NI	P		2 00
3. 00	Hospi tai	WI THAM MEMORIAL HOSPITAL	150104	269	/00	1	07/01/1966	N	P	0	3. 00
4. 00	Subprovider - IPF	WI THAM HOSPI TAL GEROPSYCH	15S104	269	000	4	01/01/2000	N	Р	N	4. 00
5.00	Subprovider - IRF										5. 00
6. 00	Subprovi der - (Other)										6. 00
7.00	Swing Beds - SNF										7.00
8. 00 9. 00	Swing Beds - NF Hospital-Based SNF	WITHAM HOSPITAL ECU	155832	269	200		05/07/2015	N	P	N	8. 00 9. 00
10. 00	Hospi tal -Based NF	WITHAW HOSTITAL ECO	133032	207	,00		03/07/2013	'\	'	'`	10.00
11. 00	Hospi tal -Based OLTC										11. 00
12. 00	Hospi tal -Based HHA										12. 00
13.00	Separately Certified ASC										13.00
14. 00 15. 00	Hospi tal -Based Hospi ce Hospi tal -Based Health Clinic - RHC										14. 00 15. 00
16. 00	Hospital-Based Health Clinic - FQHC										16. 00
17. 00	Hospi tal -Based (CMHC) I										17. 00
18. 00	Renal Dialysis										18. 00
19. 00	Other						L				19. 00
							1.00		To 2. (
20. 00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20. 00
	Type of Control (see instructions)						9				21. 00
	Inpatient PPS Information					1. 00	2. 00		3. (00	
22. 00	Does this facility qualify and is it	currently receiving pay	ments for	-		Υ	N				22. 00
	disproportionate share hospital adju			₹							
	§412.106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		enament								
22. 01	Did this hospital receive interim un		s for thi	s		Υ	Y				22. 01
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft			COST							
22. 02	Is this a newly merged hospital that			-e		N	N				22. 02
	payments to be determined at cost re			ns)							
	Enter in column 1, "Y" for yes or "N	" for no, for the portion	n of the								
	cost reporting period prior to Octobor "N" for no, for the portion of th	er I. Enter In Column 2, e cost reporting period	on or aft	yes ter							
	October 1.	e cost reporting perrod	on or an								
22. 03	Did this hospital receive a geograph					N	N		N		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for			"							
	reporting period occurring on or aft										
	Does this hospital contain at least		•								
	counted in accordance with 42 CFR 41 yes or "N" for no.	2. 105)? Enter Th Corumn	3, 1 10	וכ							
22. 04	Did this hospital receive a geograph	ic reclassification from	urban to	,		N	N		N		22. 04
	rural as a result of the revised OMB										
	adopted by CMS in FY 2021? Enter in										
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for			=1							
	reporting period occurring on or aft										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 41	2.105)? Enter in column	1 3, "Y" 1	for							
23. 00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24	and/or 2	5			3 N				23. 00
	below? In column 1, enter 1 if date]				
	if date of discharge. Is the method			cost							
	reporting period different from the reporting period? In column 2, enter										
	properting period: The Column 2, effe	. I TOT YES OF IN TOT	110.		1		1	1			I

					To 12/3		Date/Ti		
		In-State	In-State	Out-of	Out-of	Medi cai	5/27/20 d 0	122 12: ther	47 pm
		Medi cai d	Medi cai d	State	State	HMO day		di cai d	
		paid days		Medicaid	Medi cai d			lays	
			unpai d days	paid days	el i gi bl e unpai d				
		1.00	2. 00	3. 00	4. 00	5. 00		5. 00	-
24. 00	If this provider is an IPPS hospital, enter the	317					254		24. 00
	in-state Medicaid paid days in column 1, in-state								
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3,								
	out-of-state Medicaid eligible unpaid days in column								
	4, Medicaid HMO paid and eligible but unpaid days in								
25 00	column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state			0	0		0		25. 00
20.00	Medicaid paid days in column 1, the in-state		1]					20.00
	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.								
					Urban/R				
26.00	Enter your standard geographic classification (not wa	ane) status	at the her	ginning of 1	1. C	1	2. (JU	26. 00
20.00	cost reporting period. Enter "1" for urban or "2" for		. at the bet	g		'			20.00
27. 00	Enter your standard geographic classification (not was				st	1			27. 00
	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi			opi i cabi e,					
35. 00	If this is a sole community hospital (SCH), enter the			CH status ir	n	O			35. 00
	effect in the cost reporting period.								
					Begi nr		Endi 2. (-
36. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	script line	36 for numb					36. 00
07.00	of periods in excess of one and enter subsequent date			I MDII I I					07.00
37.00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numbe	er or period	as MDH STATI	ıs	0			37. 00
37. 01	Is this hospital a former MDH that is eligible for the	he MDH tran	nsitional pa	ayment in					37. 01
	accordance with FY 2016 OPPS final rule? Enter "Y" fo	or yes or "	N" for no.	(see					
38. 00	instructions) If line 37 is 1, enter the beginning and ending date:	s of MDH st	atus. If li	ne 37 is					38. 00
	greater than 1, subscript this line for the number of								
	enter subsequent dates.				Y/	N	Υ/	'NI	
					1.0		2.0		-
39. 00	Does this facility qualify for the inpatient hospital				ıme Y		Y		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(i)				nn				
	1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)				es				
	or "N" for no. (see instructions)	•		,					
40. 00	Is this hospital subject to the HAC program reduction						N	l	40. 00
	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1	. (see inst	ructions)	yes or in i	OI				
		`	,		<u> </u>	V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1. 00	2.00	3.00	
45. 00	Does this facility qualify and receive Capital paymen	nt for disp	proporti onat	te share in	accordance	N	N	N	45. 00
	with 42 CFR Section §412.320? (see instructions)								
46. 00	Is this facility eligible for additional payment exceptursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
	Pt. III.	l. L, Fl. I	II allu WKSI	i. L-1, Fi.	i tili ougii				
	Is this a new hospital under 42 CFR §412.300(b) PPS of	•		,		N	N	N	47. 00
48. 00	Is the facility electing full federal capital paymen	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48. 00
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	approved G	ME programs	s? Enter "Y	for ves or	· N	I	1	56. 00
00.00	"N" for no in column 1. For column 2, if the response	e to columr	n 1 İs "Y",	or if this $% \left(1\right) =\left(1\right) \left(1\right) $	hospi tal	"			00.00
	was involved in training residents in approved GME pr	9		, ,					
	year, and are you are impacted by CR 11642 (or application of the second		MA direct (swe payment	reduction?				
57. 00	If line 56 is yes, is this the first cost reporting		ng which re	esidents in	approved				57. 00
	GME programs trained at this facility? Enter "Y" for						1		
	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	l, if appli	cabl e.						
58. 00	If line 56 is yes, did this facility elect cost reim			ans' service	es as				58. 00
59. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00
								-	-

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 12:47 pm Pass-Through NAHE 413.85 Worksheet A Qualification Y/N Line # Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 IME IME Direct GME Direct GME 3. 00 4.00 1.00 2.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 62.01 0.00 62.01 Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00 Unwei ghted Ratio (col. 1/ Unwei ghted FTES FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 2.00 1.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0. 00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care

resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

HUSPI I	AL AND HOSPITAL HEALTH CARE COMPL	LEX IDENIIFICATION DA	IA Provider Co		eriod: -om 01/01/202 o 12/31/202	1 Date/Time Pre	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	5/27/2022 12: Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2.00	3. 00	4. 00	5.00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)			0.00	O. C	0. 000000	65.00
	i)). (see marractions)			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2. 00	3.00	
	Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	or cost report	ing periods	
	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident If the ratio of	0.00	O. C	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	4.00 0.0	5.00 0 0.000000	67. 00
	.,,, (333 1.131 401 613)						
	Inpatient Psychiatric Facility P	PS			1. (00 2.00 3.00	
70. 00	Is this facility an Inpatient Ps		PF), or does it conta	ain an IPF subp	rovi der? Y	.	70.00
71. 00	Enter "Y" for yes or "N" for no If line 70 is yes: Column 1: Did recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indice instructions) Inpatient Rehabilitation Facilit	the facility have an efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for yo lity train residents (D)? Enter "Y" for yo	es or "N" for n in a new teach es or "N" for n	o. (see i ng o.	N O	71. 00
75. 00	Is this facility an Inpatient Re		(IRF), or does it co	ontain an IRF	l N		75. 00
76. 00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. the facility have an ing on or before Nove train residents in a r "Y" for yes or "N"	approved GME teachin mber 15, 2004? Enter new teaching program for no. Column 3: If	ng program in t "Y" for yes or in accordance column 2 is Y,	he most "N" for	0	76. 00

	Period: From 01/01/2021 Fo 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/27/2022 12:	- epared:		
		1.00	-		
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	80. 0 81. 0		
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 5.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. C 86. C		
7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87. 0		
	V	XIX			
Title V and XIX Services	1. 00	2. 00	_		
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Υ	90.0		
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Υ	91. 0		
full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.0		
instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93. 0		
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 0		
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00	0. 00	95. (
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.0		
7.00 F line 96 is "Y", enter the reduction percentage in the applicable column. 3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y	0. 00 Y	97. 98.		
column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	Y	98.		
3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1				
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.		
Does title V, and III column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.		
3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.		
3.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.		
Rural Providers D5.00 Does this hospital qualify as a CAH?	N		105.		
06.00 f this facility qualifies as a CAH, has it elected the all-inclusive method of payment			106.		
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?	N		107.		
Enter "Y" for yes or "N" for no in column 2. (see instructions) 08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42	N		108.		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational	Speech	Respiratory			
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.	3. 00 N	4. 00 N	109.		
		1 00			
10.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§4 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. I	10A	1.00 N	110. (

alth Financial Systems WITHAM MEMORIA SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		Peri od:	worksheet S-	
			rom 01/01/2021 o 12/31/2021	Part I Date/Time Pro	opor
		'		5/27/2022 12	
			1.00	2.00	4
1.00 f this facility qualifies as a CAH, did it participate in the	he Frontier Co	ommuni ty	1. 00 N	2.00	111
Health Integration Project (FCHIP) demonstration for this cos	st reporting p	period? Enter			
"Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is par					
Enter all that apply: "A" for Ambulance services; "B" for add					
for telle-heal th services.					
		1.00	2. 00	3.00	-
2.00Did this hospital participate in the Pennsylvania Rural Heal	th Model	N	2.00	0.00	11:
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 cease					
participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information					
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			011!
in column 1. If column 1 is yes, enter the method used (A, B,	, or E only)				
in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (3" percent				
psychiatric, rehabilitation and long term hospitals providers					
the definition in CMS Pub. 15-1, chapter 22, §2208.1.	-				
b. 00 Is this facility classified as a referral center? Enter "Y" in the second of	for yes or	N			110
7.00 Is this facility legally-required to carry malpractice insura	ance? Enter	Y			111
"Y" for yes or "N" for no.	iou O Enton 1				118
3.00 Is the malpractice insurance a claims-made or occurrence polifithe policy is claim-made. Enter 2 if the policy is occurrence.			2		
		Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	
3.01 List amounts of malpractice premiums and paid losses:		984, 17	5 0)	0 11
			1. 00	2.00	1
3.02 Are mal practice premiums and paid losses reported in a cost of			N		118
Administrative and General? If yes, submit supporting scheduland amounts contained therein.	ure risting co	ost centers			
P. OO DO NOT USE THIS LINE					11
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold			N	N	120
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua					
Hold Harmless provision in ACA §3121 and applicable amendmen					
Enter in column 2, "Y" for yes or "N" for no.					
			· · · · · · · · · · · · · · · · · · ·		10
1.00 Did this facility incur and report costs for high cost impla	ntable devices	s charged to	Y		12
1.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defined	ined in §1903	(w)(3) of the	Y N		
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home office and enter the home offi		contractor numbe				_
141.00 Name:	Contractor's Name:		Contracto	or's Number:		141. 00
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143. 00 Ci ty:	State:		Zi p Code:	<u> </u>		143. 00
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144.00 Are provider based physicians' cost:	s included in Worksheet	A?			Y	144. 00
				1. 00	2.00	
145.00 If costs for renal services are cla						145. 00
inpatient services only? Enter "Y"						
no, does the dialysis facility incluperiod? Enter "Y" for yes or "N" for		n for this cost	reporting			
146.00 Has the cost allocation methodology		nusty filed cost	renort?	N		146. 00
Enter "Y" for yes or "N" for no in						140.00
yes, enter the approval date (mm/dd.						
		"11"			1.00	1.17.00
147.00 Was there a change in the statistics					N	147. 00 148. 00
148.00 Was there a change in the order of a 149.00 Was there a change to the simplifier				no	N N	148.00
149.00 was there a change to the shipithre	a cost irriding method: L	Part A	Part B	Title V	Ti tle XIX	149.00
		1.00	2.00	3.00	4.00	1
Does this facility contain a provide	er that qualifies for an	n exemption from				
or charges? Enter "Y" for yes or "N	' for no for each compor	nent for Part A	and Part B.	(See 42 CFR §41	3. 13)	
155.00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER		N	N	N	N	157. 00 158. 00
158. 00 S0BPR0V1 DER 159. 00 SNF		N	N	N	N	158.00
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161. 00 CMHC		14	N	N N	N N	161. 00
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Multicampus						1
165.00 Is this hospital part of a Multicam	ous hospital that has or	ne or more campu	ises in diffe	rent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code CBSA	FTE/Campus	
	0	County 1.00		3.00 4.00	5. 00	
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00 4.00		166. 00
campus enter the name in column						
O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						

Enter "Y" for yes or "N" for no.							
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each						0.00	166. 00
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Ac	t		
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), en	ter the		168. 00
reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a h	ardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N")	, enter the	9. 99	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 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 individuals enrolled in	N	(171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section	1		
1876 Medicare days in column 2. (see instructions)			

	Financial Systems WITHAM MEMORI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0104	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet S- Part II Date/Time Pro 5/27/2022 12	2 epared:
				Y/N	Date	
	0 11 1 1 5 1 V C 11 VEC 5 1 N	1.6 11 110		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	i for all NO re	esponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1. 0
	reporting period? If yes, enter the date of the change in c	column 2. (see	Y/N	Date	V/I	
			1.00	2.00	3. 00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. 00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.00
			Y/N	Type	Date	
	Fire and Description		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" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, milable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provide	^ N		6. 00
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e N		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N		11. 0
					Y/N 1. 00	
	Bad Debts				1.00	
	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.			ost reporting	Y N	12. 00 13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		-		N	14. 0
5. 00	Did total beds available change from the prior cost reporti				N	15. 0
		Y/N	rt A Date	Par Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 0
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	07/01/2021	Y	07/01/2021	17. 0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 0

Heal th	Financial Systems WITHAM MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0104	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/27/2022 12	epared:
		Descri	pti on	Y/N	Y/N	47 piii
		(1. 00	3.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	-	Y/N 1.00	Date 2.00	Y/N 3. 00	Date 4.00	
21. 00	Was the cost report prepared only using the provider's	N 1.00	2.00	3. 00 N	4.00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	OSPI TALS)			
22.00	Capital Related Cost				I	
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost		22. 00 23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered			· ·		24. 00
	If yes, see instructions	· ·				
25. 00	Have there been new capitalized leases entered into during instructions.	•	0.			25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit		27. 00
28. 00	<u>Interest Expense</u> Were new Loans, mortgage agreements or Letters of credit en		28. 00			
29. 00	period? If yes, see instructions. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)					
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	uctions rity with new	debt? If ves	see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is:					31.00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care servarrangements with suppliers of services? If yes, see instruc		d through co	ntractual		32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.		g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an arilf yes, see instructions.	rangement with	provi der-ba	sed physicians?		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see ins		ts with the	provi der-based		35. 00
	physicians during the cost reporting period: 11 yes, see the	Structions.		Y/N	Date	
				1. 00	2. 00	
26 00	Home Office Costs					26 00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro	epared by the	home office?			36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi					38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other					39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see			40. 00
	-	1	00		00	
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41. 00
42. 00		BLUE & CO., LL	С			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL	In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provider CCN:	Peri od:	Worksheet S	-2
			From 01/01/2021 To 12/31/2021	Part II Date/Time P 5/27/2022 1	repared: 2:47 pm
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the ti	tle/position	MANAGER			41. 00
held by the cost report preparer in column	is 1, 2, and 3,				
respectively.					
42.00 Enter the employer/company name of the cos	st report				42. 00
preparer.					
43.00 Enter the telephone number and email addre	ess of the cost				43.00
report preparer in columns 1 and 2, respec	ti vel y.				

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 |
 Heal th Financial
 Systems
 WI THAM

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

				1	0 12/31/2021	5/27/2022 12:	
						I/P Days / 0/P	77 DIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	63	22, 995	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO 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, 995	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	16	5, 840	0.00	0	8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		79	28, 835	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF	40. 00	7	2, 555		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00	0	0		0	17. 00
18. 00	SUBPROVI DER	42. 00	0	1		0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	18	6, 570		0	19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		104				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/27/2022 | 12: 47 pm

						5/27/2022 12:	47 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 034	314	6, 352			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds)	1, 479	2, 149				2.00
3.00	HMO and other (see instructions) HMO IPF Subprovider	428	2, 149				3.00
4. 00	HMO IRF Subprovider	420	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF		0	C			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	o o	0				6.00
7. 00	Total Adults and Peds. (exclude observation	2, 034	314	6, 352			7.00
7.00	beds) (see instructions)	2,001	011	0,002			7.00
8.00	INTENSIVE CARE UNIT	817	0	3, 379			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		0	C			13. 00
14.00	Total (see instructions)	2, 851	314	9, 731	0.00	794. 69	
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVIDER - I PF	1, 206	0	2, 033		15. 25	
17. 00	SUBPROVIDER - IRF	0	0	C	0.00		
18.00	SUBPROVI DER	1 755	0	2 473	0.00		
19. 00	SKILLED NURSING FACILITY	1, 755	0	3, 472	0.00	14. 48	
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)			27			24. 10
25. 00	CMHC - CMHC			_,			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	824. 42	27. 00
28. 00	Observation Bed Days		0	2, 321			28. 00
29. 00	Ambul ance Tri ps	1, 387					29. 00
30.00	Employee discount days (see instruction)			85			30. 00
31. 00	Employee discount days - IRF			C			31. 00
32.00	Labor & delivery days (see instructions)	0	78	123			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
00.00	outpatient days (see instructions)						00.00
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

					To 12/31/2021	Date/Time Pre 5/27/2022 12:	
		Full Time Equivalents	1	Di sc	harges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13. 00	14.00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		(27		2, 037	2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY	0.00				0.007	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14.00	Total (see instructions)	0.00	(63	1 46	2, 037	
15. 00 16. 00 17. 00	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF	0. 00 0. 00	(-1	2 0	175 0	15. 00 16. 00 17. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00			0	0	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges			1			33. 00 33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0104

					To	12/31/2021	Date/Time Prep 5/27/2022 12:4	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.		Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	0.00	A-6)	3)	col. 4	,	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES	222 22	40.004.704	1 (00 70)	T =0 (33 540)	1 005 (11 00		
1. 00	Total salaries (see instructions)	200. 00	69, 984, 726	692, 784	70, 677, 510	1, 025, 614. 00	68. 91	1. 00
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		C	O	0	0.00	0.00	3. 00
4. 00	Physician-Part A - Administrative		C	C	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C	0	O O	0. 00 0. 00	1	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	O	О	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	o	О	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	O	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	C	О	0.00	0.00	8. 00
9.00	SNF	44. 00	835, 987	•		30, 121. 00		9. 00
10. 00	Excluded area salaries (see instructions)		35, 316, 580	49, 540	35, 366, 120	689, 167. 00	51. 32	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		2, 724, 010	0	2, 724, 010	31, 392. 00	86. 77	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		C	C	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part		C	o	0	0.00	0. 00	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		C	O	О	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		C		0	0. 00	0.00	14. 01
14. 02	Related organization salaries		C	o o	o	0.00	0.00	14. 02
15. 00	Home office: Physician Part A - Administrative		C	0	0	0.00	0.00	15. 00
16. 00	Home office and Contract		C	o	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C	0	0	0.00	0.00	16. 01
16. 02	- Teaching Home office contract		C	O	0	0.00	0.00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		15, 755, 773	0	15, 755, 773			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		7, 085, 646 0	0	7, 085, 646 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	O	0			21. 00
22. 00	Physician Part A - Administrative		C	0	0			22. 00
22. 01	Physician Part A - Teaching		C	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		C	0	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		C	0	0			25. 00
25. 50	Home office wage-related (core)		C	C	0			25. 50
25. 51	Related organization wage-related (core)		C	o	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	O	0			25. 52

					T	o 12/31/2021	Date/Time Prep 5/27/2022 12:4	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARII		FF7 047		FF7 047	12 022 00	42.47	27.00
26.00	Employee Benefits Department	4. 00	557, 847		557, 847	12, 832. 00		
27. 00	Administrative & General	5. 00	7, 121, 240			208, 843. 00		
28. 00	Administrative & General under		2, 797, 257	0	2, 797, 257	1, 016. 00	2, 753. 21	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	_	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	714, 767	10, 000	724, 767	20, 849. 00		
31. 00	Laundry & Linen Service	8. 00	36, 922		·	2, 181. 00		
32.00	Housekeepi ng	9. 00	529, 456		· ·	24, 851. 00		
33. 00	Housekeeping under contract	7.00	327, 430 O	11,000	340, 430 0	0.00		33.00
33.00	(see instructions)		0	0	0	0.00	0.00	33.00
34. 00	Di etary	10. 00	1, 051, 839	-382, 849	668, 990	23, 181. 00	28. 86	34. 00
35. 00	Dietary under contract (see		0,001,007	0.002	0	0.00	l .	
00.00	instructions)		· ·		Ĭ	0.00	0.00	00.00
36.00	Cafeteri a	11. 00	0	414, 348	414, 348	30, 882. 00	13. 42	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	580, 474	5, 250	585, 724	10, 650. 00	55. 00	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	615, 145	7, 750	622, 895	15, 539. 00	40. 09	40. 00
41.00	Medical Records & Medical	16. 00	1, 258, 086	23, 953	1, 282, 039	44, 944. 00	28. 53	41. 00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared:

					'	0 12/31/2021	5/27/2022 12:4	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		72, 781, 983	692, 784	73, 474, 767	1, 026, 630. 00	71. 57	1.00
	instructions)							
2.00	Excluded area salaries (see		36, 152, 567	66, 657	36, 219, 224	719, 288. 00	50. 35	2.00
	instructions)							
3.00	Subtotal salaries (line 1		36, 629, 416	626, 127	37, 255, 543	307, 342. 00	121. 22	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 724, 010	0	2, 724, 010	31, 392. 00	86. 77	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		15, 755, 773	0	15, 755, 773	0.00	42. 29	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		55, 109, 199	626, 127	55, 735, 326	338, 734. 00	164. 54	6.00
7.00	Total overhead cost (see		15, 263, 033	288, 823	15, 551, 856	395, 768. 00	39. 30	7.00
	instructions)							

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0104	Peri od: Worksheet S-3 Part IV To 12/31/2021 Date/Time Prepared: 5/37/2023 13:47 pm

	To 12/31/2021	Date/Time Prep 5/27/2022 12:4	
		Amount	, , , , , , , , , , , , , , , , , , ,
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	3, 115, 811	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	11, 023, 898	8. 02
8.03	Heal th Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 728, 727	9. 00
10.00	Dental, Hearing and Vision Plan	524, 022	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	52, 962	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	202, 817	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	583, 659	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	4, 431, 361	•
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	178, 162	1
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER	_	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement		23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	22, 841, 419	1
24.00	Part B - Other than Core Related Cost	22, 041, 417	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	Total Michigan Control (Or Edit 1)	i 1	20.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: Worksheet S-3 From 01/01/2021 Part V To 12/31/2021 Date/Time Prepared:

		0 12/31/2021	5/27/2022 12:	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	Hospi tal -Based SNF	0	0	8.00
9. 00	Hospi tal -Based NF			9. 00
10. 00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12. 00	Separately Certified ASC			12.00
13. 00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16. 00
17. 00	Renal Di al ysi s			17.00
18. 00	Other	0	0	18.00

alth Financial Systems WITHAM MEMORIAL HOSPITA SPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provid	AL der CCN: 15-0104		u of Form CMS-2 Worksheet S-10					
SPITAL UNCOMPENSATED AND INDIGENT CARE DATA PROVID	der CCN: 15-0104	Peri od: From 01/01/2021	worksneet 5-10	U				
	,	To 12/31/2021	Date/Time Pre 5/27/2022 12:	pared 47 pr				
			1. 00					
Uncompensated and indigent care cost computation								
OO Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided I	by line 202 colum	n 8)	0. 202684	1.				
Medicaid (see instructions for each line)								
00 Net revenue from Medicaid			3, 688, 931	2.				
OD Did you receive DSH or supplemental payments from Medicaid?			Y	3.				
Old If line 3 is yes, does line 2 include all DSH and/or supplemental pay		ai d'?	N 1, 724, 304	4. 5.				
00 If line 4 is no, then enter DSH and/or supplemental payments from Med 00 Medicaid charges	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid							
	Medicaid cost (line 1 times line 6)							
OD Difference between net revenue and costs for Medicaid program (line	7 minus sum of li	nes 2 and 5 if	10, 342, 336 4, 929, 101					
< zero then enter zero)	.,,							
Children's Health Insurance Program (CHIP) (see instructions for each	h line)							
00 Net revenue from stand-alone CHIP			0					
. 00 Stand-al one CHIP charges			0					
	Stand-alone CHIP cost (line 1 times line 10)							
.00 Difference between net revenue and costs for stand-alone CHIP (line enter zero)	II minus line 9;	IT < zero then	0	12.				
Other state or local government indigent care program (see instruction	ons for each line)						
.00 Net revenue from state or local indigent care program (Not included o			0	13.				
.00 Charges for patients covered under state or local indigent care progr			0	14.				
10)								
.00 State or local indigent care program cost (line 1 times line 14)			0					
.00 Difference between net revenue and costs for state or local indigent	care program (li	ne 15 minus line	0	16.				
13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and	state/Local indi	gent care program	ns (saa					
instructions for each line)	State/Tocal Thai	gent care program	13 (300					
.00 Private grants, donations, or endowment income restricted to funding			0	17.				
6.00 Government grants, appropriations or transfers for support of hospita			0					
.00 Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)	gent care program	is (sum of lines	4, 929, 101	19.				
0, 12 and 10)	Uni nsured	Insured	Total (col. 1					
	pati ents	pati ents	+ col . 2)					
	1.00	2. 00	3. 00					
Uncompensated Care (see instructions for each line) On Charity care charges and uninsured discounts for the entire facility	5, 236, 9	983 0	5, 236, 983	20				
(see instructions)	5, 230, 9	0	5, 230, 703	20.				
.00 Cost of patients approved for charity care and uninsured discounts (see 1,061,4	53 0	1, 061, 453	21.				
instructions)			, ,					
.00 Payments received from patients for amounts previously written off as	s	0 0	0	22.				
charity care			4 0/4 450					
.00 Cost of charity care (line 21 minus line 22)	1, 061, 4	53 0	1, 061, 453	23.				
			1. 00					
.00 Does the amount on line 20 column 2, include charges for patient days	s bevond a Length	of stav limit	N N	24.				
imposed on patients covered by Medicaid or other indigent care progra								
.00 If line 24 is yes, enter the charges for patient days beyond the indistay limit	igent care progra	m's length of	0	25.				
Total bad debt expense for the entire hospital complex (see instruction	i ons)		8, 702, 226	26.				
.00 Medicare reimbursable bad debts for the entire hospital complex (see			34, 434					
	structions)		52, 976	27.				
.01 Medicare allowable bad debts for the entire hospital complex (see in			0 (40 050	28.				
.01 Medicare allowable bad debts for the entire hospital complex (see in: Non-Medicare bad debt expense (see instructions)			8, 649, 250					
.01 Medicare allowable bad debts for the entire hospital complex (see in: Non-Medicare bad debt expense (see instructions) .00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense	(see instructions)	1, 771, 607	29.				
.01 Medicare allowable bad debts for the entire hospital complex (see in: Non-Medicare bad debt expense (see instructions))		29. 30.				

	Financial Systems	WITHAM MEMORIAL				eu of Form CMS-	<u> 2552-10</u>
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0104	Period: From 01/01/2021	Worksheet A	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
		0.1		T 1 1 / 1 4	D 1 'C' 1'	5/27/2022 12:	47 pm
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				+ COI. 2)	Olis (See A-O)	(col. 3 +-	
						col . 4)	
	OFFICE OF	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		4, 828, 597	4, 828, 59	7 -22, 387	4, 806, 210	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		4, 828, 347		4, 957, 731	4, 957, 731	
3. 00	00300 OTHER CAPITAL RELATED COSTS		Ö		0 0		1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	557, 847	18, 463, 642	19, 021, 48	9 -190, 392	18, 831, 097	
5.00	00500 ADMINISTRATIVE & GENERAL	7, 121, 240	12, 984, 240	20, 105, 48			
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	714, 767 36, 922	2, 791, 648 540, 782	3, 506, 41 577, 70		1	1
9. 00	00900 HOUSEKEEPING	529, 456	346, 161	875, 61			
10.00	01000 DI ETARY	1, 051, 839	1, 546, 430				1
11. 00	01100 CAFETERI A	0	0		1, 075, 320		1
13.00	01300 NURSI NG ADMI NI STRATI ON	580, 474	53, 372	633, 84			1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	615, 145 1, 258, 086	10, 090, 996 780, 117	10, 706, 14 2, 038, 20		1	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 230, 000	700, 117	2, 030, 20	5 17,037	2,033,202	10.00
30.00	03000 ADULTS & PEDIATRICS	3, 429, 885	1, 587, 696	5, 017, 58	1 -329, 690	4, 687, 891	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 851, 379	1, 338, 640	3, 190, 01		1	1
40.00	04000 SUBPROVI DER - I PF	1, 081, 549	131, 507	1, 213, 05	6 -19, 941	l	1
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER		0		0	0	
43. 00	04300 NURSERY	o	Ö		0	Ö	43. 00
44.00	04400 SKILLED NURSING FACILITY	835, 987	540, 798	1, 376, 78	-74, 167	1, 302, 618	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 694, 409	6, 023, 110				1
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 677, 496	4, 653, 817	6, 331, 31	3 -572, 276	5, 759, 037 0	1
55. 01	05501 ULTRA SOUND	224, 204	701, 208	925, 41	2 -137, 627	1	1
57.00	05700 CT SCAN	190, 340	1, 137, 372	1, 327, 71	-415, 609	912, 103	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	391, 817	457, 876	849, 69			1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	399, 693	1, 850, 216	2, 249, 90			1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 204, 212	5, 093, 786 200, 731	8, 297, 99 200, 73			1
64. 00	06400 NTRAVENOUS THERAPY	o	0	200,70	0 0	0	1
66. 00	06600 PHYSI CAL THERAPY	1, 495, 591	195, 596	1, 691, 18			1
67.00	06700 OCCUPATI ONAL THERAPY	540, 673	45, 619	586, 29			1
67. 01 68. 00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	209, 257 204, 442	195, 723 16, 501	404, 98 220, 94			1
69. 00	06900 ELECTROCARDI OLOGY	204, 442	10, 501	220, 74	0 0	0	1
69. 01	06901 CARDI OLOGY	1, 416, 338	804, 018	2, 220, 35	-418, 056		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76, 644	76, 64		1	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0.454.00	1, 667, 296		
/3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	286, 978	2, 167, 289	2, 454, 26	7 9, 196, 473	11, 650, 740	/3.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	94, 656	30, 078	124, 73	-4, 851	119, 883	
90. 02	09002 CLI NI C	0	0		0	1	
90. 03	09003 DERMATOLOGY CLINIC	0	2, 502	2, 50		_, -,	
90. 04 90. 05	09004 ENT CLINIC 09005 SURGERY CLINIC	0	1, 156 1, 594	1, 15 1, 59			1
90. 03	09007 UROLOGY CLINIC	29, 332	5, 781	35, 11			1
90. 09	09009 GASTROENTEROLOGY CLINIC	-3, 092	7, 903	4, 81			1
90. 11	09011 NEUROLOGY CLINIC	0	30, 209	30, 20			1
90. 12	09012 OPTHAMOLOGY CLINIC	0	14, 758	14, 75			1
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	53, 566 252, 864	28, 631 457, 547	82, 19 710, 41		82, 991 664, 690	1
91. 00	09100 EMERGENCY	2, 722, 343	3, 757, 221	6, 479, 56		6, 040, 713	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_,,	-, ,	2,, 55		2, 2.3,	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	2, 379, 158	489, 314	2, 868, 47	2 -75, 274	2, 793, 198	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	38, 128, 853	84, 470, 826	122, 599, 67	9 418, 243	123, 017, 922	118 00
110.00	NONREI MBURSABLE COST CENTERS	30, 120, 033	04, 470, 020	122, 377, 07	7 410, 243	123,017,722	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	31, 804, 936	10, 491, 335	42, 296, 27	1 -417, 250		1
	07950 THORNTOWN OFFICE BUILDING	0 E0 037	0 E2 271	102.20	0	l	194. 00
	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB	50, 937	52, 271 5, 010	103, 20 5, 01			194. 01
	07953 RETAIL PHARMACY		0,010	3, 01	0 0		194. 02
200.00		69, 984, 726	95, 019, 442	165, 004, 16		•	

Peri od: From 01/01/2021 To 12/31/2021

Worksheet A Date/Time Prepared: 5/27/2022 12:47 pm

			5/27/2022 12: 4	47 pm
Cost Center Description		Net Expenses or Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-863	4, 805, 347		1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	О	4, 957, 731		2. 00
3.00 00300 OTHER CAPITAL RELATED COSTS	0	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 490, 171	12, 340, 926		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-3, 324, 134	14, 948, 408		5. 00
7.00 00700 OPERATION OF PLANT	-22, 508	3, 333, 918		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	579, 044		8. 00
9. 00 00900 HOUSEKEEPI NG	0	883, 355		9. 00
10. 00 01000 DI ETARY	-392, 066	1, 128, 942		10.00
11. 00 01100 CAFETERI A	0	1, 075, 320		11.00
13.00 01300 NURSING ADMINISTRATION	0	636, 357		13.00
15. 00 01500 PHARMACY	-4, 245	1, 426, 199		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-35, 802	2, 019, 460		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				ı
30. 00 03000 ADULTS & PEDI ATRI CS	0	4, 687, 891		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	2, 940, 255		31. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	1, 193, 115		40.00
41. 00 04100 SUBPROVI DER - RF	0	0		41. 00
42. 00 04200 SUBPROVI DER	0	0		42.00
43. 00 04300 NURSERY	0	0		43. 00
44.00 04400 SKILLED NURSING FACILITY	-6, 000	1, 296, 618		44. 00
ANCILLARY SERVICE COST CENTERS				n
50. 00 05000 OPERATING ROOM	0	5, 151, 943		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-529, 549	5, 229, 488		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
55. 01 05501 ULTRA SOUND	0	787, 785		55. 01
57. 00 05700 CT SCAN	0	912, 103		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	817, 338		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-38, 375	716, 446		59. 00
60. 00 06000 LABORATORY	-334, 200	7, 753, 852		60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	199, 194		63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
66. 00 06600 PHYSI CAL THERAPY	-92	1, 691, 918		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-171	593, 695		67. 00
67. 01 06701 AUDI OLOGY	-254, 938	133, 612		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	222, 443		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
69. 01 06901 CARDI OLOGY	0	1, 802, 300		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-774	4, 215, 443		71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 667, 296		72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	-2, 314, 333	9, 336, 407		73. 00
OUTPATIENT SERVICE COST CENTERS	اه	اء		
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	-100	119, 783		90. 01
90. 02 09002 CLI NI C	0	0		90. 02
90. 03 09003 DERMATOLOGY CLI NI C	-2, 502	0		90. 03
90. 04 09004 ENT CLINIC	-1, 071	0		90. 04
90. 05 09005 SURGERY CLINIC	-1, 018	11 24		90. 05
90. 07 09007 UROLOGY CLI NI C	-24, 480	11, 246		90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	-4, 811	2, 000		90. 09
90. 11 09011 NEUROLOGY CLI NI C 90. 12 09012 OPTHAMOLOGY CLI NI C	6 740	30, 209 0		90. 11 90. 12
1 1	-6, 740			
90. 13 09013 ALLERGY CLINIC	41	82, 991		90. 13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	-41	664, 649 3, 438, 513		90. 14 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 602, 200	3, 430, 313		91.00
				92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	024	2 702 274		05 00
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	-924	2, 792, 274		95. 00
	-16, 392, 108	106, 625, 814		118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	- 10, 372, 108	100, 023, 614		110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	41, 879, 021		190.00
194. 00 07950 THORNTOWN OFFICE BUILDING	0	41, 879, 021		192.00
194. 00 07950 THORNTOWN OFFICE BUILDING 194. 01 07951 CAFE/BOUTI QUE	0	102, 774		194. 00 194. 01
194. 01 07951 CAFE/ BOOTT QUE 194. 02 07952 OTHER NONREI MB	0	4, 451		194. 01 194. 02
194. 03 07953 RETALL PHARMACY	0	4, 401		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-16, 392, 108	148, 612, 060		200. 00
200. 00 TOTAL (00m of LINES 110 through 177)	10, 072, 100	1 10, 012, 000		_55.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 15-0104 Date/Time Prepared: 5/27/2022 12:47 pm

					5/27/2022 12:	4/ pm
	C+ C+	Increases	Callani	0+1		
	Cost Center 2.00	Li ne #	Sal ary	Other 5 00		
	A - INSURANCE RECLASS	3. 00	4. 00	5. 00		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	159, 023		1. 00
1.00	FIXT	1.00	o o	134, 023		1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	509, 163		2. 00
2.00	O DELL'ALTERNATION OF THE PROPERTY OF THE PROP		 	668, 186		2.00
	B - CAFETERIA RECLASS		٥,	000, 100		
1.00	CAFETERI A	11.00	414, 348	660, 972		1. 00
1.00	0		414, 348	660, 972		1.00
	C - MME DEPRECIATION RECLASS		111,010	000,772		
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	4, 957, 731		1. 00
1.00	EQUI P	2.00	٩	1, 707, 701		1.00
2.00	Legit	0.00	o	0		2. 00
3.00		0.00	o	Ö		3. 00
4. 00		0.00	Ö	0		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
			0			
9.00		0.00	0	0		9.00
10.00		0.00		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		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	o	0		21. 00
22.00		0.00	O	0		22. 00
23. 00		0.00	O	0		23. 00
24. 00		0.00	o	0		24. 00
25. 00		0.00	o	0		25. 00
26. 00		0.00	ő	0		26. 00
27. 00		0.00	Ö	O		27. 00
28. 00		0.00	o	0		28. 00
29. 00	•	0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31. 00		0.00	0	0		31. 00
32. 00		0.00	0	0		32. 00
33. 00		0.00	0	0		33. 00
34.00		0. 00	0	0		34. 00
35. 00		0. 00	0	0		35. 00
36. 00		0.00	0	0		36. 00
37.00		0.00	0	0		37. 00
38. 00		0.00	0	0		38. 00
39.00		0.00	0	0		39. 00
	0		0	4, 957, 731		
	D - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	9, 255, 666		1. 00
	0			9, 255, 666		
	E - IMPLANTABLES RECLASS					
1.00	I MPL. DEV. CHARGED TO	72. 00	0	1, 667, 296		1. 00
	PATI ENT					
2.00		0.00	0	0		2. 00
3. 00		0.00	ol	0	İ	3. 00
4.00		0.00	o	n	İ	4. 00
5. 00		0.00	ol o	n		5. 00
6. 00		0.00	n o	n		6. 00
5.00			#	1, 667, 296		3. 50
	F - CHARGEABLE SUPPLIES RECLA	SS	O ₁	1, 307, 270		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	o	4, 156, 015		1. 00
1.00	PATIENTS	/ 1.00	Ч	4, 100, 015		1.00
2. 00	IAITENIS	0.00	o	0		2. 00
			0	0	-	
3.00		0.00	- 1	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9.00		0. 00	0	0		9. 00
10.00		0. 00	0	0		10.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | Date/Time Prepared: | 5/27/2022 12: 47 pm Provider CCN: 15-0104

					5/27/2022 12:	:47 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4.00	5. 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	O	0		14. 00
15.00		0.00	o	0		15. 00
16. 00		0.00	ol	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	Ö		19. 00
20. 00		0.00	Ö	0		20.00
21. 00		0.00	Ö	0		21.00
22. 00		0.00	Ö	0		22. 00
23. 00	+	0.00	0	0		23. 00
24. 00	+	0.00	o	0		24. 00
25. 00		0.00	o	0		1
		I I	-			25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	0		30.00
31. 00		0.00		0		31. 00
	0		0	4, 156, 015		
	G - BONUS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5. 00	197, 871	0		1. 00
2.00	OPERATION OF PLANT	7.00	10, 000	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	1, 500	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	11, 000	0		4. 00
5.00	DI ETARY	10.00	31, 499	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	5, 250	0		6. 00
7. 00	PHARMACY	15. 00	7, 750	0		7. 00
8. 00	MEDICAL RECORDS & LIBRARY	16. 00	23, 953	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	54, 486	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	21, 432	0		10.00
11. 00	SUBPROVI DER - I PF	40.00	17, 000	0		11. 00
12.00	SKILLED NURSING FACILITY	44.00	17, 117	0		12.00
13.00	OPERATING ROOM	50.00	50, 845	0		13. 00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	26, 500	0		14. 00
15.00	ULTRA SOUND	55. 01	3, 700	0		15. 00
16.00	CT SCAN	57. 00	4, 143	0		16. 00
17.00	MAGNETIC RESONANCE IMAGING	58.00	6, 512	0		17. 00
	(MRI)					
18.00	CARDIAC CATHETERIZATION	59.00	10, 061	0		18. 00
19.00	LABORATORY	60.00	53, 247	0		19. 00
20.00	PHYSI CAL THERAPY	66.00	20, 250	0		20. 00
21.00	OCCUPATI ONAL THERAPY	67.00	8, 000	0		21. 00
22.00	AUDI OLOGY	67. 01	4, 000	0		22. 00
23. 00	SPEECH PATHOLOGY	68.00	1, 500	0		23. 00
24.00	DRUGS CHARGED TO PATIENTS	73.00	3, 500	0		24.00
25. 00	CARDI OLOGY	69. 01	22, 727	0		25. 00
26. 00	OTHER OUTPATIENT SERVICE	90. 01	2, 250	0		26. 00
	COST CENTER	,3.01	2, 200	J.		-5.00
27. 00	UROLOGY CLINIC	90. 07	1, 000	0		27. 00
28. 00	GASTROENTEROLOGY CLINIC	90. 09	2,000	0		28. 00
29. 00	ALLERGY CLINIC	90. 13	1, 500	0		29. 00
30. 00	WOUND CARE	90. 14	4, 000	0		30.00
31. 00	EMERGENCY	91.00	34, 559	0		31. 00
32. 00	AMBULANCE SERVICES	95.00	32, 540			32. 00
02.00	0	75.00	691, 692	0		52.00
	H - GASTROENTEROLOGY CLINIC	RECLASS	371, 372	<u> </u>		1
1. 00	GASTROENTEROLOGY CLINIC	90.09	1, 092	0		1. 00
	TOTALS	 	1, 092	0		1
500.00	Grand Total: Increases		1, 107, 132	21, 365, 866		500.00
	•	. '			•	•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0104

Peri od: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Ti me Prepared: 5/27/2022 12:47 pm

						5/27/2022	
		Decreases					
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00 A - INSURANCE RECLASS	7. 00	8. 00	9. 00	10. 00		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	ol	668, 186	12		1.00
2.00		0.00	0	0	o		2. 00
	0		0	668, 186			
1. 00	B - CAFETERIA RECLASS	10.00	414, 348	660, 972	0		1. 00
1.00	DI ETARY		414, 348	660, 972			1.00
	C - MME DEPRECIATION RECLASS		,				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	181, 410	9		1. 00
2. 00	FIXT EMPLOYEE BENEFITS DEPARTMENT	4.00	o	6, 443	0		2. 00
3. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 349, 550			3. 00
4.00	OPERATION OF PLANT	7. 00	ō	159, 927	o		4. 00
5.00	LAUNDRY & LINEN SERVICE	8. 00	0	160			5. 00
6.00	HOUSEKEEPI NG	9.00	0	2, 679			6. 00
7. 00 8. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	29, 908 2, 739	0		7. 00 8. 00
9. 00	PHARMACY	15. 00	o	4, 811	O		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	О	6, 543			10. 00
11.00	ADULTS & PEDIATRICS	30.00	0	116, 668	1		11. 00
12. 00 13. 00	INTENSIVE CARE UNIT SUBPROVIDER - IPF	31. 00 40. 00	0	86, 669 12, 870	1		12. 00 13. 00
14. 00	SKILLED NURSING FACILITY	44.00	Ö	52, 218	1		14. 00
15.00	OPERATING ROOM	50. 00	О	491, 740	O		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	505, 727	0		16. 00
17. 00 18. 00	ULTRA SOUND CT SCAN	55. 01 57. 00	0	131, 515 403, 979	1		17. 00 18. 00
19. 00	MAGNETIC RESONANCE I MAGING	58.00	o	30, 100			19. 00
	(MRI)						
20.00	CARDI AC CATHETERI ZATI ON	59.00	0	165, 057	0		20. 00
21. 00 22. 00	LABORATORY BLOOD STORING, PROCESSING &	60. 00 63. 00	0	226, 549 1, 537	0		21. 00 22. 00
22.00	TRANS.	03.00	٥	1, 557			22.00
23. 00	PHYSI CAL THERAPY	66. 00	0	16, 393			23. 00
24. 00	OCCUPATIONAL THERAPY	67.00	0	372	0		24. 00
25. 00 26. 00	AUDI OLOGY CARDI OLOGY	67. 01 69. 01	0	20, 107 422, 125	0		25. 00 26. 00
27. 00	DRUGS CHARGED TO PATIENTS	73. 00	Ö	681	o		27. 00
28. 00	OTHER OUTPATIENT SERVICE	90. 01	О	3, 212	0		28. 00
20.00	COST CENTER	00.04		0.5			20.00
29. 00 30. 00	ENT CLINIC SURGERY CLINIC	90. 04 90. 05	0	85 391	0		29. 00 30. 00
31. 00	UROLOGY CLINIC	90. 07	o	293			31.00
32.00	OPTHAMOLOGY CLINIC	90. 12	О	8, 018			32. 00
33. 00	ALLERGY CLINIC	90. 13	0	561	0		33. 00
34. 00 35. 00	WOUND CARE EMERGENCY	90. 14 91. 00	0	20, 637 116, 320	0		34. 00 35. 00
36. 00	AMBULANCE SERVICES	95.00	Ö	86, 362			36.00
37.00	PHYSICIANS' PRIVATE OFFICES	192. 00	О	292, 382			37. 00
38. 00	CAFE/BOUTI QUE	194. 01	0	434			38. 00
39. 00	OTHER NONREIMB	194.02		<u>5</u> 59 4, 957, 731			39. 00
	D - DRUGS RECLASS		<u> </u>	4, 737, 731			
1.00	PHARMACY	1500	0	<u>9, 255, 6</u> 66			1. 00
	O LMDI ANTARI EC DECLASC		0	9, 255, 666			
1. 00	E - IMPLANTABLES RECLASS INTENSIVE CARE UNIT	31.00	O	513	0		1. 00
2. 00	OPERATING ROOM	50.00	Ö	1, 207, 091	o o		2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	О	57, 669			3. 00
4.00	CARDIAC CATHETERIZATION	59.00	0	323, 583	1		4. 00
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	16, 442	0		5. 00
6.00	DRUGS CHARGED TO PATIENTS	73. 00	О	61, 998	О		6. 00
	0		0	1, 667, 296			
1 00	F - CHARGEABLE SUPPLIES RECLA			1 400			1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	1, 420 13, 073			1. 00 2. 00
3. 00	OPERATION OF PLANT	7. 00	0	13, 073			3. 00
4.00	HOUSEKEEPI NG	9. 00	Ō	583	0		4. 00
5.00	DIETARY	10.00	O	3, 532			5. 00
6. 00 7. 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	O	22, 970 351	0		6. 00 7. 00
7. 00 8. 00	ADULTS & PEDIATRICS	30.00	0	267, 508			8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	o	184, 014			9. 00
	<u> </u>	<u> </u>	<u> </u>				

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/27/2022 12:47 pm Provider CCN: 15-0104

						5/27/2022 12:	47 pm
		Decreases				.	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
10. 00	SUBPROVI DER - I PF	40. 00	0	24, 071	0		10. 00
11. 00	SKILLED NURSING FACILITY	44. 00	0	39, 066	0		11. 00
12.00	OPERATING ROOM	50.00	0	1, 917, 590	0		12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	35, 380	0		13. 00
14. 00	ULTRA SOUND	55. 01	0	9, 812	0		14. 00
15. 00	CT SCAN	57. 00	0	15, 773	0		15. 00
16. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	8, 767	0		16. 00
17 00	(MRI)	FO 00		1 01/ 500			17.00
17. 00	CARDIAC CATHETERIZATION	59.00	0	1, 016, 509	0		17. 00
18.00	LABORATORY	60.00	0	36, 644	0		18.00
19. 00	PHYSI CAL THERAPY	66.00	0	3, 034	0		19. 00
20.00	OCCUPATIONAL THERAPY	67.00	0	54	0		20.00
21. 00	AUDI OLOGY	67. 01	0	323	0		21. 00
22. 00	CARDI OLOGY	69. 01	0	18, 658	0		22. 00
23. 00	DRUGS CHARGED TO PATIENTS	73.00	0	14	0		23. 00
24. 00	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	U	3, 889	U		24. 00
25 00		00.05	0	105	0		25 00
25. 00 26. 00	SURGERY CLINIC UROLOGY CLINIC	90. 05 90. 07	0	185 94	0		25. 00 26. 00
27. 00	1	90. 07 90. 13	0		0		
28. 00	ALLERGY CLINIC		0	145	0		27. 00
	WOUND CARE	90. 14	Ŭ,	29, 084	0		28. 00
29. 00	EMERGENCY	91. 00	0	357, 090	0		29. 00
30.00	AMBULANCE SERVICES	95.00	0	21, 452			30.00
31. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	124, 868			31. 00
	O DONING DECLACE		0	4, 156, 015			
1 00	G - BONUS RECLASS	4 00	0	691, 692	0		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		·	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0. 00 0. 00	0	0	0		4.00
5.00	•	0.00	0	0	0		5. 00 6. 00
6.00	•	0.00	0	0			1
7.00		0.00	0	0	0		7. 00 8. 00
8. 00 9. 00		0.00	0	0	0		1
10.00		0.00	0	0	0		9. 00 10. 00
11. 00		0.00	0	0	0		11.00
12. 00		0.00	0	0	0		12.00
13. 00		0.00	0	0	0		13. 00
14. 00		0.00	0	0			14. 00
15. 00		0.00	0	0			15. 00
16. 00		0.00	0	0			16. 00
17. 00		0.00	0	0	0		17. 00
18. 00		0.00	0	0	0		18.00
19. 00		0.00	0	0	0		19. 00
20. 00		0.00	0	0	0		20.00
21. 00		0.00	0	0	0		21. 00
22. 00		0.00	0	0			22. 00
23. 00		0.00	0	0	0		1
			0	0	0		23. 00
24. 00 25. 00		0. 00 0. 00	0	0	0		24. 00 25. 00
			0	0			
26. 00 27. 00		0. 00 0. 00	0	0	0		26. 00 27. 00
28. 00		0.00	0	0	0		28.00
			0	0	0		
29. 00		0.00	0	0	0		29.00
30.00		0. 00 0. 00	0	0			30.00
31.00			0	0	0		31.00
32. 00		0.00	— — <u> </u>	00	0		32. 00
	U CASTDOENTEDOLOGY CLINIC S	DECLASS	0	691, 692			-
1 00	H - GASTROENTEROLOGY CLINIC F			1 000			1 00
1. 00	GASTROENTEROLOGY CLINIC	9009	— — <u> </u>	1, 092	0		1. 00
E00 00	TOTALS Grand Total: Decreases		414 240	1, 092			E00 00
500.00	priand rotal: Decreases		414, 348	22, 058, 650			500.00

| Peri od: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 |

S/27/2022 12: 47 pm S/27/2022 12: 47 pm Beginning Balances Donation Total Disposals and Retirements Disposals and Retirements Donation Total Disposals and Retirements Donation Do
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES
1.00 Land 2,845,261 50,000 0 50,000 0 1.00 2.00 Land Improvements 3,053,583 0 0 0 0 0 2.00 3.00 Buil dings and Fixtures 128,653,270 3,869,220 0 3,869,220 0 3.00 4.00 Buil ding Improvements 0 0 0 0 0 0 0 5.00 Fi xed Equi pment 4,992,623 0 0 0 0 0 5.00 6.00 Movable Equi pment 73,158,859 2,691,906 0 2,691,906 0 6.00 7.00 HIT desi gnated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8.00 9.00 Reconciling Items 0 0 0 0 0 0 0 9.00
2.00 Land Improvements 3,053,583 0 0 0 0 0 2.00 3.00 Buildings and Fixtures 128,653,270 3,869,220 0 3,869,220 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 4,992,623 0 0 0 0 0 5.00 6.00 Movable Equipment 73,158,859 2,691,906 0 2,691,906 0 </td
3.00 Buildings and Fixtures 128,653,270 3,869,220 0 3,869,220 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 4,992,623 0 0 0 0 0 5.00 6.00 Movable Equipment 73,158,859 2,691,906 0 0 2,691,906 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8.00 9.00 Reconciling Items 0 0 0 0 0 0 9.00
4.00 Building Improvements 0 0 0 0 0 4.00 5.00 Fixed Equipment 4,992,623 0 0 0 0 0 5.00 6.00 Movable Equipment 73,158,859 2,691,906 0 0 2,691,906 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8.00 9.00 Reconciling Items 0 0 0 0 0 0 9.00
5.00 Fi xed Equipment 4,992,623 0 0 0 0 5.00 6.00 Movable Equipment 73,158,859 2,691,906 0 2,691,906 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8.00 9.00 Reconciling Items 0 0 0 0 0 9.00
6.00 Movable Equipment 73,158,859 2,691,906 0 2,691,906 0 6.00 7.00 HIT designated Assets 0 0 0 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8.00 9.00 Reconciling Items 0 0 0 0 0 0 9.00
7. 00 HIT designated Assets 0 0 0 0 0 7. 00 8. 00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 8. 00 9. 00 0 0 0 0 9. 00
8.00 Subtotal (sum of lines 1-7) 212,703,596 6,611,126 0 6,611,126 0 9.00 0 0 0 9.00
9.00 Reconciling I tems 0 0 0 0 9.00
10.00 Total (line 8 minus line 9) 212.703.596 6.611.126 0 6.611.126 0 0.00
Ending Balance Fully
Depreciated
Assets
6.00 7.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1 00 Land 2 895 261 0 1 00
1. 00 Edita
2.00 Land Improvements 3,053,583 0 2.00
3.00 Buildings and Fixtures 132,522,490 0
4.00 Building Improvements 0 0 4.00
5. 00 Fi xed Equi pment
6. 00 Movable Equipment 75, 850, 765 0
7. 00 HIT designated Assets 0 0 7. 00
8.00 Subtotal (sum of lines 1-7) 219, 314, 722 0 8.00
9.00 Reconciling Items 0 0 9.00
10.00 Total (line 8 minus line 9) 219,314,722 0 10.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CC	CN: 15-0104	Peri od: From 01/01/2021	Worksheet A-7 Part II	
				To 12/31/2021	Date/Time Pre 5/27/2022 12:	pared: 47 pm
		SU	IMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	•	
		40.00	44.00		instructions)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	4, 828, 597	0		0	0	1. 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00 Total (sum of lines 1-2)	4, 828, 597	0		0 0	0	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15. 00				

0 0 0

4, 828, 597 4, 828, 597 1. 00 2. 00 3. 00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

1.00 NEW CAP REL COSTS-BLDG & NEW CAP REL COSTS-MVBLE E 3.00 Total (sum of lines 1-2)

NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP

Heal th	n Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/27/2022 12:4	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	0.00	1.00	0.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	143, 463, 957	C	143, 463, 95	7 0. 654146	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	75, 850, 765	C	75, 850, 76	5 0. 345854	0	2.00
3.00	Total (sum of lines 1-2)	219, 314, 722		219, 314, 72			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DART III DECONCILIATION OF CARLTAL COSTS OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CINEW CAP REL COSTS-BLDG & FIXT	ENTERS 0		1	0 4, 647, 187	0	1. 00
2.00	NEW CAP REL COSTS-BEDG & TTXT	0	_		0 4, 957, 731	0	2.00
3.00	Total (sum of lines 1-2)	0	_		0 9, 604, 918	-	3. 00
0.00	Total (Sam of Titles 1 2)	J	SI	JMMARY OF CAPI		Ü	0.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	10.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12. 00	13.00	14. 00	15. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	-863	159, 023		0 0	4, 805, 347	1. 00
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0		1	o o	4, 957, 731	2. 00
3.00	Total (sum of lines 1-2)	-863			o o	9, 763, 078	
		1		1			

Health Financial Systems
ADJUSTMENTS TO EXPENSES WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet A-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0104

				To	12/31/2021	Date/Time Prep 5/27/2022 12:	
				Expense Classification on	Worksheet A	3/2//2022 12.	47 pili
				To/From Which the Amount is			
					-		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG &	1. 00	0	1. 00
	REL COSTS-BLDG & FIXT (chapter			FLXT			
2. 00	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2. 00	0	2. 00
2.00	REL COSTS-MVBLE EQUIP (chapter		O	EQUI P	2.00	J	2.00
	2)						
3.00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
4.00	di scounts (chapter 8)		O		0.00	O	4.00
5.00	Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay	В	-4 066	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
7.00	stations excluded) (chapter		1, 000	TOWN WE A SENERAL	0.00	J	7.00
	21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician	A-8-2	-3, 465, 749		0.00	0	10.00
	adjustment		0, 100, 7.17			J	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)		_			_	
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00	Laundry and Linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-345, 218	DI ETARY	10. 00	0	
15.00	Rental of quarters to employee		0		0. 00	0	15. 00
	and others		_			_	
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
	patients						
17. 00	1.		0		0. 00	0	17. 00
	patients						
18. 00	Sale of medical records and	В	-33, 812	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
20. 00	Vendi ng machi nes	В	-1, 203	DI ETARY	10. 00	0	
21. 00	Income from imposition of		0		0. 00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00			0		0. 00	0	22. 00
	overpayments and borrowings to						
00.00	repay Medicare overpayments	1 400	-	 	/F 00		22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
05.00	limitation (chapter 14)				444.00		05.00
25. 00	Utilization review - physicians' compensation		Ü	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
	COSTS-BLDG & FIXT			FLXT			
27. 00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	Sost center bereted	0.00	0	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of				- 1		
00.0-	limitation (chapter 14)		=	ABULTO A DEBLATS: CO	22		00.05
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
2 50	pathology costs in excess of				55.00		
	limitation (chapter 14)						

				To	om 01/01/2021 o 12/31/2021	Date/Time Prep 5/27/2022 12:4	
				Expense Classification on		3/21/2022 12.4	47 piii
				To/From Which the Amount is	to be Adjusted		
				0 1 0 1		W . A 7 D C	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	HOSPITAL ADMINISTRAT	А	-7, 032	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	SPONSORSHI PS/DO BANK FEES	А		OPERATING ROOM	50.00	0	33. 01
33. 02 33. 03	HEARING AID COSTS BANK FEES	A A		AUDI OLOGY ADMI NI STRATI VE & GENERAL	67. 01 5. 00	0	33. 02 33. 03
33. 04	LOBBYING EXPENSE-IHA DUES	A	-3, 980	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05 33. 06	LOBBYING EXPENSE-AHA DUES NON-REIMBURSABLE ADVERTISING	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 05 33. 06
	COSTS	В				12	
33. 07 33. 08	SELF INSURANCE CLAIMS PAID HAF FEE	A A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	
33. 09	WIT EXTENDED CARE UNIT OTHER OPERATI	A	-6, 000	SKILLED NURSING FACILITY	44. 00	0	33. 09
33. 10	WIT PHYSICIAN CLINIC LB MISC REVENUE	A	-100	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	0	33. 10
33. 11	WIT CLINICAL LAB LB OTHER OPERATING	A	-200	LABORATORY	60.00	О	33. 11
33. 12	WIT PHARMACY LB OTHER OPERATING REVE	А	-23	PHARMACY	15. 00	0	33. 12
33. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 13
33. 14	(3) WIT EDUCATION COVID VACCINE ADMINI	А	-144, 724	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	WIT EDUCATION OTHER OPERATING REVE	А	-5	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	WIT PLANT OPERATIONS LB ELECTRIC CAR	A	-106	OPERATION OF PLANT	7. 00	0	33. 16
33. 17	WIT PLANT OPERATIONS LB OTHER OPERAT	А	-22, 402	OPERATION OF PLANT	7. 00	0	33. 17
33. 18	WIT FINANCE ACCOUNTING REVENUE SHARE	А	-15, 236	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 19
33. 20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 20
33. 21	WIT ADMIN HOSPITAL UNRESTRICTED CONT	A	-2, 825	ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	WIT ADMIN HOSPITAL INVEST IN	A	-242, 008	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	WIT HR EMPLOYEE BENEFITS EMP	A	-44, 492	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 23
33. 24	WIT AMBULANCE EDUCATION REIMBURSEM	А	-826	AMBULANCE SERVICES	95. 00	0	33. 24
33. 25	WIT DERMATOLOGY CLINIC RENTAL REVENU	A	-2, 502	DERMATOLOGY CLINIC	90. 03	0	33. 25
33. 26	WIT EAR NOSE THROAT CLIN RENTAL REVE	А	-1, 071	ENT CLINIC	90. 04	0	33. 26
33. 27	WIT SURGERY CLINIC RENTAL REVENUE	А	-1, 018	SURGERY CLINIC	90. 05	0	33. 27
33. 28	WIT UROLOGY CLINIC RENTAL REVENUE	А	-24, 480	UROLOGY CLINIC	90. 07	0	33. 28
33. 29	WIT GASTROENTEROLOGY CLI RENTAL REVE	А	-4, 811	GASTROENTEROLOGY CLINIC	90. 09	0	33. 29
33. 30	WIT DIALYSIS CENTER RENTAL REVENUE	А	-41	WOUND CARE	90. 14	0	33. 30
33. 31	WIT EYE INSTITUTE RENTAL REVENUE	A	-6, 740	OPTHAMOLOGY CLINIC	90. 12	0	33. 31
33. 32	WIT CARDIAC CATHETERIZAT PURCHASING	В	-38, 375	CARDIAC CATHETERIZATION	59. 00	0	33. 32
33. 33	WIT PHARMACY LB PURCHASING DI SCOUNTS	В	-4, 222	PHARMACY	15. 00	0	33. 33
33. 34	WIT CENTRAL SUPPLY PURCHASING DI SCOU	В	-774	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	33. 34
33. 35	WIT HEALTH INFORMATION M PHYSICIAN Q	В	-1, 990	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 35
33. 36	WIT DIETARY HOME DELIVERED MEALS	В		DI ETARY	10. 00	0	33. 36
33. 37	WIT DIETARY HEAD START	В	-13, 548	DI ETARY	10. 00	0	33. 37

From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					0 12/31/2021	5/27/2022 12:	
				Expense Classification on	Worksheet A	072772022 12.	T7 PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
33. 38	WIT DIETARY CICOA MEAL	1. 00 B	2.00	3. 00 DI ETARY	4. 00 10. 00	5. 00	33. 38
33. 38	VOUCHERS	В	-480	DIETARY	10.00	U	33. 38
33. 39	WIT FINANCE MATERIALS MG	В	-46, 797	ADMINISTRATIVE & GENERAL	5. 00	0	33. 39
	PURCHASI NG		0.4.0.4.7	ADMINISTRATIVE A SEVERAL			
33. 40	WIT FINANCE MATERIALS MG PURCHASING	В	-94, 847	ADMINISTRATIVE & GENERAL	5. 00	0	33. 40
33. 41	WIT FINANCE HOSPITAL BIL CASH	В	1, 221	ADMINISTRATIVE & GENERAL	5. 00	0	33. 41
	(SHORT		,				
33. 42	WIT FINANCE HOSPITAL BIL	В	-10, 996	ADMINISTRATIVE & GENERAL	5. 00	11	33. 42
33. 43	INTEREST IN OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 43
55. 45	(3)		0		0.00	0	33. 43
33. 44	WIT ADMIN HOSPITAL LAND LEASE	В	-20, 484	ADMINISTRATIVE & GENERAL	5. 00	10	33. 44
00.45	REVENU	В	00.047	ADMINISTRATIVE A SENERAL	F 00		00.45
33. 45	WIT ADMIN HOSPITAL MANAGEMENT	В	-28, 947	ADMINISTRATIVE & GENERAL	5. 00	0	33. 45
33. 46	WIT ADMIN HOSPITAL OTHER	В	-93	ADMINISTRATIVE & GENERAL	5. 00	0	33. 46
	OPERATING R						
33. 47	WIT ADMIN HOSPITAL INTEREST ON	В	-132, 210	ADMINISTRATIVE & GENERAL	5. 00	11	33. 47
33. 48	WIT HR EMPLOYEE BENEFITS	A	-539. 139	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 48
00. 10	EMPLOYEE DR		007,107		00		00. 10
33. 49	WIT HR WELLNESS PROGRAM OTHER	В	-52, 000	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 49
33. 50	OPERAT WIT INSURANCE INSURANCE CLAIM	В	15 701	ADMINISTRATIVE & GENERAL	5. 00	12	33. 50
33. 30	PROC		-13, 701	ADMINISTRATIVE & GENERAL	3.00	12	33. 30
33. 51	VOL VOLUNTEERS VOLUNTEER MISC	В	-5, 404	ADMINISTRATIVE & GENERAL	5. 00	0	33. 51
00 50	REV		475	ADMINISTRATIVE A SENERAL	F 00	4.4	00 50
33. 52	VOL VOLUNTEERS INTEREST ON INVESTME	В	-1/5	ADMINISTRATIVE & GENERAL	5. 00	11	33. 52
33. 53	BCH 2015 BOND INTEREST ON	В	-688	NEW CAP REL COSTS-BLDG &	1.00	11	33. 53
	INVESTME			FIXT			
33. 54	BCH 2017 BOND INTEREST ON INVESTME	В		NEW CAP REL COSTS-BLDG & FLXT	1. 00	11	33. 54
33. 55	RECRUITING OFFSET-EH&W	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 55
33. 56	RECRUITING OFFSET A&G	A		ADMINISTRATIVE & GENERAL	5. 00	o	33. 56
33. 57	RECRUITING OFFSET PT	Α	-92	PHYSI CAL THERAPY	66.00	0	33. 57
33. 58	RECRUITING OFFSET OT	Α	-171	OCCUPATI ONAL THERAPY	67. 00	0	33. 58
33. 59	RECRUITING OFFSET AMBULANCE	А		AMBULANCE SERVICES	95. 00	0	33. 59
33. 60	RETAIL PHARMACY	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 60
33. 61	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 61
	(3)]	-
50.00	TOTAL (sum of lines 1 thru 49)		-16, 392, 108				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provi der CCN: 15-0104

Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepa

3, 465, 749

200.00

Date/Time Prepared: 5/27/2022 12:47 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 7.00 1. 00 2.00 3. 00 4. 00 5. 00 6. 00 1.00 54. 00 RADI OLOGY-DI AGNOSTI C 529, 549 529, 549 1.00 0 0 60. 00 LABORATORY 0 2.00 334,000 334,000 0 0 2.00 3.00 91. 00 EMERGENCY 2, 602, 200 2, 602, 200 0 0 3.00 0 4.00 0.00 0 0 0 4.00 0.00 5.00 0 0 0 5.00 6.00 0.00 0 0 6.00 0 0 0 7.00 0.00 0 0 7.00 8.00 0.00 0 0 0 8.00 0 9.00 0.00 0 9.00 10.00 0.00 0 10.00 3, 465, 749 3, 465, 749 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1.00 2.00 8.00 9.00 12. 00 13.00 14.00 54. 00 RADI OLOGY-DI AGNOSTI C 1. 00 1.00 0 0 0 0 2.00 60. 00 LABORATORY 0 0 0 0 0 2.00 3.00 91. 00 EMERGENCY 0 0 0 0 3.00 0 0 4.00 0.00 0 0 0 0 0 0 0 0 4.00 0.00 5.00 0 5 00 6.00 0.00 0 6.00 7.00 0.00 0 0 0 7.00 0 0.00 0 0 8.00 8.00 0.00 0 0 9.00 9.00 10.00 0.00 10.00 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 1. 00 2.00 15. 00 16. 00 17. 00 18. 00 54. 00 RADI OLOGY-DI AGNOSTI C 1. 00 1.00 529.549 0 0 0 0 2.00 60. 00 LABORATORY 0 0 334,000 2.00 3.00 91. 00 EMERGENCY 0 0 2, 602, 200 3.00 4.00 0.00 0 0 0 0 0 4.00 0 0.00 5.00 0 0 0 5 00 6.00 0.00 0 0 0 6.00 7.00 0.00 0 0 0 7.00 0.00 0 0 0 0 8.00 8.00 0.00 9.00 0 0 9.00 10.00 0.00 0 0 0 10.00

200.00

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104

CAPITAL RELATED COSTS Cost Center Description Net Expenses NEW BLDG & NEW MVBLE for Cost FIXT EQUIP BENEFITS	5/27/2022 12: 4 Subtotal	ŧ7 pili
	Subtotal	
	Subtotal	
All ocation DEPARTMENT		
(from Wkst A col. 7)		
0 1.00 2.00 4.00	4A	
GENERAL SERVICE COST CENTERS		1 00
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4, 805, 347 4, 805, 347 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4, 957, 731 4, 957, 731 4, 957, 731		1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12,340,926 28,284 29,181 12,398,391		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL 14,948,408 371,547 383,329 1,294,151 7.00 00700 OPERATION OF PLANT 3,333,918 308,560 318,345 128,152	16, 997, 435	5. 00 7. 00
7. 00 00700 OPERATI ON OF PLANT 3, 333, 918 308, 560 318, 345 128, 152 8. 00 00800 LAUNDRY & LI NEN SERVI CE 579, 044 0 0 6, 794	4, 088, 975 585, 838	8. 00
9. 00 00900 HOUSEKEEPI NG 883, 355 44, 362 45, 769 95, 562	1, 069, 048	9. 00
10. 00 01000 DI ETARY	1, 448, 982 1, 148, 584	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 636, 357 0 0 103, 567	739, 924	13. 00
15. 00 01500 PHARMACY 1, 426, 199 30, 655 31, 627 110, 139	1, 598, 620	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 2, 019, 460 48, 425 49, 961 226, 688 INPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 344, 534	16. 00
30. 00 03000 ADULTS & PEDI ATRI CS 4, 687, 891 322, 093 332, 307 616, 100	5, 958, 391	30.00
31. 00 03100 NTENSI VE CARE UNI T 2, 940, 255 88, 456 91, 261 331, 147	3, 451, 119	31.00
40. 00 04000 SUBPROVI DER - I PF 1, 193, 115 101, 278 104, 489 194, 243 41. 00 04100 SUBPROVI DER - I RF 0 0 0	1, 593, 125 0	40. 00 41. 00
42. 00 04200 SUBPROVI DER 0 0 0 0	o	42.00
43. 00 04300 NURSERY	0 1, 603, 280	43. 00 44. 00
ANCI LLARY SERVI CE COST CENTERS	1, 003, 200	44.00
50. 00 05000 OPERATI NG ROOM 5, 151, 943 343, 563 354, 458 485, 410	6, 335, 374	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 229, 488 314, 394 324, 364 301, 297 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0	6, 169, 543 0	54. 00 55. 00
55. 01 05501 ULTRA SOUND 787, 785 0 0 40, 298	828, 083	55. 01
57. 00 05700 CT SCAN 912, 103 0 0 34, 388	946, 491	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 817, 338 26, 972 27, 827 70, 432 59. 00 05900 CARDI AC CATHETERI ZATI ON 716, 446 22, 735 23, 455 72, 452	942, 569 835, 088	58. 00 59. 00
60. 00 06000 LABORATORY 7, 753, 852 158, 746 163, 780 575, 977	8, 652, 355	60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 199, 194 0 0 0	199, 194	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 2, 248, 264	64. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 593, 695 0 0 97, 015	690, 710	67. 00
67. 01 06701 AUDI OLOGY 133, 612 14, 118 14, 566 37, 708 68. 00 06800 SPEECH PATHOLOGY 222, 443 0 0 36, 414	200, 004	67. 01
68. 00 06800 SPEECH PATHOLOGY 222, 443 0 0 36, 414 69. 00 06900 ELECTROCARDI OLOGY 0 0 0	258, 857 0	68. 00 69. 00
69. 01 06901 CARDI OLOGY 1, 802, 300 14, 624 15, 088 254, 453	2, 086, 465	69. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 4, 215, 443 0 0 0 0 0 0 0 0 0	4, 215, 443 1, 667, 296	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 9, 336, 407 6, 324 6, 524 51, 362	9, 400, 617	73. 00
OUTPATIENT SERVICE COST CENTERS		00.00
90. 00 09000 CLINI C 0 0 0 0 90. 01 09001 074 075	0 259, 684	90. 00 90. 01
90. 02 09002 CLI NI C 0 0 0	0	90. 02
90. 03 09003 DERMATOLOGY CLINI C	0	90. 03 90. 04
90. 04 09004 ENT CLINI C 0 0 0 0 0 0 0 0 90. 05 09005 SURGERY CLINI C 0 0 0 0 0	0	90. 04
90. 07 09007 UROLOGY CLI NI C 11, 246 0 0 5, 363	16, 609	90. 07
90. 09 09009 GASTROENTEROLOGY CLINI C 2, 000 0 0 0 0 0 90. 11 09011 NEUROLOGY CLINI C 30, 209 0 0 0	2, 000 30, 209	90. 09 90. 11
90. 12 09012 0PTHAMOLOGY CLINI C 0 0 0 0	30, 209	90. 11
90. 13 09013 ALLERGY CLINIC 82, 991 14, 118 14, 566 9, 737	121, 412	90. 13
90. 14 09014 WOUND CARE 664, 649 119, 206 122, 986 45, 418 91. 00 09100 EMERGENCY 3, 438, 513 388, 384 400, 700 487, 470	952, 259 4, 715, 067	90. 14 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	92. 00
OTHER REI MBURSABLE COST CENTERS	2 274 (22	05.00
95. 00 09500 AMBULANCE SERVI CES 2, 792, 274 75, 255 77, 641 426, 432 SPECI AL PURPOSE COST CENTERS	3, 371, 602	95. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 106, 625, 814 3, 220, 427 3, 322, 549 6, 765, 729	97, 773, 050	118. 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,865 10,178 0	20.042	100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 9,865 10,178 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 41,879,021 1,382,950 1,426,807 5,623,655	20, 043 50, 312, 433	
194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0	0	194. 00
194. 01 07951 CAFE/BOUTI QUE 102, 774 22, 387 23, 097 9, 007 194. 02 07952 OTHER NONREI MB 4, 451 169, 718 175, 100 0	157, 265 349, 269	
194. 02 07952 01FER NOINEETMB 4, 451 169, 718 175, 100 0 194. 03 07953 RETALL PHARMACY 0 0 0 0		194. 02 194. 03
200.00 Cross Foot Adjustments		200. 00
201.00 Negative Cost Centers 0 0 0 0	0	201. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part Date/Time Pre	pared:
					5/27/2022 12:	47 pm
		CAPI TAL REL	LATED COSTS			
0 1 0 1 0 1 1		NEW DI DO A	NEW MYDLE	EMBI OVEE	6 1 1 1 1	
Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE FOULP	EMPLOYEE BENEFITS	Subtotal	
	Allocation	1171	LQUIF	DEPARTMENT		
	(from Wkst A			DELAKTIMENT		
	col . 7)					
	0	1. 00	2.00	4. 00	4A	
202.00 TOTAL (sum lines 118 through 201)	148, 612, 060	4, 805, 347	4, 957, 73	1 12, 398, 391	148, 612, 060	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0104

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

5/27/2022 12:47 pm Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 16, 997, 435 5 00 5 00 7.00 00700 OPERATION OF PLANT 528,071 4, 617, 046 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 75,658 661, 496 8.00 9.00 00900 HOUSEKEEPI NG 138, 062 49, 994 0 1, 257, 104 9.00 01000 DI ETARY 1, 831, 904 10.00 10.00 187, 129 111, 907 0 83.886 01100 CAFETERI A 148, 334 0 27, 969 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 95, 557 0 12, 647 0 13.00 01500 PHARMACY 206, 454 34.547 0 15 00 15 00 25 536 0 16.00 01600 MEDICAL RECORDS & LIBRARY 302, 785 54, 573 55, 937 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 769, 496 424, 937 715, 215 30.00 362, 982 39, 488 30.00 424, 729 03100 INTENSIVE CARE UNIT 31.00 445, 695 99, 685 14.341 112, 847 31.00 40.00 04000 SUBPROVIDER - IPF 205, 744 114, 134 4, 248 134, 190 255, 541 40.00 04100 SUBPROVIDER - IRF 41.00 C 41.00 04200 SUBPROVI DER 42.00 0 0 0 0 42.00 0 04300 NURSERY 43.00 0 Λ 0 Λ 43.00 04400 SKILLED NURSING FACILITY 436, 419 44.00 44.00 207, 056 86, 429 3, 144 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 818.182 387, 177 85.709 25, 050 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 796, 766 354, 305 53, 493 113, 333 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05501 ULTRA SOUND 106, 943 7, 296 55.01 55.01 13, 188 0 05700 CT SCAN 57 00 122, 235 80, 356 11, 187 Λ 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 121, 728 30, 395 28, 531 10, 701 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 107, 847 25, 621 35, 145 0 59.00 06000 LABORATORY 1, 117, 408 178, 899 108. 737 47, 911 60.00 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 25, 725 1.870 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 5, 323 0 64.00 06600 PHYSI CAL THERAPY 66.00 290, 352 159, 924 9, 707 17, 268 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 89 202 4 212 8 269 67 00 0 6, 080 06701 AUDI OLOGY 67.01 25,830 15, 910 1, 130 0 67.01 06800 SPEECH PATHOLOGY 33, 430 0 68.00 68.00 1.467 3.648 69.00 06900 ELECTROCARDI OLOGY 0 69.00 06901 CARDI OLOGY 69.01 269, 457 16, 481 27, 097 36, 724 0 69.01 544, 403 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16,046 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 215, 323 18, 939 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 1, 214, 043 42, 365 26, 509 0 73 00 7.127 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 33, 537 68,096 0 65, 179 0 90.01 09002 CLINIC 0 90 02 90 02 0 0 0 90.03 09003 DERMATOLOGY CLINIC 0 0 0 0 90.03 90.04 09004 ENT CLINIC 0 0 0 0 90.04 09005 SURGERY CLINIC 0 90.05 90.05 0 0 0 09007 UROLOGY CLINIC 90 07 90 07 2.145 200 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 258 C 0 90.09 09011 NEUROLOGY CLINIC 0 90.11 3,901 0 90.11 0 09012 OPTHAMOLOGY CLINIC 90. 12 90.12 0 0 15, 910 90 13 09013 ALLERGY CLINIC 15, 680 319 0 0 90 13 09014 WOUND CARE 122, 979 134, 339 9, 131 90.14 90.14 0 91 00 09100 EMERGENCY 608, 927 437, 688 50, 990 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 435, 426 95.00 84, 808 6, 320 0 0 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 10, 431, 768 2, 830, 931 661, 496 1, 257, 104 1, 831, 904 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 2 588 11, 118 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 6, 497, 663 0 0 0 192, 00 1, 558, 505 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 194.00 194. 01 07951 CAFE/BOUTI QUE 20, 310 0 0 0 194. 01 25, 229 194. 02 07952 OTHER NONREIMB 191, 263 0 0 0 194. 02 45, 106 194. 03 07953 RETAIL PHARMACY 0 194, 03 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 16, 997, 435 4, 617, 046 661, 496 1, 257, 104 1, 831, 904 202. 00

Provider CCN: 15-0104

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 |

			To	12/31/2021	Date/Time Pre 5/27/2022 12:	
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	Subtotal	, p
	•	ADMI NI STRATI ON		RECORDS & LIBRARY		
	11. 00	13. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00 8. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	1, 324, 887					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	25, 634	873, 762	1 01/ 10/			13.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	51, 269 103, 886	0	1, 916, 426 0	2, 861, 715		15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	103, 000	<u> </u>	<u> </u>	2,001,713		10.00
30. 00 03000 ADULTS & PEDIATRICS	349, 434	167, 543	181	703, 243	9, 490, 910	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	28, 333	77, 659	3, 827	146, 219	4, 804, 454	31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	44, 523 0	56, 587	20	174, 070	2, 582, 182 0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	Ö	Ō	0	O	0	43. 00
44. 00 O4400 SKILLED NURSING FACILITY	0	53, 459	2	0	2, 389, 789	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	31, 031	138, 199	1, 842	252, 402	0.074.066	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	37, 777	21, 979	767	675, 393	8, 074, 966 8, 223, 356	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 05501 ULTRA SOUND	4, 048	0	260	73, 110	1, 032, 928	55. 01
57. 00 05700 CT SCAN	5, 397	0	10, 806	83, 554	1, 260, 026	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	13, 492 0	22, 885	3, 202	45, 258 0	1, 195, 876 1, 026, 586	
60. 00 06000 LABORATORY	110, 632	22, 003	7	69, 628	10, 285, 577	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	226, 789	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	5, 323	64. 00
66. 00 06600 PHYSI CAL THERAPY	55, 316	61, 656	227	135, 775	2, 978, 489	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY	22, 936 24, 285	26, 531 12, 689	0	59, 184 0	901, 044 285, 928	67. 00 67. 01
68. 00 06800 SPEECH PATHOLOGY	25, 634	7, 475	0	o	330, 511	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	O	0	0	0	69. 00
69. 01 06901 CARDI OLOGY	55, 316	66, 479	38	130, 553	2, 688, 610	69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	28, 333 0	0	0	Ol	4, 804, 225 1, 901, 558	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	o	1, 380, 131	o	12, 070, 792	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 90. 02 09002 CLINIC	45, 872	1, 899	4	292, 438	766, 709 0	90. 01 90. 02
90. 03 09003 DERMATOLOGY CLI NI C	0	0	0	0	0	90. 02
90. 04 09004 ENT CLINIC	o	0	0	0	0	
90. 05 09005 SURGERY CLI NI C	0	0	0	0	0	90. 05
90. 07 09007 UROLOGY CLI NI C 90. 09 09009 GASTROENTEROLOGY CLI NI C	0	7 507	0	0	18, 954 9, 765	90. 07 90. 09
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC	0	7, 507 0	3, 980	0	38, 090	1
90. 12 09012 OPTHAMOLOGY CLINIC	Ö	Ō	0	O	0	90. 12
90. 13 09013 ALLERGY CLI NI C	0	2, 172	0	0	155, 493	90. 13
90. 14 09014 WOUND CARE	0	14, 634	3, 143	0	1, 236, 485	90. 14
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	86, 347	103, 608	120, 742	O	6, 123, 369	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVICES	175, 392	0	2, 683	0	4, 076, 231	95. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 324, 887	842, 961	1, 531, 862	2, 840, 827	88, 985, 015]118.00]
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	ol	0	ol	33, 749	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	Ö	27, 195	384, 564	20, 888	58, 801, 248	
194. 00 07950 THORNTOWN OFFICE BUILDING	o	О	0	o		194. 00
194. 01 07951 CAFE/BOUTI QUE	0	3, 606	0	0	206, 410	1
194. 02 07952 OTHER NONREIMB 194. 03 07953 RETAIL PHARMACY	0	O O	0	0	585, 638 0	194. 02 194. 03
200.00 Cross Foot Adjustments	Ĭ	Ĭ		J		200. 00
201.00 Negative Cost Centers	О	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 324, 887	873, 762	1, 916, 426	2, 861, 715	148, 612, 060	202. 00

WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/27/2022	12:47 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104

				5/27/2022 12:4	
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
		25. 00	26. 00		
	RAL SERVICE COST CENTERS	1			
	ONEW CAP REL COSTS-BLDG & FIXT				1.00
1	O NEW CAP REL COSTS-MVBLE EQUIP				2.00
1	OO EMPLOYEE BENEFITS DEPARTMENT				4. 00
	OO ADMINISTRATIVE & GENERAL				5. 00
	OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO				7. 00
	OO LAUNDRY & LINEN SERVICE				8. 00
9.00 0090	OO HOUSEKEEPI NG				9. 00
10.00 0100	00 DI ETARY				10.00
11. 00 0110	OO CAFETERI A				11. 00
13.00 0130	OO NURSING ADMINISTRATION				13. 00
15. 00 0150	OO PHARMACY				15. 00
16. 00 0160	MEDICAL RECORDS & LIBRARY				16. 00
I NPA	TIENT ROUTINE SERVICE COST CENTERS				
30.00 0300	O ADULTS & PEDIATRICS	0	9, 490, 910		30.00
31. 00 0310	OO INTENSIVE CARE UNIT	O	4, 804, 454		31.00
	00 SUBPROVI DER – I PF	o	2, 582, 182		40.00
	O SUBPROVI DER - I RF	l ol	0	1	41.00
	OO SUBPROVI DER	o	0		42.00
	NURSERY	o	0		43. 00
	O SKILLED NURSING FACILITY		2, 389, 789		44. 00
	LLARY SERVICE COST CENTERS	٩	2,007,707		11.00
	O OPERATING ROOM	l	8, 074, 966		50.00
	O RADI OLOGY-DI AGNOSTI C		8, 223, 356		54.00
	00 RADI OLOGY-THERAPEUTI C		0, 223, 330		55. 00
	11 ULTRA SOUND		1, 032, 928		55. 01
	OO CT SCAN		1, 260, 026	1	57. 00
1	ł	0		1	1
•	OO MAGNETIC RESONANCE IMAGING (MRI)	1 -1	1, 195, 876	1	58.00
	OO CARDI AC CATHETERI ZATI ON	0	1, 026, 586		59.00
	DO LABORATORY	0	10, 285, 577		60.00
	00 BLOOD STORING, PROCESSING & TRANS.	0	226, 789	1	63.00
	O I NTRAVENOUS THERAPY	0	5, 323	1	64.00
	O PHYSI CAL THERAPY	0	2, 978, 489	1	66.00
	O OCCUPATIONAL THERAPY	0	901, 044	1	67. 00
	1 AUDI OLOGY	0	285, 928		67. 01
	O SPEECH PATHOLOGY	0	330, 511		68. 00
	O ELECTROCARDI OLOGY	0	0	I	69. 00
	1 CARDI OLOGY	0	2, 688, 610	1	69. 01
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 804, 225		71. 00
	OO IMPL. DEV. CHARGED TO PATIENT	0	1, 901, 558		72. 00
73. 00 0730	O DRUGS CHARGED TO PATIENTS	0	12, 070, 792		73. 00
OUTF	ATIENT SERVICE COST CENTERS				
90.00 0900	OO CLI NI C	0	0		90.00
	OTHER OUTPATIENT SERVICE COST CENTER	0	766, 709		90. 01
90. 02 0900	02 CLINIC	0	0		90. 02
	3 DERMATOLOGY CLINIC	O	0		90. 03
90. 04 0900	04 ENT CLINIC	0	0		90. 04
90. 05 0900	5 SURGERY CLINIC	O	O		90. 05
90. 07 0900	07 UROLOGY CLINIC	O	18, 954		90. 07
	9 GASTROENTEROLOGY CLINIC		9, 765	1	90. 09
	1 NEUROLOGY CLINIC		38, 090		90. 11
	2 OPTHAMOLOGY CLINIC	o	0		90. 12
•	3 ALLERGY CLINIC		155, 493		90. 13
	4 WOUND CARE	o	1, 236, 485	1	90. 14
	OO EMERGENCY	o	6, 123, 369	1	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	0	0, 120, 001		92.00
	R REIMBURSABLE COST CENTERS	<u> </u>			/2.00
	O AMBULANCE SERVICES	0	4, 076, 231		95. 00
	I AL PURPOSE COST CENTERS	<u> </u>	1, 575, 231		75.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	88, 985, 015		118. 00
	EIMBURSABLE COST CENTERS	<u> </u>	00, 700, 010		1 10.00
	O GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	33, 749		190. 00
	O PHYSICIANS' PRIVATE OFFICES	0			190.00
			58, 801, 248 0		194. 00
	O THORNTOWN OFFICE BUILDING	- 1	- 1		
	CAFE/BOUTI QUE	0	206, 410	1	194. 01
	52 OTHER NONRELMB	0	585, 638		194. 02
	3 RETAIL PHARMACY	0	0		194. 03
200.00	Cross Foot Adjustments	0	0		200.00
201.00	Negative Cost Centers	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	0	148, 612, 060		202. 00
	<u> </u>				

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

					То	12/31/2021	Date/Time Pre 5/27/2022 12:	
				CAPI TAL REI	ATED COSTS			, , , , , , , , , , , , , , , , , , ,
		Cost Center Description	Directly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Section Bessirption	Assigned New	FLXT	EQUI P	ous total	BENEFITS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
1 00		AL SERVICE COST CENTERS	T					1 00
1. 00 2. 00		NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	28, 284	29, 181	57, 465	57, 465	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	371, 547	383, 329	754, 876	6, 002	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	0	308, 560 0	318, 345	626, 905 0	594 32	7. 00 8. 00
9. 00		HOUSEKEEPI NG	o	44, 362	45, 769	90, 131	443	9. 00
10.00	1	DIETARY	0	99, 301	102, 450	201, 751	549	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	0	0	0	340 480	11. 00 13. 00
15. 00		PHARMACY	0	30, 655		62, 282	511	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	48, 425	49, 961	98, 386	1, 051	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	O	322, 093	332, 307	654, 400	2, 857	30. 00
31. 00	1	INTENSIVE CARE UNIT	0	88, 456	· ·	179, 717	1, 536	
40.00		SUBPROVI DER - I PF	0	101, 278	104, 489	205, 767	901	40. 00
41. 00 42. 00	1	SUBPROVI DER - I RF SUBPROVI DER	0	0	0	0	0	41. 00 42. 00
43. 00		NURSERY	o o	0	o	0	0	43. 00
44. 00		SKILLED NURSING FACILITY	0	76, 693	79, 125	155, 818	700	44. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	343, 563	354, 458	698, 021	2, 251	50. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	0	314, 394	324, 364	638, 758	1, 397	54. 00
55. 00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 57. 00	1	ULTRA SOUND	0	0	0	0	187	55. 01
58.00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	26, 972	27, 827	54, 799	159 327	57. 00 58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	22, 735		46, 190	336	
60.00	1	LABORATORY	0	158, 746		322, 526	2, 671	60.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
66. 00		PHYSI CAL THERAPY	0	141, 909	146, 409	288, 318	1, 243	
67.00		OCCUPATIONAL THERAPY	0	0	0	0	450	67.00
67. 01 68. 00	1	AUDI OLOGY SPEECH PATHOLOGY	0	14, 118 0	14, 566	28, 684 0	175 169	67. 01 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	0	0	Ö	0	69. 00
69. 01		CARDI OLOGY	0	14, 624	15, 088	29, 712	1, 180	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0	6, 324	6, 524	12, 848	238	
00.00		TIENT SERVICE COST CENTERS	O			ol	0	00.00
90. 00 90. 01		OTHER OUTPATIENT SERVICE COST CENTER	0	0 60, 425		0 122, 766	0 79	90. 00 90. 01
90. 02		CLINIC	O	0		0	0	90. 02
90. 03	1	DERMATOLOGY CLINIC	0	0	0	0	0	90. 03
90. 04 90. 05		ENT CLINIC SURGERY CLINIC	0	0	0	0	0	90. 04 90. 05
90. 07		UROLOGY CLINIC	o	0	o	Ö	25	90. 07
90. 09		GASTROENTEROLOGY CLINIC	0	0	0	0	0	90. 09
90. 11 90. 12		NEUROLOGY CLINIC OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 11 90. 12
90. 13	1	ALLERGY CLINIC	o	14, 118	14, 566	28, 684	45	90. 13
90. 14		WOUND CARE	0	119, 206		242, 192	211	90. 14
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	388, 384	400, 700	789, 084 0	2, 261	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS				<u> </u>		72.00
95. 00		AMBULANCE SERVI CES	0	75, 255	77, 641	152, 896	1, 978	95. 00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	O	3, 220, 427	3, 322, 549	6, 542, 976	31, 378	110 00
110.00		IMBURSABLE COST CENTERS	l o	3, 220, 427	3, 322, 349	0, 342, 970	31, 370	116.00
	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9, 865		20, 043		190. 00
		PHYSICIANS' PRIVATE OFFICES THORNTOWN OFFICE BUILDING	0	1, 382, 950 0	1, 426, 807	2, 809, 757	26, 045 0	192. 00 194. 00
		CAFE/BOUTIQUE	0	22, 387	23, 097	45, 484		194. 00 194. 01
194. 02	07952	OTHER NONREIMB	0	169, 718		344, 818	0	194. 02
		RETAIL PHARMACY	0	0	0	0	0	194. 03
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		n	n	0	n	200. 00 201. 00
202. 00	1	TOTAL (sum lines 118 through 201)	0	4, 805, 347	4, 957, 731	9, 763, 078		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0104

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/27/2022 12:47 pm

Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 760 878 5 00 7.00 00700 OPERATION OF PLANT 23, 638 651, 137 7.00 00800 LAUNDRY & LINEN SERVICE 3, 387 3, 419 8.00 8.00 9.00 00900 HOUSEKEEPI NG 6, 180 7, 051 103.805 9.00 0 01000 DI ETARY 233, 386 10.00 8.377 15, 782 0 6.927 10.00 2, 309 01100 CAFETERI A 6,640 0 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 4, 278 0 1,044 0 13.00 01500 PHARMACY 4.872 9 242 0 2.109 15 00 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 13, 554 7, 696 0 4, 619 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 34, 445 210 35, 090 91, 119 30.00 51, 191 30.00 14, 058 9, 318 03100 INTENSIVE CARE UNIT 19, 951 54, 111 31.00 76 31.00 40.00 04000 SUBPROVIDER - IPF 9, 210 16, 096 23 11,081 32, 556 40.00 04100 SUBPROVIDER - IRF 41.00 0 41.00 04200 SUBPROVI DER 42.00 0 0 0 42.00 0 0 04300 NURSERY O 43.00 0 0 Λ 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 9, 269 12, 189 17 55, 600 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 54, 603 50.00 36,625 455 2.069 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 35, 666 49, 967 284 9, 358 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C C 0 55.00 05501 ULTRA SOUND 4, 787 70 602 55.01 55.01 0 05700 CT SCAN 57 00 5.472 427 924 Λ 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 5, 449 4, 287 151 884 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 4,828 3, 613 187 0 59.00 06000 LABORATORY 50.019 60.00 25, 230 482 3.956 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1, 152 10 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 28 0 64.00 06600 PHYSI CAL THERAPY 66.00 12, 997 22, 554 52 1, 426 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 3.993 22 67 00 683 0 06701 AUDI OLOGY 67.01 1, 156 2, 244 502 0 67.01 06800 SPEECH PATHOLOGY 1, 496 8 301 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 0 06901 CARDI OLOGY 69.01 12,062 2, 324 144 3,032 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 24, 369 85 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 9,639 101 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 54, 345 <u>1, 0</u>05 225 2, 189 0 73 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 C 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 1,501 9,603 0 5, 382 0 90.01 09002 CLI NI C 0 90 02 90 02 0 0 0 90.03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 90.03 90.04 09004 ENT CLINIC 0 0 0 0 0 90.04 09005 SURGERY CLINIC 0 0 0 90.05 90.05 0 0 09007 UROLOGY CLINIC 96 1 90 07 90 07 Ω 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 12 0 0 0 90.09 09011 NEUROLOGY CLINIC 90.11 175 0 90.11 0 09012 OPTHAMOLOGY CLINIC 0 90. 12 90.12 0 0 90 13 09013 ALLERGY CLINIC 702 2 244 2 0 0 90 13 09014 WOUND CARE 5,505 18, 946 48 0 90.14 90.14 0 91 00 09100 EMERGENCY 27, 258 61, 727 271 O O 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 19, 491 95.00 11, 960 34 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 466, 966 399, 242 3, 419 103, 805 233, 386 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 116 1, 568 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 219, 795 290, 868 0 0 0 192, 00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 194.00 194. 01 07951 CAFE/BOUTI QUE 909 0 0 0 194. 01 3, 558 o 194. 02 07952 OTHER NONREIMB 2,019 26, 974 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 194, 03 0 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 233, 386 202. 00 202.00 TOTAL (sum lines 118 through 201) 760.878 651, 137 3.419 103, 805

Provider CCN: 15-0104

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021

			To	12/31/2021	Date/Time Pre 5/27/2022 12:	
Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	Subtotal	,, p
	•	ADMI NI STRATI ON		RECORDS & LI BRARY		
	11. 00	13. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 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						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A	9, 289					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	180	5, 982	70 275			13.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	359 728	O O	79, 375 0	126, 034		15. 00 16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	720	<u> </u>	<u> </u>	120,001		10.00
30. 00 03000 ADULTS & PEDIATRICS	2, 448	1, 148	7	30, 971	903, 886	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	199	532	158	6, 440	286, 096	31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	312 0	387 0	0	7, 666	284, 000 0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	0	0	0	ol	0	42. 00
43. 00 04300 NURSERY	o	0	0	0	0	43.00
44. 00 O4400 SKILLED NURSING FACILITY	0	366	0	0	233, 959	44. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	210	044	7/	11 11/	007 300	FO 00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	218 265	946 150	76 32	11, 116 29, 745	806, 380 765, 622	50. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	2,,,,,0	0	55. 00
55. 01 05501 ULTRA SOUND	28	0	11	3, 220	8, 905	55. 01
57. 00 05700 CT SCAN	38	0	448	3, 680	11, 148	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	95 0	0 157	133	1, 993	68, 118 55, 311	58. 00 59. 00
60. 00 06000 LABORATORY	776	0	0	3, 067	408, 727	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	Ö	0	1, 162	63. 00
64.00 06400 I NTRAVENOUS THERAPY	O	0	0	0	28	64. 00
66. 00 06600 PHYSI CAL THERAPY	388	422	9	5, 980	333, 389	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY	161 170	182 87	0	2, 607	8, 098 33, 024	67. 00 67. 01
68. 00 06800 SPEECH PATHOLOGY	180	51	0	ol	2, 205	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01 06901 CARDI OLOGY	388	455	2	5, 750	55, 049	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	199	0	0	0	24, 653	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0 0	0 0	57, 165	0	9, 740 128, 015	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	37, 100	<u> </u>	120,010	70.00
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	322	13	0	12, 879	152, 545	90. 01
90. 02 09002 CLI NI C 90. 03 09003 DERMATOLOGY CLI NI C	0	0	0	0	0	90. 02 90. 03
90. 04 09004 ENT CLI NI C	o	o	0	0	0	
90. 05 09005 SURGERY CLI NI C	О	0	0	0	0	90. 05
90. 07 09007 UROLOGY CLI NI C	0	0	0	0	122	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC	0	51	0 165	0	63 340	90. 09 90. 11
90. 12 09012 0PTHAMOLOGY CLINIC	0	0	0	o	0	90. 11
90. 13 09013 ALLERGY CLI NI C	Ö	15	0	0	31, 692	90. 13
90. 14 09014 WOUND CARE	0	100	130	0	267, 132	90. 14
91. 00 09100 EMERGENCY	605	709	5, 000	0	886, 915	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	1, 230	ol	111	0	187, 700	95. 00
SPECIAL PURPOSE COST CENTERS		- 1	,			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 289	5, 771	63, 448	125, 114	5, 954, 024	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	ol	ام	0	ما	21, 727	100 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	186	15, 927	920	3, 363, 498	
194.00 07950 THORNTOWN OFFICE BUILDING	o	0	0	0		194. 00
194. 01 07951 CAFE/BOUTI QUE	o	25	0	0	50, 018	
194.02 07952 OTHER_NONREIMB	0	0	0	O	373, 811	
194.03 07953 RETAIL PHARMACY 200.00 Cross Foot Adjustments	٥	O ₁	U	٩		194. 03 200. 00
201.00 Negative Cost Centers	О	o	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	9, 289	5, 982	79, 375	126, 034	9, 763, 078	

WITHAM MEMORIAL HOSPITAL

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

			To 12/31/2021 Date/Time Prep 5/27/2022 12:4	
Cost Center Description	Intern &	Total	372772022 12.	T7 pill
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments 25.00	26. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT				1. 00
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP				2. 00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT		-		5. 00 7. 00
8.00 00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00 00900 HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11. 00
13.00 01300 NURSING ADMINISTRATION				13. 00
15. 00 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY				16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	903, 886		30. 00
31. 00 03100 NTENSI VE CARE UNI T		286, 096		31. 00
40. 00 04000 SUBPROVI DER - PF		284, 000		40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0		41.00
42. 00 04200 SUBPROVI DER	0	О		42. 00
43. 00 04300 NURSERY	0	0		43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	233, 959		44. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	806, 380		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	765, 622		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0		55. 00
55. 01 05501 ULTRA SOUND	o	8, 905		55. 01
57.00 05700 CT SCAN	0	11, 148		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	68, 118		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	55, 311		59. 00
60. 00 06000 LABORATORY	0	408, 727		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	1, 162 28		63. 00 64. 00
66. 00 06600 PHYSI CAL THERAPY		333, 389		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	O	8, 098		67. 00
67. 01 06701 AUDI OLOGY	o	33, 024		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	2, 205		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
69. 01 06901 CARDI OLOGY	0	55, 049		69. 01 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	24, 653 9, 740		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		128, 015		73. 00
OUTPATIENT SERVICE COST CENTERS		120, 0.10		
90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	152, 545		90. 01
90. 02 09002 CLI NI C	0	0		90. 02
90. 03 09003 DERMATOLOGY CLINIC 90. 04 09004 ENT CLINIC	0	0		90. 03 90. 04
90. 05 09005 SURGERY CLINIC		0		90.05
90. 07 09007 UROLOGY CLI NI C	o	122		90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	o	63		90. 09
90. 11 09011 NEUROLOGY CLI NI C	0	340		90. 11
90. 12 09012 0PTHAMOLOGY CLINIC	0	0		90. 12
90. 13 09013 ALLERGY CLINIC	0	31, 692		90. 13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	0	267, 132 886, 915		90. 14 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		880, 915		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			72.00
95. 00 09500 AMBULANCE SERVI CES	0	187, 700		95. 00
SPECIAL PURPOSE COST CENTERS	,			
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 954, 024		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	21, 727		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		3, 363, 498		192. 00
194.00 07950 THORNTOWN OFFICE BUILDING	o o	0		194. 00
194. 01 07951 CAFE/BOUTI QUE	0	50, 018		194. 01
194. 02 07952 OTHER NONREI MB	0	373, 811		194. 02
194. 03 07953 RETAIL PHARMACY	0	0		194. 03
200.00 Cross Foot Adjustments	0	0		200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 0	9, 763, 078		201.00
202. 00 TOTAL (Sum Titles Tit till ough 201)	١	7, 703, 070	ı	1202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 WITHAM MEMORIAL HOSPITAL Provider CCN: 15-0104 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 12:47 pm CAPITAL RELATED COSTS

	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation		
		FIXT (SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT		& GENERAL (ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
		1.00	2. 00	SALARI ES) 4. 00	5A	5. 00	
	ERAL SERVICE COST CENTERS	1.00	2.00	4.00	JA.	3. 00	
	OO NEW CAP REL COSTS-BLDG & FIXT	303, 947					1. 00
	OO NEW CAP REL COSTS-MVBLE EQUIP OO EMPLOYEE BENEFITS DEPARTMENT	1, 789	303, 947 1, 789				2. 00 4. 00
	OO ADMINISTRATIVE & GENERAL	23, 501	23, 501			131, 614, 625	5. 00
7. 00 007	OO OPERATION OF PLANT	19, 517	19, 517			4, 088, 975	1
	OO LAUNDRY & LINEN SERVICE	0	0			585, 838	1
	200 HOUSEKEEPI NG 200 DI ETARY	2, 806 6, 281	2, 806 6, 281			1, 069, 048 1, 448, 982	1
	OO CAFETERI A	0, 201	0, 201			1, 148, 584	1
	NURSING ADMINISTRATION	0	0	000,72.		739, 924	
	600 PHARMACY 600 MEDI CAL RECORDS & LI BRARY	1, 939 3, 063	1, 939			1, 598, 620	
	ATIENT ROUTINE SERVICE COST CENTERS	3,003	3, 063	1, 202, 039	U	2, 344, 534	16.00
30.00 030	000 ADULTS & PEDIATRICS	20, 373	20, 373	3, 484, 371	0	5, 958, 391	30. 00
	00 I NTENSI VE CARE UNI T	5, 595	5, 595		0	3, 451, 119	
	000 SUBPROVI DER – I PF 00 SUBPROVI DER – I RF	6, 406	6, 406 0	1, 098, 549	0	1, 593, 125 0	40. 00 41. 00
	OO SUBPROVI DER	0	0	Ö	0	0	42. 00
	NURSERY	0	0	0	0	0	43. 00
	OO SKILLED NURSING FACILITY ILLARY SERVICE COST CENTERS	4, 851	4, 851	853, 104	0	1, 603, 280	44. 00
	OOO OPERATING ROOM	21, 731	21, 731	2, 745, 254	0	6, 335, 374	50.00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	19, 886	19, 886			6, 169, 543	1
	RADI OLOGY-THERAPEUTI C	0	0		-	0	55. 00
	001 ULTRA SOUND 100 CT SCAN	0	0	227, 904 194, 483		828, 083 946, 491	55. 01 57. 00
	MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706			942, 569	1
59. 00 059	OO CARDI AC CATHETERI ZATI ON	1, 438	1, 438	409, 754	0	835, 088	59. 00
	OOO LABORATORY	10, 041	10, 041	1		8, 652, 355	1
	000 BLOOD STORING, PROCESSING & TRANS. 000 INTRAVENOUS THERAPY	0	0	0	_	199, 194 0	63. 00 64. 00
	000 PHYSI CAL THERAPY	8, 976	8, 976		0	2, 248, 264	
	OO OCCUPATIONAL THERAPY	0	0			690, 710	1
	O1 AUDI OLOGY OO SPEECH PATHOLOGY	893	893 0			200, 004 258, 857	67. 01 68. 00
	OO ELECTROCARDI OLOGY	0	0		0	230, 037	69. 00
	O1 CARDI OLOGY	925	925			2, 086, 465	1
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	·	0	4, 215, 443	1
	200 IMPL. DEV. CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS	400	400		_	1, 667, 296 9, 400, 617	
OUT	PATIENT SERVICE COST CENTERS				_	.,,	
90.00 090	OOO CLINIC	0	0			0	90.00
	001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822 0	96, 906 0		259, 684 0	90. 01 90. 02
	03 DERMATOLOGY CLINIC	0	0				
	004 ENT CLINIC	0	0	1		0	
	005 SURGERY CLINIC 007 UROLOGY CLINIC	0	0	0 30, 332		0 16, 609	
	009 GASTROENTEROLOGY CLINIC	0	0	0 0		2, 000	1
90. 11 090	11 NEUROLOGY CLINIC	0	0	0	0	30, 209	90. 11
	012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
	013 ALLERGY CLINIC 014 WOUND CARE	893 7, 540	893 7, 540			121, 412 952, 259	90. 13 90. 14
	OO EMERGENCY	24, 566	24, 566			4, 715, 067	1
	OO OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	ER REIMBURSABLE COST CENTERS	4.740	4 740	2 411 400	0	2 271 402	95. 00
	600 AMBULANCE SERVICES CLAL PURPOSE COST CENTERS	4, 760	4, 760	2, 411, 698	0	3, 371, 602	95.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	203, 698	203, 698	38, 263, 790	-16, 997, 435	80, 775, 615	118. 00
	REIMBURSABLE COST CENTERS	404	424			20,042	100.00
	000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	624 87, 474	624 87, 474		_	20, 043 50, 312, 433	190. 00 192. 00
194. 00 079	THORNTOWN OFFICE BUILDING	0	0	0	0		194. 00
	051 CAFE/BOUTI QUE	1, 416	1, 416			157, 265	
	P52 OTHER NONREIMB P53 RETAIL PHARMACY	10, 735	10, 735 0		_	349, 269 0	194. 02 194. 03
200. 00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers			<u> </u>	<u> </u>		201. 00

Health Finan	cial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
		CAPITAL RELA	TED COSTS				
	Cost Center Description	NEW BLDG & FIXT (SQUARE	NEW MVBLE EQUIP (SQUARE	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM.	
		FEET)	FEET)	(GROSS SALARI ES)		COST)	
		1. 00	2.00	4. 00	5A	5. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 805, 347	4, 957, 731	12, 398, 39	1	16, 997, 435	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 809819	16. 311169	0. 17681	8	0. 129145	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			57, 46	5	760, 878	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00082	0	0. 005781	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST CALLOCATION STATISTICAL DAILS Provider COR: 15 Oral Provider COR:		Financial Systems	WI IHAM MEMORI		ON 45 0404 D		U OT FORM CMS	
Cost Center Description	COSTA	LLUCATION - STATISTICAL BASIS		Provider C	F	rom 01/01/2021		pared:
STATE STAT			ODEDATION OF	L ALINDRY O	LIQUICEVEEDING	DI ETADY		47 pm
CEBBRAL SERVICE COST CENTERS 7.00 8.00 9.00 10.00 11.00 11.00 12.00 10.00 11.00 11.00 10.00 10.00 11.00 10.00 10.00 11.00 10.00 10.00 10.00 10.00 11.00 10.00		Cost Center Description						
FFFTY ONLOGENES 10.00 10.00 11.00						,	•	
Company Comp					02	0223)	02.1123)	
1.00 00100 INST CAP HEL COSTS SELECT A FIXT			7. 00	8. 00	9. 00	10.00	11. 00	
2.00 DODOO BIRST ON PELCOSIS-MONLE CORP 3.00 DODOO BIRST ON OF PLANT 4.00 DODOO BIRST ON								
4.00 000000 EMPLOYEE EIRCH IS DEPARTMENT 259, 148 5.00 000000 EMPLOYEE ELEMENT 5.00 0 5.00 000000 EMPLOYEE ELEMENT 5.00 0 5.00 000000 EMPLOYEE 5.00 0 5.00 0 5.00 000000 EMPLOYEE 5.00 0 5.0								
5.00 00000 ADMINISTRATIVE & CENERAL 7.00 00000 (PERRATIVE & CENERAL 8.00 00000 (LAUROW & LINES SERVICE 9.00 00000 (LAUROW								
7.00 00 00 00 00 00 00 0		1						
8.00 000000 LAIMBREY A. LININ STRVICT 0 239,032,314 9,00 000000			259 140					
9.00 00000 MOUSEREEPI NG								
11.00 01100 CAFETERIA 0 0 2, 275 0 992 11.00 13.00			2, 806	0				
13.00 01300 PURSING ADMINISTRATION 0 0 1, 300 0 19 13.00			6, 281	0	8, 623	43, 722		10. 00
15.00 01500 MARMACY 1,939 0 2,675 0 38 15.00 0 77 16.00 16.0			0	0				
16.00			0	0				
IMPATIENT ROUTH SERVICE COST CENTERS 20, 373 20, 203, 075 43, 681 17, 070 259 30, 00 00000 0000 0000 0000 0000 00000 00000 00000 00000 00000 00000 00000 00000				, and the second second second second second second second second second second second second second second se				
30.00 30000 ADULTS & PEDIATRICS 20, 373 26, 203, 075 43, 681 17, 070 299 30, 00	10.00		3,003	0	ıj 5,750	U		10.00
31.00 0 31000 INTERNIVE CARE UNIT 5.995 9.516, 370 11, 600 10, 137 21 31, 00 41. 00 00 00 0100 00 01 01	30. 00		20, 373	26, 203, 075	43, 681	17. 070	259	30.00
11.00 0.0100 SUBPROVIDER - IRF								
42.00 04.00 04.00 04.00 0 0 0 0 0 0 0 0 0	40.00		6, 406	2, 818, 665	13, 794	6, 099	33	40. 00
43.00 0.400 SURLEEN NIRSH NG FACILITY 4,851 2,086,939 0 10,416 0.44			0	0	0	0	-	
			0	0	0	0	-	
## MICLILARY SERVICE COST CENTERS 54. 00. 06400 (DEPATTIN RENOM) 19. 086 35. 496. 597 11, 650 0 23 55. 00 23 55. 00 55. 00 05. 00 550. 00 55			4 051	2 007 202	0	10 414		
	44.00		4, 601	2,000,393	0	10, 410		44.00
54.00 05400 RADIOLOGY-PIAGNOSTIC 19,886 35,496,592 11,650 0 0 0 0 55.00 55.00 05500 RADIOLOGY-FIRERAPEUTIC 0 0 0 0 0 55.00 55.00 05500 CT SCAN 0 55.00 55.00 05500 CT SCAN 0 55.00 55.00 05.	50 00		21 731	56 874 206	2 575	0	23	50 00
55.00								
57.00 65700 CT SCAM 0 53, 321, 915 1, 150 0 4 57.00 59.00 6500 MASKETI C RESONANCE I MAGING (MRI) 1, 766 18, 92, 088 1, 100 0 0 0 59.00 69.00 6500 6400							0	55. 00
58. 00 05800 MAGNETI C RESONANCE INACING (MRI) 1,706 18,932,088 1,100 0 0 0 0,59,00 0,000 0,	55. 01	05501 ULTRA SOUND	0	8, 751, 408	750	0	3	55. 01
59.00 0.6900 CARDIAC CATHETER IZATION 1. 438 23, 320, 955 0 0 59, 00 63.00 63.00 ABORATORY 10.041 72, 228, 093 4, 925 0 0 63.00 63.00 64.00 0.640 0.07 0.0			0			0		
60.00 06000 LABORATORY 10.041 72.238.093 4.925 0 82 60.00 63.00 63.00 06300 BLODD STORI NG, PROCESSING & TRANS. 0 1.240.961 0 0 0 0 0 64.00 64.00 64.00 06400 INTRAVENOUS THERAPY 8.976 6.441.292 1.775 0 41 66.00 66.00 06500 PHSIS CLAI THERAPY 8.976 6.441.292 1.775 0 0 41 66.00 67.00 06700 DIVISICAL THERAPY 8.976 6.441.292 1.775 0 0 41 66.00 67.00 06700 DIVISICAL THERAPY 8.976 6.441.292 1.775 0 0 18 67.00 0 0 0 0 0 0 0 0 0						0		
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67. 01 06701 AUDI OLOCY			8, 976			O	-	
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69 01 06901 CARDIOLOGY			0	973, 361		0		
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12, 50		1	i e					
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90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	400			0	0	73. 00
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90. 02 09002 CLINIC				0				
90.03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 0 0 0 0				0				
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90. 05			0	0		0		
90. 07 09007 LROLLOGY CLINIC 0 132, 410 0 0 0 0 90. 07 90. 09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 90. 07 90. 11 09011 NEUROLOGY CLINIC 0 0 0 0 0 0 90. 17 90. 12 09012 OPTHAMOLOGY CLINIC 893 211, 808 0 0 0 0 90. 17 90. 13 09013 ALLERGY CLINIC 893 211, 808 0 0 0 0 90. 17 90. 14 09010 CARE 7,540 6,059, 191 0 0 0 0 0 91. 00 09100 EMERGENCY 24,566 33,835, 186 0 0 0 0 0 92. 00 095200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 95. 00 095200 AMBULANCE SERVICES 4,760 4,193,622 0 0 130 95. 00 SPECIAL PURPOSE COST CENTERS 95. 00 0 130 95. 00 SUBTOTALS (SUM OF LINES 1 through 117) 158,891 439,032,314 129,223 43,722 982 118. 00 118. 00 SUBTOTALS (SUM OF LINES 8 4,760 4,193,622 0 0 0 0 192. 00 192. 00 19200 19200 19700 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 192. 00 194. 00 07950 THORNTOWN OFFICES 87,474 0 0 0 0 0 192. 00 194. 01 07951 CAFE/BOUTIQUE 1,416 0 0 0 0 0 194. 01 194. 02 07952 OTHER NOINEI MB 10,735 0 0 0 0 194. 01 194. 02 07952 OTHER NOINEI MB 10,735 0 0 0 0 194. 02 190. 00 Negative Cost Centers 200. 00 201. 00 202. 00 Rogative Cost Centers 201. 00 201. 00 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 203. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 203. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,			0	0	o	0	0	
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90. 12 09012 OPTHAMOLOGY CLINIC 0 0 0 0 0 0 0 0 12 90. 13 09013 ALLERGY CLINIC 893 211,808 0 0 0 0 90. 13 90. 14 09014 WOUND CARE 7,540 6,059,191 0 0 0 0 49. 10 91. 00 09100 EMERGENCY 24,566 33,835,186 0 0 64 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 000 OPTHER REI MBURSABLE COST CENTERS 4,760 4,193,622 0 0 130 000 SPECIAL PURPOSE COST CENTERS 18. 00 0 130 000 SPECIAL PURPOSE COST CENTERS 18. 00 0 0 0 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 192. 00 19200 PHYSI CLANS* PRI VATE OFFI CES 87,474 0 0 0 0 0 194. 00 07950 THORNTOWN OFFI CE BUILDING 0 0 0 0 194. 00 07950 THORNTOWN OFFI CE BUILDING 0 0 0 0 194. 01 07951 CAFE/BOUTIQUE 1,416 0 0 0 0 194. 02 07952 OTHER NONREI MB 10,735 0 0 0 0 194. 03 07953 RETAIL PHARMACY 0 0 0 0 194. 04 07950 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 202. 00 203 203 203 203 203 203 203 OPTHER NONEI MB 1,324,887 202. 00 204 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 205 OPTHER NONEI MB 1,324,887 202. 00 206 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00 207 OPTHER NONEI MB 1,324,887 202. 00 208 OPTHER NONEI MB 1,324,887 202. 00 209 OPTHER NONEI MB 1,324,887 202. 00 200 OPTHER NONEI MB 1,324,887 20	90. 09		0	0	0	0	0	90. 09
90. 13 09013 ALLERGY CLINIC 893 211, 808 0 0 0 0 90. 13 90. 14 09014 WOUND CARE 7, 540 6, 059, 191 0 0 0 0 90. 14 91. 00 09200 DEMERGENCY 24, 566 33, 835, 186 0 0 0 64 91. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 92. 00 07 07 07 07 07 07 07			0	0	0	0		
90. 14 09014 WOUND CARE 7,540 6,059,191 0 0 0 90. 14 91. 00 92. 00 990. 00			0	0	0	0		
91. 00 09100 EMERGENCY 09200 O9500 O						0		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 9500 AMBULANCE SERVI CES 4,760 4,193,622 0 0 130 95. 00 SPECIAL PURPOSE COST CENTERS 158,891 439,032,314 129,223 43,722 982 118. 00 NONREIMBURSABLE COST CENTERS 982 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 87,474 0 0 0 0 192. 00 194. 00 07950 THORNTOWN OFFI CE BUILDING 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTI QUE 1,416 0 0 0 0 0 194. 02 07952 OTHER NONREI MB 10,735 0 0 0 0 194. 02 194. 03 07953 RETAI L PHARMACY 0 0 0 0 0 194. 03 194. 03 07953 RETAI L PHARMACY 0 0 0 0 0 194. 04 03 07953 OTHER NONREI MB 10,735 0 0 0 0 0 194. 05 07953 OTHER NONREI MB 10,735 0 0 0 0 0 194. 06 07953 OTHER NONREI MB 10,735 0 0 0 0 0 194. 07954 OTHER NONREI MB 10,735 0 0 0 0 0 194. 08 07953 OTHER NONREI MB 10,735 0 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09 07953 OTHER NONREI MB 10,735 0 0 0 194. 09						0		
95. 00 OFFICE CAPITER CONTINUE CONT			24, 300	33, 033, 100		Ŭ	04	
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 158,891 439,032,314 129,223 43,722 982 118.00								
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 158,891 439,032,314 129,223 43,722 982 118.00	95.00	09500 AMBULANCE SERVI CES	4, 760	4, 193, 622	2 0	0	130	95. 00
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 87, 474 0 0 0 0 0 0 0 192.00 194.00 07950 THORNTOWN OFFI CE BUI LDI NG 0 0 0 0 0 0 0 0 194.00 194.01 07951 CAFE/BOUTI QUE 1, 416 0 0 0 0 0 0 0 194.01 194.02 07952 OTHER NONREI MB 10, 735 0 0 0 0 0 0 194.02 194.03 07953 RETAI L PHARMACY 0 0 0 0 0 0 0 194.02 194.03 07953 RETAI L PHARMACY 0 0 0 0 0 0 0 0 0 194.02 194.04 07951 07952 07952 07952 07952 07952 194.05 07953 07			1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 624 0 0 0 0 0 0 190. 00 192. 00 192. 00 192. 00 192. 00 192. 00 192. 00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 194. 00 194. 01 194. 01 194. 02 19752 CAFE/BOUTI QUE 1, 416 0 0 0 0 0 0 0 194. 01 194. 01 194. 02 19752 OTHER NONREIMB 10, 735 0 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 0 0 0 0 0 194. 03 194. 03 07953 RETAIL PHARMACY 0 0 0 0 0 0 0 194. 03 194. 03 07953 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, 4, 617, 046 661, 496 1, 257, 104 1, 831, 904 1, 324, 887 202. 00 Part I)	118.00		158, 891	439, 032, 314	129, 223	43, 722	982	1118. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 87,474 0 0 0 0 0 0 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 194.00 194.01 07951 CAFE/BOUTIQUE 1,416 0 0 0 0 0 0 194.01 194.02 07952 OTHER NONREIMB 10,735 0 0 0 0 0 194.02 194.03 07953 RETAIL PHARMACY 0 0 0 0 0 0 194.03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 4,617,046 661,496 1,257,104 194.02 1,831,904 1,324,887 202.00 200.00	100.00		424		1	٥		100 00
194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 194. 00 194. 00 194. 01 194. 02 07951 CAFE/BOUTIQUE 1,416 0 0 0 0 194. 01 194. 02 194. 03 07952 OTHER NONREI MB 10,735 0 0 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 0 0 0 0 194. 03 194. 03 200. 00 0 0 0 0 0 0 0 0				_	1			
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194. 03 07953 RETAIL PHARMACY 0 0 0 0 194. 03 200. 00 201. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202. 00	194. 02	07952 OTHER NONREIMB		0	0	O	0	194. 02
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202.00			0	0	0	О	0	1
202.00 Cost to be allocated (per Wkst. B, 4,617,046 661,496 1,257,104 1,831,904 1,324,887 202.00 Part I)								
Part I)			4 417 044	444 404	1 057 104	1 001 004	1 224 007	
	202. UC	1 ''	4, 617, 046	001, 496	1, 257, 104	1, 831, 904	1, 324, 887	202.00
	203.00	1 1 '	17. 816802	0. 001507	9. 728175	41. 898907	1, 349. 172098	203. 00
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Heal th Finar	ncial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS	
		(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)	
		FEET)	CHARGES)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204.00	Cost to be allocated (per Wkst. B,	651, 137	3, 419	103, 80	5 233, 386	9, 289	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2. 512684	0. 000008	0. 80330	5. 337953	9. 459267	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
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0104 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

				T	o 12/31/2021 Date/Time Pr 5/27/2022 12	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL	0,27,2022 12	
		ADMI NI STRATI ON	(COSTED REQUIS.)	RECORDS & LI BRARY		
		(DI RECT	,	(TIME		
		NRSI NG 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	OO4OO					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	456, 946				13. 00
	01500 PHARMACY	0	14, 544, 276			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	41, 100		16. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	87, 619	1, 373	10, 100		30.00
31. 00	03100 NTENSI VE CARE UNI T	40, 613	29, 041	2, 100		31. 00
40.00	04000 SUBPROVI DER - I PF	29, 593	152	2, 500		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0		41. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0	0		42. 00 43. 00
	04400 SKILLED NURSING FACILITY	27, 957	16	0		44. 00
	ANCILLARY SERVICE COST CENTERS			_		
50. 00	05000 OPERATI NG ROOM	72, 273	13, 977	3, 625		50. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	11, 494	5, 820	9, 700 0		54. 00 55. 00
55. 00 55. 01	05501 ULTRA SOUND	0	1, 972	1, 050		55. 00
57. 00	05700 CT SCAN	0	82, 007	1, 200		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	24, 304	650		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	11, 968	0	1 000		59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	52 0	1, 000 0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ō	0		64. 00
66. 00	06600 PHYSI CAL THERAPY	32, 244	1, 726	1, 950		66. 00
67. 00 67. 01	O6700 OCCUPATI ONAL THERAPY O6701 AUDI OLOGY	13, 875 6, 636	0	850 0		67. 00 67. 01
68. 00	06800 SPEECH PATHOLOGY	3, 909	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0		69. 00
69. 01	06901 CARDI OLOGY	34, 766	291	1, 875		69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	10, 474, 186	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0		90.00
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	993	30	4, 200		90. 01 90. 02
	09003 DERMATOLOGY CLINIC	0	o	0		90. 03
90. 04	09004 ENT CLINIC	0	0	0		90. 04
	09005 SURGERY CLINIC	0	0	0		90. 05
	09007 UROLOGY CLI NI C 09009 GASTROENTEROLOGY CLI NI C	3, 926	0	0		90. 07 90. 09
	09011 NEUROLOGY CLINIC	0	30, 209	0		90. 11
	09012 OPTHAMOLOGY CLINIC	0	0	0		90. 12
	09013 ALLERGY CLINIC	1, 136	0	0		90. 13
	09014 WOUND CARE 09100 EMERGENCY	7, 653 54, 183	23, 854 916, 340	0		90. 14 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 103	710, 540	J		92. 00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVI CES	0	20, 364	0		95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	440, 838	11, 625, 714	40, 800		118. 00
110.00	NONREI MBURSABLE COST CENTERS	440,030	11,023,714	40, 000		110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	14, 222	2, 918, 562	300		192.00
	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	1, 886	0	0		194. 00 194. 01
	07952 OTHER NONREIMB	0	o	0		194. 01
194. 03	07953 RETAIL PHARMACY	0	Ō	0		194. 03
200.00						200. 00
201. 00 202. 00		873, 762	1, 916, 426	2, 861, 715		201. 00 202. 00
۷۵. ۵۵	Part I)	073,702	1, 710, 420	2,001,713		202.00
						

Heal th	Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL			
		ADMI NI STRATI ON	(COSTED	RECORDS &			
			REQUIS.)	LI BRARY			
		(DI RECT		(TIME			
		NRSING HRS)		SPENT)			
		13.00	15. 00	16.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 912178	0. 131765	69. 62810	2		203.00
204.00	Cost to be allocated (per Wkst. B,	5, 982	79, 375	126, 03	4		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 013091	0. 005457	3. 06652	1		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

| Peri od: | Worksheet C | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 |

					0 12/31/2021	5/27/2022 12:	
			Title	XVIII	Hospi tal	PPS	., p
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				,		
30. 00	03000 ADULTS & PEDI ATRI CS	9, 490, 910		9, 490, 910		9, 490, 910	
31.00	03100 I NTENSI VE CARE UNI T	4, 804, 454		4, 804, 454		4, 804, 454	31.00
40.00	04000 SUBPROVI DER - I PF	2, 582, 182		2, 582, 182		2, 582, 182	40.00
41. 00	04100 SUBPROVI DER - I RF	0				0	41. 00
42. 00	04200 SUBPROVI DER 04300 NURSERY	0				0	42. 00 43. 00
43. 00 44. 00	04400 SKILLED NURSING FACILITY	2, 389, 789		2, 389, 789		0 2, 389, 789	
44.00	ANCI LLARY SERVICE COST CENTERS	2, 389, 789		2, 389, 789	y U	2, 389, 789	44.00
50. 00	05000 OPERATING ROOM	8, 074, 966		8, 074, 966	ol	8, 074, 966	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 223, 356		8, 223, 356		8, 223, 356	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0, 223, 330		0, 223, 330		0, 223, 330	55. 00
55. 01	05501 ULTRA SOUND	1, 032, 928		1, 032, 928	1 4	1, 032, 928	
57. 00	05700 CT SCAN	1, 260, 026		1, 260, 026		1, 260, 026	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 195, 876		1, 195, 876		1, 195, 876	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 026, 586		1, 026, 586		1, 026, 586	
60.00	06000 LABORATORY	10, 285, 577		10, 285, 577		10, 285, 577	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	226, 789		226, 789		226, 789	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	5, 323		5, 323		5, 323	64. 00
66. 00	06600 PHYSI CAL THERAPY	2, 978, 489	0			2, 978, 489	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	901, 044	0			901, 044	67. 00
67. 01	06701 AUDI OLOGY	285, 928	0	285, 928	o	285, 928	67. 01
68.00	06800 SPEECH PATHOLOGY	330, 511	0	330, 511	o	330, 511	68. 00
69.00	06900 ELECTROCARDI OLOGY	0		C	o	0	69. 00
69. 01	06901 CARDI OLOGY	2, 688, 610		2, 688, 610	0	2, 688, 610	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 804, 225		4, 804, 225	0	4, 804, 225	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 901, 558		1, 901, 558		1, 901, 558	
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 070, 792		12, 070, 792	. 0	12, 070, 792	73. 00
	OUTPATIENT SERVICE COST CENTERS	,					
90.00	09000 CLI NI C	0		C		0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	766, 709		766, 709	0	766, 709	90. 01
90. 02	09002 CLI NI C	0		0	0	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0			0	0	90. 03
90. 04	09004 ENT CLINIC	0			0	0	90. 04
90.05	09005 SURGERY CLINIC	10.054		10.054		10.054	90. 05
90. 07 90. 09	O9007 UROLOGY CLINIC O9009 GASTROENTEROLOGY CLINIC	18, 954		18, 954		18, 954	90. 07
90. 09	09011 NEUROLOGY CLINIC	9, 765 38, 090		9, 765 38, 090		9, 765 38, 090	90. 09 90. 11
90. 11	09012 OPTHAMOLOGY CLINIC	30, 090		30,090		36, 090	90. 11
90. 12	09013 ALLERGY CLINIC	155, 493		155, 493	-	155, 493	90. 12
90. 13	09014 WOUND CARE	1, 236, 485		1, 236, 485		1, 236, 485	90. 13
91. 00	09100 EMERGENCY	6, 123, 369		6, 123, 369		6, 123, 369	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 539, 894		2, 539, 894		2, 539, 894	92. 00
,2. 00	OTHER REIMBURSABLE COST CENTERS	2,007,074		2,007,074		2,007,074	, 2. 00
95.00	09500 AMBULANCE SERVICES	4, 076, 231		4, 076, 231	0	4, 076, 231	95. 00
200.00		91, 524, 909	0			91, 524, 909	
201.00		2, 539, 894		2, 539, 894	.	2, 539, 894	
202.00	Total (see instructions)	88, 985, 015	0	88, 985, 015	o	88, 985, 015	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES WITHAM MEMORIAL HOSPITAL Provider CCN: 15-0104 Title XVIII

			Title	xVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	The state of the s			+ col. 7)	Ratio	Inpati ent	
				'		Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18, 055, 586		18, 055, 586			30.00
31. 00	03100 INTENSIVE CARE UNIT	9, 516, 370		9, 516, 370			31. 00
40. 00	04000 SUBPROVI DER - I PF	2, 818, 665		2, 818, 665			40. 00
41. 00	04100 SUBPROVI DER – I RF	2,010,000		2,010,000			41. 00
42. 00	04200 SUBPROVI DER	0					42.00
43. 00	04300 NURSERY	0					43. 00
44. 00	04400 SKILLED NURSING FACILITY	2, 086, 393		2, 086, 393			44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	2,000,393		2,000,393			44.00
50. 00	05000 OPERATING ROOM	7, 048, 319	49, 825, 887	56, 874, 206	0. 141979	0. 000000	50. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 039, 988	33, 456, 604			0. 000000	
		2, 039, 988					
55. 00	05500 RADI OLOGY-THERAPEUTI C	(20, 205	0 121 112			0.000000	
55. 01	05501 ULTRA SOUND	620, 295	8, 131, 113			0.000000	
57. 00	05700 CT SCAN	7, 407, 297	45, 914, 618			0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	966, 315	17, 965, 773			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 601, 215	17, 719, 740			0. 000000	
60.00	06000 LABORATORY	13, 170, 806	59, 067, 287			0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	634, 526	606, 435			0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	1, 364, 718	2, 167, 382			0. 000000	
66.00	06600 PHYSI CAL THERAPY	1, 991, 835	4, 449, 457	6, 441, 292		0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	1, 828, 031	966, 760	2, 794, 791	0. 322401	0. 000000	67. 00
67. 01	06701 AUDI OLOGY	0	750, 106	750, 106	0. 381183	0.000000	67. 01
68. 00	06800 SPEECH PATHOLOGY	168, 407	804, 954	973, 361	0. 339556	0. 000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0.000000	0.000000	69. 00
69. 01	06901 CARDI OLOGY	6, 621, 464	11, 359, 250	17, 980, 714	0. 149527	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 182, 911	7, 464, 616		0. 451206	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 216, 975	10, 350, 642	12, 567, 617	0. 151306	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 909, 352	17, 202, 516	28, 111, 868	0. 429384	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·		<u>'</u>		
90.00	09000 CLI NI C	0	0	C	0.000000	0.000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0. 000000	
90. 02	09002 CLI NI C	0	0			0. 000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0	0		0. 000000	
90. 04	09004 ENT CLINIC	0	0	l d		0. 000000	
90. 05	09005 SURGERY CLINIC		0	l o		0. 000000	
90. 07	09007 UROLOGY CLINIC		132, 410				
90. 07	09009 GASTROENTEROLOGY CLINIC	0	132, 410	132, 410	0.000000	0.00000	
90. 09	09011 NEUROLOGY CLINIC	0	0			0.000000	
90. 11	09011 NEGROLOGY CLINIC	0	0			0. 000000	
90. 12		0	211 000				
	09013 ALLERGY CLINIC	22 217	211, 808			0.000000	
90. 14	09014 WOUND CARE	23, 217	6, 035, 974				
91. 00	09100 EMERGENCY	4, 295, 645	29, 539, 541			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	294, 759	7, 852, 730	8, 147, 489	0. 311739	0. 000000	92. 00
05.65	OTHER REIMBURSABLE COST CENTERS				0.075		
95. 00	09500 AMBULANCE SERVICES	1, 082	4, 192, 540			0. 000000	
200.00	1 /	102, 864, 171	336, 168, 143	439, 032, 314	1		200. 00
201.00		100					201. 00
202.00	Total (see instructions)	102, 864, 171	336, 168, 143	439, 032, 314	•		202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0104

Peri od: Worksheet C From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 12:47 pm

			TI 11 10 11 1		5/2//2022 12:	47 pm
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31. 00
40.00	04000 SUBPROVI DER - I PF					40.00
41.00	04100 SUBPROVI DER - I RF					41.00
42.00	04200 SUBPROVI DER					42. 00
43.00	04300 NURSERY					43.00
44.00	04400 SKILLED NURSING FACILITY					44. 00
	ANCILLARY SERVICE COST CENTERS	<u>'</u>				
	05000 OPERATING ROOM	0. 141979				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 231666				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
	05501 ULTRA SOUND	0. 118030				55. 01
4	05700 CT SCAN	0. 023631				57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 063167				58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 044020				59.00
1	06000 LABORATORY	0. 142384				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 182753				63.00
1	06400 I NTRAVENOUS THERAPY	0. 001507				64.00
	06600 PHYSI CAL THERAPY	0. 462406				66.00
	06700 OCCUPATI ONAL THERAPY	0. 322401				67. 00
	06701 AUDI OLOGY	0. 381183				67. 01
	06800 SPEECH PATHOLOGY	0. 339556				68. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	06901 CARDI OLOGY	0. 149527				69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 451206				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 151306				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 429384				73. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				90. 01
90. 02	09002 CLI NI C	0. 000000				90. 02
90. 03	09003 DERMATOLOGY CLINIC	0. 000000				90. 03
90. 04	09004 ENT CLINIC	0. 000000				90. 04
90. 05	09005 SURGERY CLINIC	0. 000000				90. 05
90. 07	09007 UROLOGY CLINIC	0. 143146				90. 07
	09009 GASTROENTEROLOGY CLINIC	0. 000000				90.09
	09011 NEUROLOGY CLINIC	0. 000000				90. 11
1	09012 OPTHAMOLOGY CLINIC	0. 000000				90. 12
1	09013 ALLERGY CLINIC	0. 734122				90. 13
1	09014 WOUND CARE	0. 204068				90. 14
	09100 EMERGENCY	0. 180976				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 180476				92.00
	OTHER REIMBURSABLE COST CENTERS	0.311/39				72.00
	09500 AMBULANCE SERVICES	0. 972007				95. 00
200.00	Subtotal (see instructions)	0.912001				200.00
1	,					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/27/2022 12:47 pm Provider CCN: 15-0104

					10 12/01/2021	5/27/2022 12:	47 pm
			Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	occi contor boson per on	(from Wkst. B,	Adj .	.014. 00010	Di sal I owance	10101 00010	
		Part I, col.	7.cg .		Di Gai i Gilanoo		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDI ATRI CS	9, 490, 910		9, 490, 91	0 0	9, 490, 910	30.00
31. 00	03100 I NTENSI VE CARE UNI T	4, 804, 454		4, 804, 45			31.00
40. 00	04000 SUBPROVI DER - I PF	1 1					40.00
41. 00	04100 SUBPROVI DER - TPF	2, 582, 182		2, 582, 18	0 0	2, 362, 162	40.00
41.00	04200 SUBPROVI DER	0			0 0	1	41.00
43.00	04300 NURSERY	0			0 0		42.00
44.00		2 200 700			-		
44.00	04400 SKILLED NURSING FACILITY	2, 389, 789		2, 389, 78	9 0	2, 389, 789	44. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.074.077		0.074.07		0.074.077	F0 00
50.00	05000 OPERATING ROOM	8, 074, 966		8, 074, 96			50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	8, 223, 356		8, 223, 35			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0		55. 00
55. 01	05501 ULTRA SOUND	1, 032, 928		1, 032, 92			55. 01
57. 00	05700 CT SCAN	1, 260, 026		1, 260, 02			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 195, 876		1, 195, 87		.,,	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 026, 586		1, 026, 58		.,,	59. 00
60.00	06000 LABORATORY	10, 285, 577		10, 285, 57			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	226, 789		226, 78	9 0	226, 789	63. 00
64.00	06400 I NTRAVENOUS THERAPY	5, 323		5, 32	3 0	5, 323	64. 00
66.00	06600 PHYSI CAL THERAPY	2, 978, 489	0	2, 978, 48	9 0	2, 978, 489	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	901, 044	0	901, 04	4 0	901, 044	67. 00
67. 01	06701 AUDI OLOGY	285, 928	0	285, 92	8 0	285, 928	67. 01
68.00	06800 SPEECH PATHOLOGY	330, 511	0	330, 51	1 0	330, 511	68. 00
69.00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
69. 01	06901 CARDI OLOGY	2, 688, 610		2, 688, 61	0	2, 688, 610	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 804, 225		4, 804, 22	5 0	4, 804, 225	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 901, 558		1, 901, 55	8 0	1, 901, 558	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 070, 792		12, 070, 79	2 0		73. 00
	OUTPATIENT SERVICE COST CENTERS				<u>'</u>	<u> </u>	
90.00	09000 CLI NI C	0			0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	766, 709		766, 70	9 0	766, 709	90. 01
90. 02	09002 CLI NI C	0			o		90. 02
90. 03	09003 DERMATOLOGY CLINIC	o			o o	0	90. 03
90. 04	09004 ENT CLINIC	0			0	0	90. 04
90. 05	09005 SURGERY CLINIC	0			0		90. 05
90. 07	09007 UROLOGY CLINIC	18, 954		18. 95	-	1	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	9, 765		9, 76			90. 09
90. 11	09011 NEUROLOGY CLINIC	38, 090		38, 09		.,	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	30,070			0 0	0	90. 12
90. 13	09013 ALLERGY CLINIC	155, 493		155, 49	-		90. 13
90. 14	09014 WOUND CARE	1, 236, 485		1, 236, 48		1,	90. 14
91. 00	09100 EMERGENCY	6, 123, 369		6, 123, 36			91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 539, 894		2, 539, 89		2, 539, 894	91.00
72.00	OTHER REIMBURSABLE COST CENTERS	2, 337, 094		2, 557, 69	71	2, 337, 094	72.00
05 00	09500 AMBULANCE SERVICES	4, 076, 231		4, 076, 23	1 0	4, 076, 231	05.00
200.00	1 1	91, 524, 909	0			1	
200.00	1 /	2, 539, 894	0	2, 539, 89		2, 539, 894	
	1 1		^				
202.00	Total (see instructions)	88, 985, 015	0	88, 985, 01	5 0	88, 985, 015	ZUZ. UU

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet C Part I Date/Time Prepared: 5/27/2022 12:47 pm Provider CCN: 15-0104 Peri od: From 01/01/2021 To 12/31/2021 Title XIX Hospi tal Cost

		_		e vi v	позрі таі	COST	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	TIENT ROUTINE SERVICE COST CENTERS						_
	O ADULTS & PEDIATRICS	18, 055, 586		18, 055, 586			30. 00
31.00 0310	O INTENSIVE CARE UNIT	9, 516, 370		9, 516, 370			31.00
40.00 0400	O SUBPROVI DER - I PF	2, 818, 665		2, 818, 665			40.00
41. 00 0410	O SUBPROVIDER - IRF	0		C			41.00
42.00 0420	O SUBPROVI DER	0		C			42.00
43.00 0430	O NURSERY	o		l c			43.00
44. 00 0440	O SKILLED NURSING FACILITY	2, 086, 393		2, 086, 393			44.00
ANCI	LLARY SERVICE COST CENTERS						1
	O OPERATING ROOM	7, 048, 319	49, 825, 887	56, 874, 206	0. 141979	0. 000000	50.00
	O RADI OLOGY-DI AGNOSTI C	2, 039, 988	33, 456, 604				
	O RADI OLOGY-THERAPEUTI C] _,,	0	1			
	1 ULTRA SOUND	620, 295	8, 131, 113			0. 000000	
	O CT SCAN	7, 407, 297	45, 914, 618			0. 000000	
	O MAGNETIC RESONANCE IMAGING (MRI)	966, 315	17, 965, 773			0. 000000	
	O CARDI AC CATHETERI ZATI ON	5, 601, 215	17, 703, 773				
	O LABORATORY	13, 170, 806	59, 067, 287			0. 000000	
	O BLOOD STORING, PROCESSING & TRANS.	634, 526	606, 435			0. 000000	
	O I NTRAVENOUS THERAPY					0. 000000	
		1, 364, 718	2, 167, 382				
	O PHYSI CAL THERAPY	1, 991, 835	4, 449, 457			0.000000	1
	O OCCUPATIONAL THERAPY	1, 828, 031	966, 760			0.000000	
	1 AUDI OLOGY	0	750, 106				
	O SPEECH PATHOLOGY	168, 407	804, 954			0.000000	
	O ELECTROCARDI OLOGY	0	0				
	1 CARDI OLOGY	6, 621, 464	11, 359, 250			0. 000000	1
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 182, 911	7, 464, 616			0. 000000	
	O IMPL. DEV. CHARGED TO PATIENT	2, 216, 975	10, 350, 642				1
	O DRUGS CHARGED TO PATIENTS	10, 909, 352	17, 202, 516	28, 111, 868	0. 429384	0. 000000	73. 00
	ATIENT SERVICE COST CENTERS						1
	O CLI NI C	0	0				
	1 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0. 000000	
	2 CLI NI C	0	0	0	0. 000000	0. 000000	90. 02
	3 DERMATOLOGY CLINIC	0	0	C		0. 000000	90. 03
90. 04 0900	4 ENT CLINIC	0	0	C	0.000000	0.000000	90. 04
	5 SURGERY CLINIC	0	0	C	0.000000	0.000000	90. 05
90. 07 0900	7 UROLOGY CLINIC	0	132, 410	132, 410	0. 143146	0.000000	90. 07
	9 GASTROENTEROLOGY CLINIC	o	0	C	0.000000	0. 000000	90. 09
90. 11 0901	1 NEUROLOGY CLINIC	o	0	l c	0.000000	0. 000000	90. 11
90. 12 0901	2 OPTHAMOLOGY CLINIC	l ol	0	l c		0. 000000	90. 12
	3 ALLERGY CLINIC	o	211, 808	211, 808		0. 000000	
	4 WOUND CARE	23, 217	6, 035, 974				
	O EMERGENCY	4, 295, 645	29, 539, 541				
	O OBSERVATION BEDS (NON-DISTINCT PART)	294, 759	7, 852, 730				
	R REIMBURSABLE COST CENTERS	2,1,757	7,002,700	0,117,407	3. 511737	0.00000	1 /2.00
	O AMBULANCE SERVICES	1, 082	4, 192, 540	4, 193, 622	0. 972007	0. 000000	95 00
200. 00	Subtotal (see instructions)	102, 864, 171	336, 168, 143			3.00000	200. 00
201.00	Less Observation Beds	102,004,171	555, 155, 145	107, 002, 014			201. 00
202.00	Total (see instructions)	102, 864, 171	336, 168, 143	439, 032, 314			202. 00
_02.00		102,007,1/1	555, 100, 145	107,002,014	1	1	1-02.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104
From 01/01/2021
To 12/31/2021 Date/Time Prepared:

5/27/2022 12:47 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 40. 00 | 04000 | SUBPROVI DER - I PF 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 42. 00 | 04200 | SUBPROVI DER 42.00 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 000000 50.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 55.01 05501 ULTRA SOUND 0.000000 55.01 57.00 05700 CT SCAN 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58. 00 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 06701 AUDI OLOGY 0.000000 67.01 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69. 01 06901 CARDI OLOGY 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 09001 OTHER OUTPATIENT SERVICE COST CENTER 90.01 0.000000 90.01 09002 CLI NI C 0.000000 90. 02 90.02 90 03 09003 DERMATOLOGY CLINIC 0.000000 90 03 09004 ENT CLINIC 0.000000 90.04 90.04 90.05 09005 SURGERY CLINIC 0.000000 90.05 09007 UROLOGY CLINIC 90.07 0.000000 90.07 09009 GASTROENTEROLOGY CLINIC 90.09 0.000000 90.09 90.11 09011 NEUROLOGY CLINIC 0.000000 90.11 09012 OPTHAMOLOGY CLINIC 90. 12 0.000000 90.12 90 13 09013 ALLERGY CLINIC 0.000000 90. 13 09014 WOUND CARE 90.14 0.000000 90.14 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201. 00

202.00

202.00

Total (see instructions)

APPORTI OMMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS	2552-10
Cost Center Description		COSTS	Provi der C		From 01/01/2021	Part I Date/Time Pre	pared: 47 pm
Related Cost (From Wkst. B, Part II), col. 26)			Title	XVIII	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description						
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00			Aujustillerit			3 / (01. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS 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		· ·		1			
INPATIENT ROUTINE SERVICE COST CENTERS 903,886 0 903,886 8,673 104.22 30.00 31.00 INTENSIVE CARE UNIT 286,096 284,000 0 284,000 2,033 139,70 40.00 42.00 43.00 44.00 50.00 45.00			2 00		4 00	5 00	
30.00 ADULTS & PEDIATRICS 903, 886 0 903, 886 8, 673 104. 22 30. 00 31. 00 INTENSI VE CARE UNIT 286, 096 286, 096 3, 379 84. 67 31. 00 31. 00 3284, 000 0 284, 000 0 0 0 0 0 0 0 0	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
31.00 NTENSIVE CARE UNIT 286,096 286,096 3,379 84.67 31.00 40.00 SUBPROVIDER - IPF 284,000 0 284,000 2,033 139.70 40.00 41.00 284,000 2,033 139.70 40.00 41.00 284,000 0 0 0 0 0 0 0 0 0		903, 886	0	903, 88	6 8, 673	104. 22	30.00
A1. 00 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0	31.00 INTENSIVE CARE UNIT			286, 09	6 3, 379	84. 67	31.00
42.00 SUBPROVI DER 0 0 0 0 0 0 0 0 0	40. 00 SUBPROVI DER - I PF	284, 000	0	284, 00	0 2, 033	139. 70	40. 00
A3.00 NURSERY O O O O O O O O O	41. 00 SUBPROVI DER - I RF	0	0)	0 0	0.00	41.00
Additional Control of Control o	42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
1,707,941 1,707,941 17,557 200.00		0			0 0		
Inpati ent		233, 959					
Program days Program Capital Cost (col. 5 x col. 6)				1, 707, 94	1 17, 557		200. 00
Capi tal Cost (col . 5 x col . 6)	Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS		Program days					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 2,034 211,983 30.00 31.00 INTENSI VE CARE UNIT 817 69,175 31.00 40.00 SUBPROVI DER - I PF 1,206 168,478 40.00 41.00 42.00 42.00 43.00 44.00 SKI LLED NURSI NG FACILITY 1,755 118,252 44.00							
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 2,034 211,983 30.00 31.00 INTENSI VE CARE UNIT 817 69,175 31.00 40.00 SUBPROVI DER - I PF 1,206 168,478 40.00 41.00 42.00 42.00 42.00 43.00 44.00 NURSERY 0 0 0 43.00 44.00 SKI LLED NURSI NG FACILITY 1,755 118,252 44.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 ADULTS & PEDI ATRI CS 2,034 211,983 30.00 31.00 INTENSI VE CARE UNIT 817 69,175 31.00 40.00 SUBPROVI DER - I PF 1,206 168,478 40.00 41.00 SUBPROVI DER - I RF 0 0 41.00 42.00 42.00 43.00 43.00 44.00 SKI LLED NURSI NG FACILITY 1,755 118,252 44.00		(00		-			
30. 00 ADULTS & PEDI ATRI CS 2, 034 211, 983 30. 00 31. 00 INTENSI VE CARE UNIT 817 69, 175 31. 00 40. 00 SUBPROVI DER - I PF 1, 206 168, 478 40. 00 41. 00 SUBPROVI DER - I RF 0 0 0 42. 00 SUBPROVI DER 0 0 0 43. 00 NURSERY 0 0 0 44. 00 SKI LLED NURSI NG FACILITY 1, 755 118, 252 44. 00	INDATIENT DOUTINE SERVICE COST CENTERS	6.00	7.00				
31. 00 I NTENSI VE CARE UNI T 817 69, 175 40. 00 SUBPROVI DER - I PF 1, 206 168, 478 40. 00 41. 00 SUBPROVI DER - I RF 0 0 41. 00 42. 00 SUBPROVI DER 0 0 42. 00 43. 00 NURSERY 0 0 43. 00 44. 00 SKI LLED NURSI NG FACILITY 1, 755 118, 252 44. 00		2 034	211 093				30 00
40. 00 SUBPROVI DER - I PF 1, 206 168, 478 40. 00 41. 00 SUBPROVI DER - I RF 0 0 41. 00 42. 00 SUBPROVI DER 0 0 42. 00 43. 00 NURSERY 0 0 43. 00 44. 00 SKI LLED NURSI NG FACI LI TY 1, 755 118, 252 44. 00							
41. 00 SUBPROVI DER - I RF 0 0 41. 00 42. 00 SUBPROVI DER 0 0 42. 00 43. 00 NURSERY 0 0 43. 00 44. 00 SKI LLED NURSI NG FACILITY 1, 755 118, 252 44. 00							
42. 00 SUBPROVI DER 0 0 42. 00 43. 00 NURSERY 0 0 43. 00 44. 00 SKI LLED NURSI NG FACI LI TY 1, 755 118, 252 44. 00		0	100, 170				
43. 00 NURSERY 0 0 0 43. 00 44. 00 SKI LLED NURSI NG FACILITY 1,755 118, 252 44. 00		0	0	,			
44. 00 SKILLED NURSING FACILITY 1, 755 118, 252 44. 00		0	Ō	,			
	44.00 SKILLED NURSING FACILITY	1, 755	118, 252				44.00
	200.00 Total (lines 30 through 199)	5, 812					200. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 12:	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	47 piii
Cost Center Description	Capi tal	Total Charges			Capital Costs	
, , , , , , , , , , , , , , , , , , ,	Related Cost			Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)	J	,	
	26)	,	,			
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	806, 380	56, 874, 206	0. 01417	8 2, 956, 346	41, 915	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	765, 622	35, 496, 592	0. 02156	9 895, 428	19, 313	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0.00000	0 0	0	55. 00
55. 01 05501 ULTRA SOUND	8, 905	8, 751, 408	0. 00101	8 60, 273	61	55. 01
57.00 05700 CT SCAN	11, 148			9 2, 557, 121	534	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	68, 118	18, 932, 088	0. 00359	8 349, 066	1, 256	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	55, 311	23, 320, 955	0. 00237	2 212, 362	504	59. 00
60. 00 06000 LABORATORY	408, 727	72, 238, 093	0. 00565	8 4, 390, 819	24, 843	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 162	1, 240, 961	0.00093	6 133, 374	125	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	28	3, 532, 100	0.00000	8 381, 550	3	64. 00
66. 00 06600 PHYSI CAL THERAPY	333, 389	6, 441, 292	0. 05175	8 374, 794	19, 399	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	8, 098	2, 794, 791	0. 00289	8 283, 918	823	67. 00
67. 01 06701 AUDI OLOGY	33, 024	750, 106	0. 04402	6 0	0	67. 01
68.00 06800 SPEECH PATHOLOGY	2, 205	973, 361	0.00226	5 63, 903	145	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	0.00000	0 0	0	69. 00
69. 01 06901 CARDI OLOGY	55, 049	17, 980, 714	0.00306	2 3, 528, 947	10, 806	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 653	10, 647, 527	0. 00231	5 861, 085	1, 993	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 740	12, 567, 617	0. 00077	5 782, 176	606	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	128, 015	28, 111, 868	0. 00455	2, 059, 003	9, 377	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C	0.00000	0 0	0	90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	152, 545	C	0.00000	0 0	0	90. 01
90. 02 09002 CLI NI C	0	C	0.00000	0 0	0	90. 02
90. 03 09003 DERMATOLOGY CLINIC	0	C	0.00000	0 0	0	90. 03
90. 04 09004 ENT CLINIC	0	C	0.0000		0	90. 04
90. 05 09005 SURGERY CLINIC	0	_	0.0000		0	90. 05
90. 07 09007 UROLOGY CLINIC	122		•		0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	63	C	0.00000	0 0	0	90. 09
90. 11 09011 NEUROLOGY CLI NI C	340	C	0.00000	0 0	0	90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0	C	0.00000	0 0	0	90. 12
90. 13 09013 ALLERGY CLINIC	31, 692				0	90. 13
90. 14 09014 WOUND CARE	267, 132				15	
91. 00 09100 EMERGENCY	886, 915				40, 003	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	241, 892	8, 147, 489	0. 02968	181, 659	5, 393	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	4, 300, 275	402, 361, 678	 	21, 598, 248	177, 114	200. 00

Heal th Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0104 Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 12: 47 pm Title XVIII Hospital PPS Cost Center Description Nursing Program Program Program Program Program Program Adjustments Figuration Cost Figuration Cost							
From 01/01/2021 Part III To 12/31/2021 Date/Time Prepared: 5/27/2022 12: 47 pm	Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
Title XVIII Hospital PPS Cost Center Description Nursing Nursing Program Program Post-Stepdown Cost Medical	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS	SS THROUGH COST	rs Provider C		From 01/01/2021	Part III	pared:
Cost Center Description Nursing Nursing Allied Health Allied Health All Other Program Program Post-Stepdown Cost Medical			Title	XVIII	Hospi tal	PPS	77 PIII
Program Program Post-Stepdown Cost Medical	Cost Center Description	Nursi na					
	oost conten becompanion						
		Post-Stepdown	og. a	Adjustments		Education Cost	
Adjustments				/ raj do tillorito		Ladouti oii ooot	
1A 1.00 2A 2.00 3.00			1. 00	2A	2, 00	3, 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30. 00		0	0	1	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 31.00	31, 00 03100 INTENSIVE CARE UNIT	0	Ó	,	0 0	o o	31.00
40, 00 04000 SUBPROVI DER - I PF 0 0 0 0 0 40, 00		0	Ó	,	0 0	o o	40.00
41. 00 04100 SUBPROVI DER - I RF 0 0 0 0 41. 00	41. 00 04100 SUBPROVI DER - RE	0	Ó	,	0	0	41.00
42. 00 04200 SUBPROVI DER		0	Ö	,	0		
43. 00 04300 NURSERY 0 0 0 0 43. 00		0	Ö	,	0		
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 44.00		0	0	1	0		
200.00 Total (lines 30 through 199) 0 0 0 0 0 0 200.00		0	Ö		0	0	
Cost Center Description Swing-Bed Total Costs Total Patient Per Diem (col. Inpatient		Swi na-Bed	Total Costs	Total Patien	t Per Diem (col.		200.00
Adjustment (sum of cols. Days 5 ÷ col. 6) Program Days							
Amount (see 1 through 3,							
instructions) minus col. 4)			minus col. 4)				
4.00 5.00 6.00 7.00 8.00				6.00	7. 00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 0 0 8, 673 0. 00 2, 034 30. 00	30. 00 03000 ADULTS & PEDI ATRI CS	0	O	8, 67	3 0.00	2, 034	30.00
31.00 03100 INTENSI VE CARE UNIT 0 3,379 0.00 817 31.00	31.00 03100 INTENSIVE CARE UNIT		0	3, 37	9 0.00	817	31.00
40. 00 04000 SUBPROVI DER - I PF 0 0 2, 033 0. 00 1, 206 40. 00	40. 00 04000 SUBPROVI DER - 1 PF	0	0	2, 03	3 0.00	1, 206	40.00
41. 00 04100 SUBPROVI DER - I RF 0 0 0 0. 00 0 41. 00	41. 00 04100 SUBPROVI DER - RF	0	0	1	0.00	0	41.00
42. 00 04200 SUBPROVI DER 0 0 0 0 0. 00 0 42. 00	42. 00 04200 SUBPROVI DER	0	0	1	0.00	0	42.00
43. 00 04300 NURSERY 0 0 0. 00 0 43. 00	43. 00 04300 NURSERY		0	1	0.00	0	43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY 0 3,472 0.00 1,755 44.00	44.00 04400 SKILLED NURSING FACILITY		0	3, 47	2 0.00	1, 755	44.00
200.00 Total (lines 30 through 199) 0 17,557 5,812 200.00	200.00 Total (lines 30 through 199)		0	17, 55	7	5, 812	200. 00
Cost Center Description Inpatient	Cost Center Description	I npati ent					
Program	· ·						
Pass-Through							
Cost (col. 7 x							
<u>col. 8)</u>							
9.00		9. 00					

30. 00 31. 00 40. 00 41. 00 42. 00

43. 00 44. 00 200. 00

30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER

42. 00 | 04300 | NURSERY 44. 00 | 04400 | SKILLED | NURSING | FACILITY 200. 00 | Total (lines 30 through 199)

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0104	Peri od:	Worksheet D

From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: THROUGH COSTS 5/27/2022 12:47 pm Title XVIII Hospi tal Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Cost Post-Stepdown Adi ustments Adjustments 1.00 3. 00 2A 2.00 ЗА ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 0 0000000000000000000 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 55.00 05501 ULTRA SOUND 0 0 55.01 55.01 05700 CT SCAN 0 57.00 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 60.00 06000 LABORATORY 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 Λ 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 0 06701 AUDI OLOGY 67.01 67.01 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 06901 CARDI OLOGY 69.01 69 01 Ω 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 90.00 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 90. 01 0000000000000 0 0 0 0 0 0 0 0 0 90.01 0 90.02 09002 CLI NI C 0 Ω 90.02 09003 DERMATOLOGY CLINIC 0 0 90.03 90.03 0 0 90.04 09004 ENT CLINIC 0 90.04 09005 SURGERY CLINIC 09007 UROLOGY CLINIC 0 0 90.05 0 90.05 0 90 07 0 0 90 07 09009 GASTROENTEROLOGY CLINIC 90.09 0 0 90.09 90.11 09011 NEUROLOGY CLINIC 0 0 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0 0 90.12 09013 ALLERGY CLINIC 0 90. 13 90 13 Ω 0 0 90.14 09014 WOUND CARE 0 0 0 90.14 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 0 92.00 0 0 92.00 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0104		Worksheet D Part IV Date/Time Prepared:

THROUG	COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/27/2022 12:	
			Title	: XVIII	Hospi tal	PPS	17 piii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			1		1	
50.00	05000 OPERATING ROOM	0	0		56, 874, 206		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		35, 496, 592		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.00000	
55. 01	05501 ULTRA SOUND	0	0		8, 751, 408		
57. 00	05700 CT SCAN	0	0	1	53, 321, 915		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1	18, 932, 088		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		23, 320, 955		
60.00	06000 LABORATORY	0	0		72, 238, 093		
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		1, 240, 961		
64.00	06400 I NTRAVENOUS THERAPY	0	0		3, 532, 100	0.000000	64. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		6, 441, 292	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		2, 794, 791	0.000000	67. 00
67. 01	06701 AUDI OLOGY	0	0		750, 106	0.000000	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0		973, 361	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
69. 01	06901 CARDI OLOGY	0	0		17, 980, 714	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 647, 527	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		12, 567, 617	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		28, 111, 868	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0	0.000000	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0.000000	90. 01
90. 02	09002 CLI NI C	0	0		0		
90. 03	09003 DERMATOLOGY CLINIC	0	0		0	0.000000	
90. 04	09004 ENT CLINIC	0	0		0	0.000000	90. 04
90. 05	09005 SURGERY CLINIC	0	0		0	0.000000	90. 05
90. 07	09007 UROLOGY CLINIC	0	0		132, 410		
90. 09	09009 GASTROENTEROLOGY CLINIC	0	0		0	0.000000	90. 09
90. 11	09011 NEUROLOGY CLINIC	0	0		0	0.000000	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0	0.000000	90. 12
90. 13	09013 ALLERGY CLINIC	0	0		211, 808		90. 13
90. 14	09014 WOUND CARE	0	0		6, 059, 191	0.000000	90. 14
91.00	09100 EMERGENCY	0	0		33, 835, 186	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		8, 147, 489	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0		402, 361, 678		200. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0104	Peri od:	Worksheet D

From 01/01/2021 | Part IV To 12/31/2021 | Date/Time Prepared: THROUGH COSTS 5/27/2022 12:47 pm Title XVIII Hospi tal PPS Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 2, 956, 346 12, 468, 162 50.00 0 οĺ 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 895, 428 9, 163, 580 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 55.00 0 05501 ULTRA SOUND 0.000000 60, 273 0 839, 511 55.01 55.01 0 05700 CT SCAN 0.000000 2, 557, 121 0 57.00 10, 271, 220 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.000000 349, 066 0 5, 009, 378 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 212, 362 899, 137 0 59.00 4, 390, 819 0 06000 LABORATORY 0.000000 5, 782, 172 60.00 60 00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.000000 133, 374 153, 734 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 381, 550 483, 061 0 64.00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 374, 794 69, 268 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 283, 918 67.00 67 00 26, 265 0 0 67.01 06701 AUDI OLOGY 0.000000 0 0 67.01 06800 SPEECH PATHOLOGY 0.000000 0 68.00 63, 903 79, 723 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69 00 0 0 69.01 06901 CARDI OLOGY 0.000000 3, 528, 947 7, 534, 921 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 861, 085 0 1, 510, 358 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.000000 782, 176 2, 678, 328 0 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 059, 003 0 11, 201, 467 73.00 73.00 0.000000 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 0 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 0 0 0 0 0 0 0 0 90.01 0 09002 CLI NI C 90 02 0.000000 0 90 02 0 09003 DERMATOLOGY CLINIC 90.03 0.000000 0 0 90.03 09004 ENT CLINIC 0.000000 0 90.04 90.04 0 90.05 09005 SURGERY CLINIC 0.000000 0 0 90.05 0 ol 90.07 09007 UROLOGY CLINIC 90. 07 0.000000 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 0 90.09 09011 NEUROLOGY CLINIC 0.000000 90.11 90. 11 0 90.12 09012 OPTHAMOLOGY CLINIC 0.000000 0 0 0 90. 12 0 09013 ALLERGY CLINIC 90 13 90.13 0.000000 0 0 90.14 09014 WOUND CARE 0.000000 1, 335, 519 0 90.14 09100 EMERGENCY 0 91.00 0.000000 1, 526, 091 4, 181, 575 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 181, 659 0 3, 146, 517 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 21, 598, 248

76, 833, 896

0 200. 00

200.00

Total (lines 50 through 199)

Heal th	n Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2021	Part V	
				[To 12/31/2021	Date/Time Pre 5/27/2022 12:	pared:
						5/27/2022 12:	47 pm_
			Title	XVIII	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 141979	12, 468, 162		0	1, 770, 217	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 231666	9, 163, 580		0	2, 122, 890	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
55. 01	05501 ULTRA SOUND	0. 118030	839, 511		0	99, 087	55. 01
57.00	05700 CT SCAN	0. 023631	10, 271, 220		9, 063	242, 719	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 063167	5, 009, 378		0	316, 427	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 044020	899, 137		o o	39, 580	
60.00	06000 LABORATORY	0. 142384	5, 782, 172		0	823, 289	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 182753	153, 734		o o	28, 095	
64. 00	06400 I NTRAVENOUS THERAPY	0. 001507	483, 061		o o	728	64. 00
66. 00	06600 PHYSI CAL THERAPY	0. 462406	69, 268		0 0	32, 030	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 402400	26, 265		0 0	8, 468	1
	1 1		20, 200		0 0		1
67. 01	06701 AUDI OLOGY	0. 381183	· ·	l .	ا ا	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 339556	79, 723	•	0	27, 070	
69. 00	06900 ELECTROCARDI OLOGY	0.000000	7 504 004		0	0	69. 00
69. 01	06901 CARDI OLOGY	0. 149527	7, 534, 921		0	1, 126, 674	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 451206	1, 510, 358	•	0	681, 483	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 151306	2, 678, 328		0	405, 247	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 429384	11, 201, 467		0 54, 728	4, 809, 731	73. 00
	OUTPATIENT SERVICE COST CENTERS			T	1		
90. 00	09000 CLI NI C	0. 000000	0		0	0	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0	0	90. 01
90. 02	09002 CLI NI C	0. 000000	0		0	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0. 000000	0		0	0	90. 03
90. 04	09004 ENT CLINIC	0. 000000	0		0	0	90. 04
90.05	09005 SURGERY CLINIC	0. 000000	0		0	0	90. 05
90. 07	09007 UROLOGY CLINIC	0. 143146	0		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		o o	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		o o	0	90. 12
90. 13	09013 ALLERGY CLINIC	0. 734122	0		0	0	90. 13
90. 14	09014 WOUND CARE	0. 204068	1, 335, 519		0 6, 244	272, 537	90. 14
91. 00	09100 EMERGENCY	0. 180976	4, 181, 575		0 0,211	756, 765	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 311739	3, 146, 517		o o		92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0. 311737	5, 170, 517		<u> </u>	700, 072	/2.00
95. 00		0. 972007			ol		95. 00
200.00		0. 7/200/	76, 833, 896	1	0 70, 035	14, 543, 929	
200.00	1 1		10, 033, 890		0 70,035		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00			76, 833, 896		0 70, 035	14, 543, 929	202 00
202.00	Inet charges (Title 200 - Title 201)	ı	10, 033, 090	1	0	14, 545, 929	1202.00

 Heal th Financial
 Systems
 WI THAM MEMORIAL
 HOSPITAL

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0104
 Peri od: From 01/01/2021 To 12/31/2021 Title XVIII Hospi tal

	·	Co	sts		
	Cost Center Description	Cost	Cost		
	·	Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	C	0		50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		Ö		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		o o		55. 00
55. 01	05501 ULTRA SOUND		o o	l .	55. 01
57. 00	05700 CT SCAN		214	l .	57. 00
			1	l .	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		59. 00
60. 00	06000 LABORATORY		0		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	C) 0		64. 00
66. 00	06600 PHYSI CAL THERAPY	C	0		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	C	0		67. 00
67. 01	06701 AUDI OLOGY	C	0		67. 01
68.00	06800 SPEECH PATHOLOGY	C	0		68. 00
69.00	06900 ELECTROCARDI OLOGY		0		69. 00
69. 01	06901 CARDI OLOGY		0		69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		23, 499	l .	73. 00
, 0, 00	OUTPATIENT SERVICE COST CENTERS		20/1//		70.00
90. 00	09000 CLI NI C	C	0		90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER		o o	l .	90. 01
90. 02	09002 CLINIC				90. 02
90. 02	09003 DERMATOLOGY CLINIC				90. 02
90.03	09004 ENT CLINIC				90.03
					1
90.05	09005 SURGERY CLINIC				90. 05
90. 07	09007 UROLOGY CLINIC				90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC		0		90. 09
90. 11	09011 NEUROLOGY CLINIC		0		90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	C	0		90. 12
90. 13	09013 ALLERGY CLINIC	C	0	l .	90. 13
90. 14	09014 WOUND CARE	C	1, 274		90. 14
91.00	09100 EMERGENCY	C	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0		92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	C)		95. 00
200.00	Subtotal (see instructions)	C	24, 987		200. 00
201.00	Less PBP Clinic Lab. Services-Program	C			201. 00
	Only Charges				
202.00		(c	24, 987		202. 00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component	CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 12:	pared: 47 pm
			Title	× XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col. 26)	8)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
50.00	05000 OPERATI NG ROOM	806, 380	56, 874, 206	0. 0141	78 5, 778	82	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	765, 622	35, 496, 592	0. 02156	59 17, 678	381	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000	00	0	55. 00
55. 01	05501 ULTRA SOUND	8, 905	8, 751, 408	0. 0010°	18 0	0	55. 01
57.00	05700 CT SCAN	11, 148	53, 321, 915	0.00020	37, 017	8	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	68, 118				0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	55, 311	23, 320, 955			5	59. 00
60.00	06000 LABORATORY	408, 727				2, 066	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 162				0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	28		1		0	
66.00	06600 PHYSI CAL THERAPY	333, 389				851	66.00
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	8, 098 33, 024		1		9	
68. 00	06800 SPEECH PATHOLOGY	2, 205	· ·	1		4	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 203	1	i		0	1
69. 01	06901 CARDI OLOGY	55, 049	1	1		30	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 653				33	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	9, 740				0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	128, 015				319	73. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			1
90.00	09000 CLI NI C	0	0	0.00000	00	0	90. 00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	152, 545	0			0	
90. 02	09002 CLI NI C	0	1			0	
90. 03	09003 DERMATOLOGY CLINIC	0	0	1 0.0000		0	
90. 04	09004 ENT CLINIC	0	0			0	1
90. 05	09005 SURGERY CLINIC	0	0	1 0.0000		0	90. 05
90. 07	09007 UROLOGY CLINIC	122		1		0	1
90. 09	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	63		0.0000		0	90. 09
90. 11 90. 12	09012 OPTHAMOLOGY CLINIC	340	l			0	90. 11 90. 12
90. 12	09013 ALLERGY CLINIC	31, 692	ı	1		0	
90. 13	09014 WOUND CARE	267, 132	l			0	
91. 00	09100 EMERGENCY	886, 915				358	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	000, 719		1		0	1
50	OTHER REIMBURSABLE COST CENTERS		2, , 107	1. 2000	<u> </u>		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	4, 058, 383	402, 361, 678		559, 983	4, 146	200. 00

	Financial Systems	WI THAM MEMORI		ON 45 0404		eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider Co	CN: 15-0104	Peri od: From 01/01/2021	Worksheet D Part IV	
I HKUUGI	H COSTS		Component	CCN: 15-S104	To 12/31/2021		
			Title	xVIII	Subprovi der - I PF	PPS	•
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00	0.4	2.00	-
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3. 00	-
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0		1	0 0		
	05500 RADI OLOGY-THERAPEUTI C	0	_		0 0		
	05501 ULTRA SOUND	0	0		0 0	٥	
	05700 CT SCAN	0	Ö		o o		
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			o o		
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
50.00	06000 LABORATORY	0	0		0 0	0	60.00
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
4. 00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
57. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	06701 AUDI OLOGY	0	0		0 0		
	06800 SPEECH PATHOLOGY	0	0		0 0	1	
	06900 ELECTROCARDI OLOGY	0	0		0 0	1	
	06901 CARDI OLOGY	0	0		0 0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0		1
	07200 I MPL. DEV. CHARGED TO PATIENT	0			0 0		
	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	73.00
	09000 CLINIC	0	0		0 0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0			0 0		
	09002 CLINIC	0			0 0		
	09003 DERMATOLOGY CLINIC	0	_		0 0	1	
	09004 ENT CLINIC	0	0		0 0		1
	09005 SURGERY CLINIC	0	Ö		o o	l o	1
0. 07	09007 UROLOGY CLINIC	0	0		0 0	0	90.0
0. 09	09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	90.09
0. 11	09011 NEUROLOGY CLINIC	0	0		0 0	0	90. 1
0. 12	09012 OPTHAMOLOGY CLINIC	0	0		0 0	0	90. 12
	09013 ALLERGY CLINIC	0	0		0 0	0	90. 13
	09014 WOUND CARE	0	0		0 0	0	
	09100 EMERGENCY	0			0 0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 0	1 ()	200. 0

54.00		Financial Systems	WITHAM MEMORI			In Li∈	eu of Form CMS-:	2552-10
Component CCK: 15-S104 To 12/31/2021 Date/Time Prepare F2/21/2022 12:47.p PFS			RVICE OTHER PASS	S Provider C	CN: 15-0104			
Title XVIII Subprovider PST	THROUG	H COSTS		Component	CCN: 15_S104			narod.
Cost Center Description				Component	CCN. 13-3104	10 12/31/2021	5/27/2022 12:	47 pm
All Other Medical on Cost Studention				Ti tl e	: XVIII	Subprovi der -		
Medical Sum of cols Cols Count of cols Cols Count of cols Cols Count of cols Cols Count of cols Cols Count of cols Cols Count of cols Cols								
Education Cost 1, 2, 3, and Cost (sum of cols. 2, 3, and 4) Repair Col. Col. 5 Col.		Cost Center Description				Total Charges	Ratio of Cost	
ANOLLIARY SERVICE COST CENTERS								
ANCILLARY SERVICE COST CENTERS			Education Cost					
MACILLARY SERVICE COST CENTERS				4)		8)		
ANCILLARY SERVICE COST CENTERS					and 4)			
ANCILLARY SERVICE COST CENTERS			4.00	F 00	4.00	7.00		
50.00		ANCILLADY SEDVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 35, 496, 592 0, 000000 54, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 55, 550 0, 000000 56, 550 0, 0000000 56, 550 0, 000000 0, 000000 0, 0000000 0,	50 00		1			0 56 974 204	0.000000	50.00
55. 00 05500 RADIOLOGY-THERAPEUTI C					l .			
55.01								
57. 00 05700 CT SCAN 0 0 0 53, 321, 915 0, 000000 58, 59. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 0 18, 932, 088 0, 000000 58, 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 23, 320, 955 0, 000000 59, 60. 00 06000 LABORATORY 0 0 0 0 0 72, 238, 093 0, 000000 63, 00 06000 CARDI AC CATHETERI ZATI ON 0 0 0 0 72, 238, 093 0, 000000 63, 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 1, 240, 961 0, 000000 63, 64. 00 0 0, 0000000 0, 0000000 0, 000000 0, 000000 0, 000000 0, 000000 0, 000000			_	1	1	-	l e	
58. 00 05800 MAGNETIC RESONANCE I IMAGING (MRI)			_	1	1		l	
59. 00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 23, 320, 955 0.000000 59. 000000 59. 000000 60. 000 60. 000 60. 000000 60. 000000 60. 000000 60. 000000 60. 000000 60. 000000 60. 000000 60. 000000 60. 000000 60. 00000000 60. 0000000 60. 00000000 60. 00000000 60. 00000000 60. 000000000 60. 000000000			_	1	l .			
60. 00 06000 LABORATORY 0 0 0 72, 238, 093 0.000000 60. 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 1, 240, 961 0.000000 63. 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 6, 441, 292 0.000000 64. 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 6, 441, 292 0.000000 64. 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0, 750, 106 0.000000 67. 68. 00 06701 AUDI OLOGY 0 0 0 0 0 775, 106 0.000000 67. 68. 00 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 01 06900 SPECH PATHOLOGY 0 0 0 0 0 0 0 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 12,567,617 0 0 69. 01 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 28,111,868 0 0 0 69. 01 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 69. 01 07200 SPERMATOLOGY CLINIC 0 0 0 0 0 0 0 69. 01 09001 CHERGEN CLINIC 0 0 0 0 0 0 0 69. 02 09002 CLINIC 0 0 0 0 0 0 0 0 69. 03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 0 0 0 69. 04 09004 ENTAPART CENTEROLOGY CLINIC 0 0 0 0 0 0 0 69. 05 09005 SURGERY CLINIC 0 0 0 0 0 0 0 0 69. 07 09007 URDICOGY CLINIC 0 0 0 0 0 0 0 0 69. 07 09007 URDICOGY C			1	1	1			
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 1,240,961 0.000000 63. 64.00 06400 INTRAVENDUS THERAPY 0 0 0 0 3,532,100 0.000000 64. 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 6,441,292 0.000000 66. 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0,750,106 0.000000 67. 68.00 06701 AUDI OLOGY 0 0 0 0 0,750,106 0.000000 67. 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0,750,106 0.000000 68. 69.00 06900 LECTROCARDI OLOGY 0 0 0 0 0 0.000000 68. 69.00 06900 LECTROCARDI OLOGY 0 0 0 0 0.000000 67. 69.01 06901 CARDI OLOGY 0 0 0 0 0,750,106 0.000000 68. 69.01 06901 CARDI OLOGY 0 0 0 0 0,000000 68. 69.01 06901 CARDI OLOGY 0 0 0 0 0,000000 68. 69.01 06901 CARDI OLOGY 0 0 0 0 0,000000 68. 69.01 06901 CARDI OLOGY 0 0 0 0 0,000000 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 10,647,527 0.000000 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 12,567,617 0.000000 72. 73.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 73. 74.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 75.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 76.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 77.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 78.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 78.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0.000000 74. 78.00 07200			_	1	l .			
64. 00 06400 NTRAVENOUS THERAPY 0 0 0 3, 532, 100 0.000000 64, 641, 292 0.000000 66, 60 06600 PHYSI CAL THERAPY 0 0 0 0 0, 441, 292 0.000000 66, 670 0.000000 67, 70 0.000000 67, 70 0.000000 67, 70 0.000000 67, 70 0.000000 67, 70 0.000000 67, 70 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.00000			_	1	1			
66.00 06600 PHYSICAL THERAPY 0 0 0 6,441,292 0.000000 66.7					l .		•	
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 2, 794, 791 0.000000 67. 67. 01 06701 AUDI OLOGY 0 0 0 0 750, 106 0.000000 68. 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0.000000 68. 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0.000000 69. 01 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.			_	1	l .			
67. 01 06701 AUDI OLOGY			_	1	1		•	
68.00 06800 SPECH PATHOLOGY 0 0 0 973, 361 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0.000000 69.0000000			-			=,,	•	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0					1			
69. 01 06901 CARDI OLOGY 71. 00 77100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 10, 647, 527 0.000000 77. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 12, 567, 617 0.000000 77. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 28, 111, 868 0.000000 77. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 28, 111, 868 0.000000 77. 000000 CLI NI C 0 0 0 0 0 0 0 0.000000 90. 90. 01 09001 CLI NI C 0 0 0 0 0 0 0.000000 90. 90. 02 09002 CLI NI C 0 0 0 0 0 0 0.000000 90. 90. 03 09003 DERMATOLOGY CLI NI C 0 0 0 0 0 0 0.000000 90. 90. 04 09004 ENT CLI NI C 0 0 0 0 0 0 0.000000 90. 90. 07 09007 UROLOGY CLI NI C 0 0 0 0 0 0.000000 90. 90. 09 09009 GASTROENTEROLOGY CLI NI C 0 0 0 0 0 0.000000 90. 90. 09 09009 GASTROENTEROLOGY CLI NI C 0 0 0 0 0 0.000000 90. 90. 10 09010 DIBLEMOLOGY CLI NI C 0 0 0 0 0 0.000000 90. 90. 10 09010 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 90. 90. 10 09010 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 90. 90. 10 09010 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 90. 90. 10 09010 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 90. 90. 11 09011 NEUROLOGY CLI NI C 0 0 0 0 0.000000 90. 90. 12 09012 DPTHAMOLOGY CLI NI C 0 0 0 0 0.000000 90. 90. 13 09013 ALLERGY CLI NI C 0 0 0 0 0.000000 90. 90. 14 09014 WOUND CARE 0 0 0 0 0 33,835, 186 0.000000 90. 91. 10 09100 BEREVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 8,147,489 0.000000 91. 91. 00 09500 AMBULANCE SERVICES					l .		l	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 10,647,527 0.000000 71. 72. 00 772. 00 772.00 IMPL. DEV. CHARGED TO PATIENT 0 0 0 12,567,617 0.000000 72. 73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 28,111,868 0.000000 73. 73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 73. 73. 00 07300 DRIGS CHARGED TO PATIENTS 0 0 0 0 0 0.000000 73. 73. 00 074 0			_	1				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 12, 567, 617 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 28, 111, 868 0.000000 73.			_		1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 28, 111, 868 0.000000 73.			-		l .			
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER OUTPATIENT SERVICE COST CENTE			-		1			
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	73.00		0		1	0 20, 111, 000	0.00000	73.00
90. 01 09001 07HER OUTPATIENT SERVICE COST CENTER 0 0 0 0 0 0 0 0 0	00 00	00000 CLINIC	1		ı	0	0.00000	90.00
90. 02 09002 CLINIC 0 0 0 0 0 0 0 0 0								
90. 03 09003 DERMATOLOGY CLINIC 0 0 0 0 0 0 0 0 0			-	l e	1	-		
90. 04 09004 ENT CLINIC 0 0 0 0 0 0 0 0 0				· -		9		
90. 05 09005 SURGERY CLINIC 0 0 0 0 0 0 0 0 0			_	١		٥	l e	
90. 07 09007 UROLOGY CLINIC 0 0 0 0 132, 410 0.000000 90. 90. 90. 90 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0.000000 90. 90. 11 09011 NEUROLOGY CLINIC 0 0 0 0 0 0 0.000000 90. 90. 12 09012 09114 09012 09114 09013 ALLERGY CLINIC 0 0 0 0 0 0.000000 90. 90. 13 09013 ALLERGY CLINIC 0 0 0 0 0 0.000000 90. 90. 14 09014 09							l	
90. 09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 0 0			_		l .	٥		
90. 11 09011 09012			1	1	1		l	
90. 12 09012 0PTHAMOLOGY CLINIC 0 0 0 0 0 0 0 0 0			0		l .	0	l e	
90. 13 09013 ALLERGY CLINIC 0 0 0 211,808 0.000000 90. 90. 14 09014 WOUND CARE 0 0 0 6,059,191 0.000000 90. 91. 00 09100 EMERGENCY 0 0 0 33,835,186 0.000000 91. 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8,147,489 0.000000 92. 95. 00 09500 AMBULANCE SERVICES 95.			0	1	1	0		
90. 14 09014 WOUND CARE 0 0 0 6, 059, 191 0. 000000 90. 91. 00 09100 EMERGENCY 0 0 0 33, 835, 186 0. 000000 91. 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8, 147, 489 0. 000000 92. 00 000000 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.			_		1	0	l	
91. 00			· ·	1				
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 8,147,489 0.000000 92. OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.					l .		l	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95.							l e	
95. 00 09500 AMBULANCE SERVICES 95.	/2.00		0		1	S ₁ S, 147, 407	0.00000	12.00
	95 00				I			95. 00
200.001 101ai 011ba 30 modul 1777 0 0 0 0 0 407.301.0761 1700	200.00		0	o	,	0 402, 361, 678		200.00

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEIGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/27/2022 12:	
			Title	XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9	
		(col. 6 ÷ col. 7)		x col . 10)	0	x col. 12)	
		9, 00	10. 00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATI NG ROOM	0. 000000	5, 778		0 0	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	17, 678		0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	Ö	
55. 01	05501 ULTRA SOUND	0. 000000	0		0 0	Ō	•
57. 00	05700 CT SCAN	0. 000000	37, 017		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 061		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	365, 172		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	2, 712		0 0	0	64. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	16, 440		0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 181		0	0	
67. 01	06701 AUDI OLOGY	0. 000000	0		0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1, 706		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
69. 01	06901 CARDI OLOGY	0. 000000	9, 745		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	14, 174		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	610		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	70, 061		0 0	0	73.00
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000			0 0		00.00
90. 00 90. 01	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000 0. 000000	0		0 0	0	
90. 01	09001 OTHER OUTPATTENT SERVICE COST CENTER	0. 000000	0		0 0	0	
90. 02	09003 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	
90. 03	09004 ENT CLINIC	0. 000000	0		0 0	0	
90. 05	09005 SURGERY CLINIC	0. 000000	0		0 0	0	90.05
90. 07	09007 UROLOGY CLINIC	0. 000000	0		0 0	Ö	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	ő	90.09
90. 11	09011 NEUROLOGY CLINIC	0. 000000	0		0 0	ő	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	Ö	
90. 13	09013 ALLERGY CLINIC	0. 000000	0		0 0	0	90. 13
90. 14	09014 WOUND CARE	0. 000000	0		0 0	0	90. 14
91.00	09100 EMERGENCY	0. 000000	13, 648		0 1, 168	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95. 00 200. 00					0 1, 168		95. 00 200. 00
	Total (lines 50 through 199)		559, 983		0 1, 168		

5/27/2022 12:47 pm Title XVIII Subprovi der -PPS Charges Costs Cost to Charge PPS Reimbursed Cost Center Description Cost PPS Services Cost Rei mbursed Ratio From Services (see Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Part I, col. Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 5. 00 1.00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 141979 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0. 231666 0 0 54.00 54.00 0 0 0 0 0 0 0 0 0 0 0 0 0 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 0 55.00 55.00 0 55.01 05501 ULTRA SOUND 0.118030 0 0 55.01 05700 CT SCAN 0.023631 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.063167 0 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 0.044020 0 0 59 00 60.00 06000 LABORATORY 0.142384 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.182753 0 63.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0.001507 0 64.00 0 66.00 06600 PHYSI CAL THERAPY 0.462406 0 0 66.00 06700 OCCUPATIONAL THERAPY 0. 322401 67.00 67.00 0 06701 AUDI OLOGY 0 67.01 0. 381183 0 0 67.01 0 68.00 06800 SPEECH PATHOLOGY 0.339556 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.01 06901 CARDI OLOGY 0.149527 0 0 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 0.451206 0 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 0.151306 72.00 07300 DRUGS CHARGED TO PATIENTS 0.429384 0 0 147 0 73.00 73.00 6, OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90 00 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 90.01 0.000000 0 0 0 90.01 09002 CLI NI C 0.000000 0 90. 02 90.02 0 0 0 0 0 0 0 0 0 0 90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 90.03 0 09004 ENT CLINIC 0.000000 0 90.04 90.04 0 90.05 09005 SURGERY CLINIC 0.000000 0 0 90.05 09007 UROLOGY CLINIC 0 0 90.07 0.143146 0 90.07 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 90.09 90 09 0 0 09011 NEUROLOGY CLINIC 0 90.11 90.11 0.000000 0 90.12 09012 OPTHAMOLOGY CLINIC 0.000000 0 0 0 90.12 90. 13 09013 ALLERGY CLINIC 0. 734122 0 0 0 90.13 09014 WOUND CARE 0 90 14 0.204068 90 14 C 0 09100 EMERGENCY 0 91.00 0.180976 1, 168 0 211 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 311739 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 0. 972007 0 95 00 09500 AMBULANCE SERVICES 200.00 Subtotal (see instructions) 1, 168 6, 147 211 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00 Only Charges

211 202. 00

0

6, 147

1, 168

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of	Form CMS-2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SE	VICES AND VACCINE COST Provider CCN: 15-0104	Peri od: Wor From 01/01/2021 Par	rksheet D
	Component CCN: 15-S10	To 12/31/2021 Dat	
	Title XVIII	Subprovi der -	PPS
	Costs	I PF	

			Title XVI	II Subprovider - IPF	PPS
		Cost:	5	IPF	
	Cost Center Description	Cost	Cost		
	'	Rei mbursed	Rei mbursed		
		Servi ces S	Services Not		
			Subject To		
			ed. & Coins.		
			(see inst.)		
	ANOLILIARY OFFICE COOT OFFITTING	6. 00	7. 00		
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	0		50, 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		55. 00
55. 00	05501 ULTRA SOUND		ol		55. 01
57. 00	05700 CT SCAN		0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		59.00
60.00	06000 LABORATORY		0		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY		o		64. 00
66. 00	06600 PHYSI CAL THERAPY		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		o		67. 00
67. 01	06701 AUDI OLOGY		0		67. 01
68. 00	06800 SPEECH PATHOLOGY		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		69. 00
69. 01	06901 CARDI OLOGY		Ö		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		o		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0		72. 00
	07300 DRUGS CHARGED TO PATIENTS		2, 639		73. 00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	2/00/		76.55
90.00	09000 CLINIC	0	0		90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	l ol	o		90. 01
90. 02	09002 CLI NI C	o	0		90. 02
90. 03	09003 DERMATOLOGY CLINIC	O	0		90. 03
90. 04	09004 ENT CLINIC	O	0		90. 04
90. 05	09005 SURGERY CLINIC	o	О		90. 05
90. 07	09007 UROLOGY CLINIC	o	О		90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	o	o		90. 09
90. 11	09011 NEUROLOGY CLINIC	o	o		90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	o	О		90. 12
90. 13	09013 ALLERGY CLINIC	o	О		90. 13
90. 14	09014 WOUND CARE	0	О		90. 14
91.00	09100 EMERGENCY	0	О		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	o		92. 00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVI CES	0			95. 00
200.00	,	0	2, 639		200. 00
201.00		0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	0	2, 639		202. 00

Title XVIII Skilled Nursing PPS

			litie	XVIII	KIIIed Nursing	PPS	
				Ch	Facility	0+-	
	0 1 0 1 5 11	0 1 1 01	DDC D ' 1 1	Charges	0 1	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Servi ces (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANGLILARY CERVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.141070	0		J		FO 00
50.00	05000 OPERATING ROOM	0. 141979	0	C	1	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 231666	0	C	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	
55. 01	05501 ULTRA SOUND	0. 118030	0		0	0	55. 01
57. 00	05700 CT SCAN	0. 023631	0	C	2, 101	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 063167	0	C	-	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 044020	0	C	-	0	59. 00
60. 00	06000 LABORATORY	0. 142384	0	C	1	0	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 182753	0	C	T .	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 001507	0	C	0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY	0. 462406	0	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 322401	0	C	0	0	67. 00
67. 01	06701 AUDI OLOGY	0. 381183	0	C	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 339556	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	C	o	0	69. 00
69. 01	06901 CARDI OLOGY	0. 149527	0	C	o	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 451206	0		o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 151306	0		o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 429384	0	d	5, 367	0	1
	OUTPATIENT SERVICE COST CENTERS			_	-/		1
90.00	09000 CLI NI C	0. 000000	0	C	0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0	ď	1	0	
90. 02	09002 CLI NI C	0. 000000	Ô	ď	1	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0. 000000	Ō			ő	90. 03
90. 04	09004 ENT CLINIC	0. 000000	O O	ď		Ö	90. 04
90. 05	09005 SURGERY CLINIC	0. 000000	0		-	0	90. 05
90. 03	09007 UROLOGY CLINIC	0. 143146	0		1	0	90. 07
90. 07	09009 GASTROENTEROLOGY CLINIC	0. 000000	0			0	90.09
90. 09	09011 NEUROLOGY CLINIC	0. 000000	0			0	90. 11
90. 11	09012 OPTHAMOLOGY CLINIC	0. 000000	0			0	90. 11
90. 12	09013 ALLERGY CLINIC	1	0			0	90. 12
90. 13	1	0. 734122	0		-	0	
	09014 WOUND CARE	0. 204068	0	_	-	ı	90. 14
91.00	09100 EMERGENCY	0. 180976	0	C	1	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 311739	0	C	0	0	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	0.070007					05.00
95. 00	09500 AMBULANCE SERVICES	0. 972007		C			95. 00
200.00			0	C	7, 468	0	200. 00
201.00					'l 0	I	201. 00
202 22	Only Charges			_	7 4/0		202 00
202.00	Net Charges (line 200 - line 201)		0	[C	7, 468	. 0	202. 00

Health Financial Systems	WI THAM MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL, OTH	HER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0104	Peri od: From 01/01/2021	Worksheet D Part V
		Component CCN: 15-5832		
		Title XVIII	Skilled Nursing	PPS
			Facility	

Cost Center Description Cost Rei mbursed Servi ces Servi ces Not Subject To Ded. & Coins. Facility Facility
Cost Center Description Cost Reimbursed Services Subject To Cost Reimbursed Services Not Subject To
Rei mbursed Rei mbursed Servi ces Not Subj ect To Subj ect To
Services Services Not Subject To Subject To
Subject To Subject To
(see inst.) (see inst.)
6.00 7.00
ANCI LLARY SERVI CE COST CENTERS
50.00 05000 OPERATI NG ROOM O 50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 0
55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 55. (
55. 01 05501 ULTRA SOUND 0 55. 0
57. 00 05700 CT SCAN 0 50 57. (
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. (
60. 00 06000 LABORATORY 0 0 60. 0
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.0
64. 00 06400 I NTRAVENOUS THERAPY 0 0 64. 0
66. 00 06600 PHYSI CAL THERAPY 0 0 66. 0
67. 00 06700 OCCUPATIONAL THERAPY 0 0 67. 0
67. 01 06701 AUDI OLOGY 0 0 67. 0
68. 00 06800 SPEECH PATHOLOGY 0 0 68. 0
69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 0
69. 01 06901 CARDI OLOGY 0 0 69. (
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.0
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 0 72. 0
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 305 73. 0
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 90. 0
90. 02 09002 CLI NI C 0 0 90. (
90. 03 09003 DERMATOLOGY CLINIC 0 0 90. 0 90
90. 05 09005 SURGERY CLINI C
90. 07 09007 UROLOGY CLI NI C
90. 09 09009 GASTROENTEROLOGY CLINI C
90. 11 09011 NEUROLOGY CLINI C 90. 1
90. 12 109012 OPTIANNOLOGY CLINIC 0 0 90. 1
90. 13 09013 ALLERGY CLINIC 90. 1
90. 14 09014 WOUND CARE 90. 91. 0 0 0 91. 0 91
91. 00 09100 EMERGENCT
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 0 95. 0
200.00 Subtotal (see instructions) 0 2,355 200.0
201.00 Less PBP Clinic Lab. Services-Program 0 201.00
Only Charges
202.00 Net Charges (line 200 - line 201) 0 2,355 202.0

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prep 5/27/2022 12:4	pared:
	Title XVIII	Hospi tal	PPS	

		T' 11 \0/111	11 11	5/27/2022 12:	47 pm	
	Cost Center Description	Title XVIII	Hospi tal	PPS		
	cost center bescription			1. 00		
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days		8, 673	1.00		
2.00	Inpatient days (including private room days, excluding swing-k			8, 673		
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ivate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		6, 352	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00	
	reporting period	3 .		 -		
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00	
7.00	reporting period (if calendar year, enter 0 on this line)		04 6 11		7 00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 of the cost	0	7. 00	
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)			- I		
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 034	9. 00	
	newborn days) (see instructions)					
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, er		days) arter	١	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00	
	through December 31 of the cost reporting period			 -		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	iii (excluding swing-bed	uays)	0	15.00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service	0. 00	17. 00			
18. 00	reporting period	0. 00	18. 00			
10.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				16.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00	
	reporting period			 -		
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0. 00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		9, 490, 910	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00	
	5 x line 17)	·	•	 -		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng poriod (line	0	24. 00	
24.00	7 x line 19)	31 of the cost reporti	ng perrod (Trile	·	24.00	
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tipo 21 minus Lipo 24)		0 9, 490, 910	26. 00 27. 00	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus Time 20)		9, 490, 910	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0		
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00 0. 00	1	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)				1	
35. 00	Average per diem private room cost differential (line 34 x lin		LI UII3)	0. 00 0. 00	35. 00	
36. 00					36.00	
37. 00					37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			1	
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1 004 21	38 00	
39.00	Program general inpatient routine service cost per diem (see	*		1, 094. 31 2, 225, 827	38. 00 39. 00	
40. 00	Medically necessary private room cost applicable to the Progra	•		2, 223, 027	40.00	
	Total Program general inpatient routine service cost (line 39			2, 225, 827	ł	

Heal th	n Financial Systems WITHAM MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prep	
		Title XVIII	Hospi tal	5/27/2022 12: 4 PPS	47 piii
	Cost Center Description Total	Total Average Per	Program Days	Program Cost	
	Inpatient costi	npatient Days Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
40.00	1.00	2.00 3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) 0 Intensive Care Type Inpatient Hospital Units	0 0.0	0 0	U	42. 00
43.00	I NTENSI VE CARE UNIT 4, 804, 454	3, 379 1, 421. 8	6 817	1, 161, 660	
44. 00 45. 00					44. 00 45. 00
46. 00					46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47. 00
	COST Centrer Description			1. 00	
48. 00				3, 914, 324	
49.00	O Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS			7, 301, 811	49.00
50.00				281, 158	50. 00
51. 00				177, 114	51. 00
	and IV)				
52. 00 53. 00				458, 272 6, 843, 539	
00.00	medical education costs (line 49 minus line 52)				00.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				54. 00
55. 00				0 0. 00	55. 00
56. 00 57. 00				0	56. 00 57. 00
58. 00				0	58. 00
59. 00				0. 00	59. 00
60. 00	market basket O Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket			0. 00	60. 00
61. 00	· · · · · · · · · · · · · · · · · · ·			0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				
62.00				0	
63. 00	00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST			0	63. 00
64. 00				0	64. 00
65. 00	instructions)(title XVIII only) 0 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See			0	65. 00
	instructions)(title XVIII only)				
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)			0	66. 00
67. 00	O Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			0	67. 00
68. 00				0	68. 00
(0.00	(line 13 x line 20)				/O OO
69.00	OO Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY			0	69. 00
70.00					70.00
71. 00 72. 00					71. 00 72. 00
73. 00					73. 00
74. 00 75. 00					74. 00 75. 00
	26, line 45)	deste (Trem normanest 2, T	a. c ,		
76. 00 77. 00					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)				78. 00
79. 00 80. 00	1 99 9 7				79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation				81. 00
82. 00 83. 00					82. 00 83. 00
84. 00					84. 00
85.00					85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 thr PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	ougn oo)			86. 00
87. 00	Total observation bed days (see instructions)	Line 2)		2, 321	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ Observation bed cost (line 87 x line 88) (see instructions)	1111e 2)		1, 094. 31 2, 539, 894	

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	903, 886	9, 490, 910	0. 09523	7 2, 539, 894	241, 892	90.00
91.00 Nursing Program cost	0	9, 490, 910	0.00000	2, 539, 894	0	91.00
92.00 Allied health cost	0	9, 490, 910	0.00000	2, 539, 894	0	92.00
93.00 All other Medical Education	0	9, 490, 910	0.00000	2, 539, 894	0	93. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-S104		
	Title XVIII	Subprovi der -	PPS
		LDE	

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 033	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 033	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 033	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 206	9. 00
	newborn days) (see instructions)	0 ,			
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			Ö	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14.00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00
16. 00	SWING BED ADJUSTMENT			U	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
40.00	reporting period				40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		2, 582, 182	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	21 of the cost reporting	noried (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 582, 182	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had abo	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	ii ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	/	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	Terential (line	2, 582, 182	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 270. 13	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		1, 531, 777 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	,		1, 531, 777	
	, J. J	- · · · /	ı		

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN:		Period: From 01/01/2021	Worksheet D-1	
			Component CCI		To 12/31/2021	5/27/2022 12:	
			Title X	WIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Costlin		Average Per em (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	Tunnan ()	1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
10.00	·					1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines)		107, 584 1, 639, 361	1
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50. 00	Pass through costs applicable to Program inp.	atient routine se	ervices (from W	kst. D, sum	of Parts I and	168, 478	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from	Wkst. D, su	um of Parts II	4, 146	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				172, 624	52. 00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ited, non-physi	cian anesth	etist, and	1, 466, 737	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	get amount (lin	e 56 minus I	ine 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	oorting period er	ndi ng 1996, upd	ated and cor	mpounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport unds	ated by the man	kot baskot		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 er	iter the Lesser	of 50% of		0.00	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 60), or 1% of	the target		
62. 00	Relief payment (see instructions)	,				0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	ions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the c	ost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cos	t reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino 6/	Inlus lino 65)	(+i+l	only) For	0	66. 00
	CAH (see instructions)		•		•		
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [December 31 of	the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dec	ember 31 of th	e cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 6	8)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID ON	LÝ			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of			it (line 37)			70.00
72.00	Program routine service cost (line 9 x line	•		25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv	•		35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•		ksheet B, Pa	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	,		ovi der records)				79.00
80.00	Total Program routine service costs for comp		st limitation (line 78 minu	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			0.00	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				1 0	89. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	284, 000	2, 582, 182	0. 10998	5 0	0	90. 00
91.00 Nursing Program cost	0	2, 582, 182	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	2, 582, 182	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 582, 182	0. 00000	0 0	0	93. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104		Worksheet D-1
	Component CCN: 15-5832	From 01/01/2021 To 12/31/2021	
	Title XVIII	Skilled Nursing	PPS

		Title XVIII	Skilled Nursing Facility	PPS			
	Cost Center Description		raciiity				
	PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days			3, 472	1. 00		
2.00	Inpatient days (including private room days, excluding swing-l			3, 472	2.00		
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 472	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00		
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00		
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember	31 of the cost	O	0.00		
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00		
8. 00	reporting period	m days) after December 3	1 of the cost	0	8. 00		
6.00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 3	i oi the cost	U	0.00		
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 755	9. 00		
40.00	newborn days) (see instructions)			0	40.00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, er			_			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including privat	e room days)	0	12. 00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13. 00		
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)				
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00		
16. 00	Nursery days (title V or XIX only)			0	16. 00		
10.00	SWING BED ADJUSTMENT				10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00		
10.00	reporting period	0.00	10.00				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00		
20.00	reporting period	3 di tel becember 31 di t	110 0031	0.00	20.00		
21. 00	Total general inpatient routine service cost (see instructions			2, 389, 789			
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00		
	x line 18)	·					
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00		
	x line 20)	. 3	'				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		0 2, 389, 789	26. 00 27. 00		
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 20)		2, 309, 709	27.00		
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00		
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	· lino 20)		0. 000000	30. 00 31. 00		
32.00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20)		0.00000	32.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00			
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)						
35. 00 36. 00							
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 389, 789	36. 00 37. 00		
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS					
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see				38. 00		
39. 00	Program general inpatient routine service cost (line 9 x line	•			39. 00		
40.00	Medically necessary private room cost applicable to the Progra				40.00		
41.00	Total Program general inpatient routine service cost (line 39	+ iine 40)			41. 00		

	Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORIA		N. 15 0104	Peri od:	eu of Form CMS-: Worksheet D-1	
IVII O I	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-5104	From 01/01/2021 To 12/31/2021	Date/Time Pre	epare
			Title	XVIII	Skilled Nursing	5/27/2022 12: PPS	47 p
	Cost Center Description	Total Inpatient Cost	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42
. 00	Intensive Care Type Inpatient Hospital Units						42
00	INTENSIVE CARE UNIT						43
00	CORONARY CARE UNIT						44
00	BURN INTENSIVE CARE UNIT						45
00	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	-
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1.00	48
	Total Program inpatient costs (sum of lines			ns)			49
	PASS THROUGH COST ADJUSTMENTS	··· •···g.· ·-/(-		,			1
00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	m of Parts I and		50
00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II		51
00	and IV) Total Program excludable cost (sum of lines!	50 and 51)					52
00	Total Program excludable cost (sum of lines a local Program inpatient operating cost excluding c	,	ated non-phy	sician anest	hetist and		52
00	medical education costs (line 49 minus line		area, non-pny	or or arr arresti	notist, and		
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
00	Program di scharges						54
00	Target amount per discharge						55
00	Target amount (line 54 x line 55)				50)		56
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)		57
00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported o	anding 1006 u	ndated and co	ompounded by the		59
00	market basket	Joi ting period e	illullig 1990, u	puateu anu ci	onipounded by the		3,
00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	lated by the m	arket basket			60
. 00	If line 53/54 is less than the lower of line						61
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target		
	amount (line 56), otherwise enter zero (see	nstructions)					١.,
. 00	Relief payment (see instructions)	ont (ooo i notruo	+: ana)				62
. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	tions)				63
00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ing period (See		64
	instructions)(title XVIII only)				9		-
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	g period (See		65
	instructions)(title XVIII only)			-> 4			١
00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 6	4 plus line 6	5)(title XVII	II only). For		66
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost ro	enorting period		67
55	(line 12 x line 19)	20010 thi bugii		5031 16	g por rou		"
00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost repo	orting period		68
	(line 13 x line 20)			•	•	1	
00	Total title V or XIX swing-bed NF inpatient					<u> </u>	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU				\	2 200 700	7,
00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	•		•	J	2, 389, 789 688. 30	
00	Program routine service cost (line 9 x line		no 70 - Title	-)		1, 207, 967	
. 00	Medically necessary private room cost applications	,	(line 14 x li	ne 35)		0	1 .
00	Total Program general inpatient routine serv		•	-		1, 207, 967	
00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, [Part II, column	0	75
00	26, line 45)	2)] _,
00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line					0.00	
	Inpatient routine service cost (line 74 minus					0	1
00	Aggregate charges to beneficiaries for excess	,	ovi der record	s)		0	
00	Total Program routine service costs for compa				nus line 79)	0	
00	Inpatient routine service cost per diem limi			•	,	0.00	
00	Inpatient routine service cost limitation (I	,				0	
. 00	Reasonable inpatient routine service costs (5)			1, 207, 967	
. 00	Program inpatient ancillary services (see in		->			865, 350	
~~	Utilization review - physician compensation					2 072 217	85
		THE LINES AT THE	บนนท ชอ)			2, 073, 317	1 86
. 00	Total Program inpatient operating costs (sum						
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions	S THROUGH COST	g,				87

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0104	Peri od:	Worksheet D-1	
		Component (CCN: 15-5832	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 12:	
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90.00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	o	0. 00000	0 0	O	93. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-010	From 01/01/2021	Worksheet D-1 Date/Time Prepared: 5/27/2022 12:47 pm
	Title XIX	Hospi tal	Cost
C+ C+			

-		Title XIX	Hospi tal	5/27/2022 12: Cost	47 pm_
	Cost Center Description	TI LIE XIX	nospi tai	COST	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.	vate room days,	8, 673 8, 673 0	1. 00 2. 00 3. 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		31 of the cost	6, 352 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)		J	314	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)		0	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, et	nter O on this line)	3 ,	0	
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	12. 00 13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	
15. 00	Total nursery days (title V or XIX only)	(exer during eming bed i	<i>aay</i>	0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	17. 00		
18. 00					18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost		19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		ne cost		20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through December S x line 17)		ng period (line	9, 490, 910 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times \text{line } 19)$	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x line 20) \times	31 of the cost reporting	period (line 8	0	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		9, 490, 910	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	lino 20)		0 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	: II ne 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin		,	0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 9, 490, 910	36. 00 37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 004 = 1	00.00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 094. 31	
39. 00 40. 00	Medically necessary private room cost applicable to the Progra	•		343, 613 0	40. 00
	Total Program general inpatient routine service cost (line 39)			343, 613	

Heal th	n Financial Systems WITHAM MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Pre	
		Title XIX	Hospi tal	5/27/2022 12: Cost	4/ pm
	Cost Center Description Total	Total Average Per	Program Days	Program Cost	
	Inpatient Cos	st Inpatient Days Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	1.00	2.00 3.00	4.00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0 0 0.0	00 0	0	42. 00
43.00	INTENSIVE CARE UNIT 4,804,45	3, 379 1, 421. 8	36 0	0	
44. 00 45. 00					44. 00 45. 00
46. 00					46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47. 00
	Cost center bescription			1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. Total Program inpatient costs (sum of lines 41 through 48			281, 845	1
49.00	PASS THROUGH COST ADJUSTMENTS) (See Tristi ucti ons)		625, 458	49.00
50. 00	9 11	e services (from Wkst. D, sum	of Parts I and	0	50. 00
51. 00		ary services (from Wkst. D, s	um of Parts II	0	51.00
F0 00	and IV)				F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital	related, non-physician anesth	etist, and	0	
	medical education costs (line 49 minus line 52)		·		
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges			0	54. 00
55. 00					55. 00
56. 00 57. 00		target amount (line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·	,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting periomarket basket	d ending 1996, updated and co	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report,			0. 00	•
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 6 which operating costs (line 53) are less than expected co			0	61. 00
	amount (line 56), otherwise enter zero (see instructions)		the target		
62. 00 63. 00		ructions)		0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64. 00	Medicare swing-bed SNF inpatient routine costs through De instructions)(title XVIII only)	cember 31 of the cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costs after Dece instructions)(title XVIII only)	mber 31 of the cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (lin	e 64 plus line 65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs throu	ah December 31 of the cost re	porting period	0	67. 00
	(line 12 x line 19)		. 3.		
68. 00	Title V or XIX swing-bed NF inpatient routine costs after (line 13 x line 20)	December 31 of the cost repo	rting period	U	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY			0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID r	outine service cost (line 37)			70. 00
71. 00 72. 00	, , , , , , , , , , , , , , , , , , , ,	(line 70 ÷ line 2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Progr				73. 00
74. 00 75. 00			art II column		74. 00 75. 00
	26, line 45)	se seste (em no konest 2, .	a. c , oo. a		
76. 00 77. 00					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)				78. 00
79. 00 80. 00	1 99 9 9	•	us line 70)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitation	•	11110 17)		81. 00
82. 00 83. 00	, ,	· · · · · · · · · · · · · · · · · · ·			82. 00 83. 00
84. 00	,	uis,			84. 00
85. 00 86. 00					85.00
60. UU	Total Program inpatient operating costs (sum of lines 83 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COS				86. 00
87. 00 88. 00		- line 2)		2, 321 1, 094. 31	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instruction	•		2, 539, 894	1

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 Fo 12/31/2021	Date/Time Prep 5/27/2022 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	903, 886	9, 490, 910	0. 09523	7 2, 539, 894	241, 892	90.00
91.00 Nursing Program cost	0	9, 490, 910	0.00000	2, 539, 894	0	91.00
92.00 Allied health cost	0	9, 490, 910	0.00000	2, 539, 894	0	92.00
93.00 All other Medical Education	0	9, 490, 910	0.00000	2, 539, 894	0	93. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Period: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/27/2022 12:	pared: 47 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				2, 199, 571		30. 00

	Title XVIII	Hospi tal	PPS	
Cost Center Description	Ratio of Cos	st Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
		_	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		2, 199, 571		30.00
31. 00 03100 INTENSIVE CARE UNIT		2, 153, 424		31.00
40. 00 04000 SUBPROVI DER - 1 PF		0		40.00
41. 00 04100 SUBPROVI DER - I RF		0		41.00
42. 00 04200 SUBPROVI DER		0		42.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 1419	79 2, 956, 346	419, 739	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 2316	66 895, 428	207, 440	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.0000	00 0	0	55. 00
55. 01 05501 ULTRA SOUND	0. 1180	30 60, 273	7, 114	55. 01
57. 00 05700 CT SCAN	0. 0236		60, 427	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 0631		22, 049	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 0440		9, 348	59.00
60. 00 06000 LABORATORY	0. 1423		625, 182	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 1827		24, 374	63. 00
64. 00 06400 NTRAVENOUS THERAPY	0. 0015		575	64.00
66. 00 06600 PHYSI CAL THERAPY	0. 4624	·	173, 307	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 3224		91, 535	67.00
67. 01 06701 AUDI OLOGY	0. 3224		91, 333	67. 01
68. 00 06800 SPEECH PATHOLOGY				68. 00
69. 00 06900 SPEECH PATHOLOGY	0. 3395		21, 699	1
	0.0000		0	69.00
69. 01 06901 CARDI OLOGY	0. 1495		527, 673	69. 01
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 4512	·	388, 527	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 1513		118, 348	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 4293	84 2, 059, 003	884, 103	73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C	0.0000	00 0	0	90.00
			0	
	0.0000			90. 01
90. 02 09002 CLINI C	0.0000		0	90. 02
90. 03 09003 DERMATOLOGY CLI NI C	0.0000		0	90. 03
90. 04 09004 ENT CLI NI C	0.0000		0	90. 04
90. 05 09005 SURGERY CLINIC	0.0000		0	90. 05
90. 07 09007 UROLOGY CLI NI C	0. 1431		0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0.0000		0	90. 09
90. 11 09011 NEUROLOGY CLI NI C	0.0000		0	90. 11
90. 12 09012 0PTHAMOLOGY CLINIC	0.0000		0	90. 12
90. 13 09013 ALLERGY CLI NI C	0. 7341		0	90. 13
90. 14 09014 WOUND CARE	0. 2040		68	90. 14
91. 00 09100 EMERGENCY	0. 1809		276, 186	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 3117	39 181, 659	56, 630	92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES				95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		21, 598, 248	3, 914, 324	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		21, 598, 248		202. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0104	Peri od:	Worksheet D-3	
		Component	CCN: 15-S104	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
		Ti tl e	e XVIII	Subprovider -	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					١
0. 00 1. 00 0. 00 1. 00 2. 00 3. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY			1, 609, 245		30. 0 31. 0 40. 0 41. 0 42. 0 43. 0
	ANCILLARY SERVICE COST CENTERS					
0. 00 4. 00 5. 00 5. 01	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05501 ULTRA SOUND		0. 14197 0. 23166 0. 00000 0. 11803	06 17, 678 00 0	820 4, 095 0 0	54. 0 55. 0
7. 00 8. 00 9. 00	05300 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 02363 0. 06316 0. 04402	37, 017 57 0	875 0 91	57. 0 58. 0
0. 00 3. 00 4. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0. 14238 0. 18275 0. 00150	0 07 2, 712	51, 995 0 4	63. 0 64. 0
6. 00 7. 00 7. 01 8. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY 06800 SPEECH PATHOLOGY		0. 46240 0. 32240 0. 38118 0. 33955	3, 181 3 0	7, 602 1, 026 0 579	67. (67. (
9. 00 9. 01 1. 00	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 00000 0. 14952 0. 45120	00 0 27 9, 745	0 1, 457 6, 395	69. (
2. 00 3. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 15130 0. 42938		92 30, 083	1
0. 00	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 00000 0. 00000	00 0	0	90.
0. 02 0. 03 0. 04	09002 CLI NI C		0. 00000 0. 00000 0. 00000	00 0	0 0	90. 90.
0. 05 0. 07 0. 09	09005 SURGERY CLINIC 09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC		0. 00000 0. 14314 0. 00000	00 0	0 0	90. 90.
0. 13	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC		0. 00000 0. 00000 0. 73412	00 0	0 0	90. 90.
	09014 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 20406 0. 18097 0. 31173	13, 648	0 2, 470 0	91.
00.00	O9500 AMBULANCE SERVICES Total (sum of lines 50 through 94 and 96 through 98			559, 983	107, 584	
01. 00 02. 00		narges (line 61)		0		201. 202.

alth Financial Systems WITHAM MEM IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ORIAL HOSPITAL Provider C	CN: 15-0104	Peri od:	wof Form CMS- Worksheet D-3	
	Component	CCN: 15-5832	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 12:	
	Titl€	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,	_		
0. 00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT					30. (
0. 00 04000 SUBPROVI DER - I PF 00 04100 SUBPROVI DER - I RF					40. (
2. 00 04200 SUBPROVI DER 3. 00 04300 NURSERY					42. 0 43. 0
ANCI LLARY SERVI CE COST CENTERS 0.00 OPERATI NG ROOM		0. 1419	79 32, 414	4, 602	50.
9. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2316		9, 897	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	1
5. 01 05501 ULTRA SOUND		0. 11803	30 3, 425	404	55.
7. 00 05700 CT SCAN		0. 02363	4, 728	112	57.
B. OO O5800 MAGNETIC RESONANCE I MAGING (MRI)		0.06316		373	58.
0.00 05900 CARDI AC CATHETERI ZATI ON		0. 04402		911	1
0. 00 06000 LABORATORY		0. 14238		30, 243	1
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1827!		374	
I. 00 06400 I NTRAVENOUS THERAPY D. 00 06600 PHYSI CAL THERAPY		0. 00150 0. 46240		22 308, 951	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 32240		238, 669	
7. 01 06701 AUDI OLOGY		0. 38118		230, 007	1
B. 00 06800 SPEECH PATHOLOGY		0. 3395		6, 143	1
0. 00 06900 ELECTROCARDI OLOGY		0.00000		0	1
P. 01 06901 CARDI OLOGY		0. 14952	96, 047	14, 362	69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45120		23, 268	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 15130 0. 42938		0 226, 448	
OUTPATIENT SERVICE COST CENTERS					1
0. 00 09000 CLI NI C		0.00000		0	
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		0	
0. 02 09002 CLI NI C		0.00000		0	1
0. 03 09003 DERMATOLOGY CLINIC		0.00000		0	1
D. 04 09004 ENT CLI NI C D. 05 09005 SURGERY CLI NI C		0.00000		0	
. 05 09005 SURGERY CLINIC . 07 09007 UROLOGY CLINIC		0. 00000 0. 14314		0	
0. 09 09009 GASTROENTEROLOGY CLINIC		0. 00000		0	
1. 11 O9011 NEUROLOGY CLINIC		0. 00000		0	
0. 12 O9012 OPTHAMOLOGY CLINIC		0. 00000		Ō	
0. 13 09013 ALLERGY CLINIC		0. 73412		0	1
0. 14 09014 WOUND CARE		0. 2040		0	90
. 00 09100 EMERGENCY		0. 18097		505	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 31173	39 211	66	92.
OTHER REIMBURSABLE COST CENTERS					4

2, 443, 445 0

2, 443, 445

95.00

865, 350 200. 00 201. 00 202. 00

95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Prep 5/27/2022 12:	pared: 47 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	

					5/2//2022 12:	4/ pm_
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost	I npati ent	Inpatient	
	'		To Charges	Program	Program Costs	
			3	Charges	(col. 1 x col.	
				g	2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			1, 158, 613		30. 00
				1, 130, 013		
	03100 INTENSIVE CARE UNIT			0		31.00
	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER - I RF			0		41. 00
	04200 SUBPROVI DER			0		42. 00
43. 00	04300 NURSERY			0		43. 00
	ANCILLARY SERVICE COST CENTERS					
50. 00	05000 OPERATING ROOM		0. 141979	308, 582	43, 812	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 231666	20, 597	4, 772	54.00
	05500 RADI OLOGY-THERAPEUTI C		0.000000	. 0	0	55. 00
	05501 ULTRA SOUND		0. 118030	0	0	55. 01
	05700 CT SCAN		0. 023631	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 063167	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON			0	0	59.00
			0. 044020	050 (05	-	
	06000 LABORATORY		0. 142384	353, 695		60.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 182753	0	0	63. 00
	06400 I NTRAVENOUS THERAPY		0. 001507	0	0	64. 00
66. 00	06600 PHYSI CAL THERAPY		0. 462406	11, 123	5, 143	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 322401	7, 216	2, 326	67.00
67. 01	06701 AUDI 0L0GY		0. 381183	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY		0. 339556	0	0	68. 00
	06900 ELECTROCARDI OLOGY		0. 000000	0	0	69. 00
	06901 CARDI OLOGY		0. 149527	0	٥	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 451206	118, 173	53, 320	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 151306	110, 173	0.55, 520	72.00
				255 240		
	07300 DRUGS CHARGED TO PATIENTS		0. 429384	255, 240	109, 596	73. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0. 000000	0	-	90. 00
	09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 000000	0	0	90. 01
	09002 CLI NI C		0. 000000	0	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC		0.000000	0	0	90. 03
90. 04	09004 ENT CLINIC		0.000000	0	0	90. 04
90. 05	09005 SURGERY CLINIC		0.000000	0	0	90. 05
	09007 UROLOGY CLINIC		0. 143146	0	0	90. 07
	09009 GASTROENTEROLOGY CLINIC		0. 000000	0	0	90. 09
	09011 NEUROLOGY CLINIC		0. 000000	0	0	90. 11
	09012 OPTHAMOLOGY CLINIC		0. 000000	0	0	90. 12
-				0	0	90. 12
	09013 ALLERGY CLINIC		0. 734122	0	1	
	09014 WOUND CARE		0. 204068	(0.451	0	90. 14
	09100 EMERGENCY		0. 180976	69, 151	12, 515	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 311739	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			1, 143, 777	281, 845	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			1, 143, 777		202. 00
		'	'		•	

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2021 To 12/31/2021 Worksheet E Part A Date/Time Prepared: 5/27/2022 12:47 pm

		T: +1 o V/////	Hooni tol	5/27/2022 12:	47 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			-	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (s	see	0 4, 547, 775	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	1, 346, 504	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	or discharges occurring p	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			_	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructi	one)		0	2. 01 2. 02
2.02	Outlier payments for discharges occurring prior to October 1 (60, 887	2. 02
2.04	Outlier payments for discharges occurring on or after October			00,007	2. 04
3.00	Managed Care Simulated Payments	(222 11121 2221 2112)		0	3. 00
4.00	Bed days available divided by number of days in the cost repor	ting period (see instru	ctions)	72. 57	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5. 00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)		·	0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ι ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat	hic and osteopathic pro	grams for	0.00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).			0.00	0.00
8. 01	The amount of increase if the hospital was awarded FTE cap sloreport straddles July 1, 2011, see instructions.	ots under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slounder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	es (8, 8,01 and 8,02) (9	see	0. 00	9. 00
10. 00	FTE count for allopathic and osteopathic programs in the curre	ent year from your record	ds	0.00	ı
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	ur anded on or after Sen	tombor 20 1007	0. 00 0. 00	
14.00	otherwise enter zero.	ii ended on or arter sep	Leiliber 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16.00	Adjustment for residents in initial years of the program			0.00	16. 00
17. 00	Adjustment for residents displaced by program or hospital clos	sure			17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4)	•		0.000000	
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22.00
22. 01				0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	·		0. 00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see	0.00	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)		·	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01 Disproportionate Share Adjustment)		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	ntient days (see instruc	tions)	1. 98	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			25. 57	31.00
32.00	Sum of lines 30 and 31			27. 55	ı
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			11. 94 175, 944	ı
57.00	propriopor a oriate share adjustment (see This huctions)		l	175, 744	1 57.00

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/27/2022 12:	pared:
		Title XVIII	Hospi tal	PPS 10.41	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35. 00
35. 01	Factor 3 (see instructions)		0. 000119550	0. 000117111	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, enterinstructions)	r zero on this line) (se	e 991, 071	842, 262	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo		741, 267	212, 296	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0. Additional payment for high percentage of ESRD beneficiary dis		953, 563		36. 00
40. 00	Total Medicare discharges (see instructions)	scharges (Triles 40 till out	0		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	i ons)	Ö		41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	,	0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46.00
47. 00	Subtotal (see instructions)		7, 084, 673		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions)		7, 084, 673	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	•		446, 492	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			33, 060	
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6			0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intro	•	1 05)	0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		nrough 35).	0	57. 00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	iv, cor. If time 200)		0 7, 564, 225	58. 00 59. 00
60.00	Primary payer payments			7, 304, 223	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		7, 564, 225	61. 00
62. 00	Deductibles billed to program beneficiaries	11116 00)		680, 244	62. 00
63. 00	Coinsurance billed to program beneficiaries			0	63. 00
64.00	Allowable bad debts (see instructions)			11, 256	
65.00	Adjusted reimbursable bad debts (see instructions)			7, 316	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	66.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6, 891, 297	67.00
68. 00	Credits received from manufacturers for replaced devices for			0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instructions	s)	0	69. 00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	nstructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		0	70. 88
70. 89 70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	I UCTI UIIS)		0	70. 89 70. 90
70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 91	Bundled Model 1 discount amount (see instructions)			0	70. 91
70. 92	HVBP payment adjustment amount (see instructions)			-19, 078	
70. 94	HRR adjustment amount (see instructions)			-77, 427	70. 94
	Recovery of accelerated depreciation			· ·	70. 95
				'	•

Health Financial Systems WITHAM MEN	MORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-0104	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/27/2022 12:	
		Title	: XVIII	Hospi tal	PPS	<u>'</u>
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Eithe corresponding federal year for the period prior to		n column 0		2021	753, 942	70. 96
70 07 Low volume adjustment for federal fiscal year (year) (E)	ntor ir	a column 0	1	2022	220 220	70 07

					5/27/2022 12: 4	47 pm
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	:	2021	753, 942	70. 96
70.07	the corresponding federal year for the period prior to 10/1)			2000	000 000	70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		•	2022	220, 330	/0.9/
70.00	the corresponding federal year for the period ending on or after Yeluma Payment 2	ter 10/1)			0	70.00
70. 98	Low Volume Payment-3				0	•
70. 99	HAC adjustment amount (see instructions)	(0 0 70)			7 7/0 0/4	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	09 & 70)			7, 769, 064	•
71. 01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration				0	71. 01
71. 02	, , , ,				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs				7 200 220	71.03
72. 00 72. 01	Interim payments Interim payments-PARHM				7, 388, 239	72. 00 72. 01
	' '				0	1
73.00	Tentative settlement (for contractor use only)				U	73. 00 73. 01
73. 01	Tentative settlement-PARHM (for contractor use only)	22 and			200 025	1
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	z, /z, and			380, 825	74. 00
74 01	73) Relance due provider (program DADUM (see instructions)					74. 01
74. 01 75. 00	Balance due provider/program-PARHM (see instructions)	noo wi th			100 101	•
75.00	Protested amounts (nonallowable cost report items) in accordar CMS Pub. 15-2, chapter 1, §115.2	nce with			108, 191	/5.00
	TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
90 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2 03			0	90.00
70.00	plus 2.04 (see instructions)	01 2.03			U	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	
93.00	Capital outlier reconciliation adjustment amount (see instruction)				0	93.00
94. 00	The rate used to calculate the time value of money (see instructions and use of money)				0. 00	
95.00	Time value of money for operating expenses (see instructions)	uctions)			0.00	95.00
96. 00	Time value of money for capital related expenses (see instructions)	tions)			0	1
70.00	Trine variae or morey for capital related expenses (see riisti de	11 0113)		Dri or to 10/1	On/After 10/1	70.00
	HSP Ronus Payment Amount			1.00	2. 00	
100.00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			1. 00	2. 00	100.00
100.00	HSP bonus amount (see instructions)				2. 00	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	5)		1. 00	2.00	101. 00
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	s)		0. 0000000000	2.00	101. 00
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	s)		1. 00 0 0. 0000000000 0	2.00 0 0.0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0. 0000000000	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	stment	0. 0000000000 0 0. 00000000000	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr) ration) Adjus		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RVBP adjustment amount for HSP bonus payment (see instructions) RVBP adjustment amount for HSP bonus payment (see instructions) RVBP adjustment amount for HSP bonus payment (see instructions) RVBP adjustment factor (see instructions)) ration) Adjus		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adjus		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adjus riod under tl		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adjus riod under tl		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)) ration) Adjus riod under tl		0. 0000000000 0 0. 00000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRB Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)) ration) Adjus riod under tl e 49)	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	nation) Adjus riod under tl e 49) first year d	he 21st	0.0000000000 0.0000000000000 0	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
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| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2021 | Part A Exhibit 4 | To 12/31/2021 | Date/Time Prepared: | 5/27/2022 12:47 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0104

W/S E, Port A Amounts (Free Previous							0 12/31/2021	5/27/2022 12:4	
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Operating payment for Model 4 SPCI occurring prior to October 1 SPCI occurring payment for Model 4 SPCI occurring payments for 2,00		1							
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BPC occurring on or after	1.04		1.04	J	O		J	J	1.04
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instructions 0									
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Dayments Dayments Dayments Dayments Dayment	3.00		2.01	J	O	٦	o o	Ŭ	3. 00
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5.00 Anount from Worksheet E, Part 21.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		payments							
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See instructions Second	7 00						0.000000		7 00
Note	7.00		27.00	0.000000	0. 000000	0.00000	0.000000		7.00
IME payment adjustment add on	8.00	,	28. 00	o	0	0	0	0	8. 00
For managed care (see instructions)									
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Care (sum of lines 6.01 and 8.01) Di sproportionate Share Adjustment Di sproportionate Share Adjustment Di sproportionate share percentage (see instructions) Di sproportionate share percentage (see instructions) Di sproportionate share adjustment (see instructions) Di sproportionate share adjust	9. 01		29. 01	n	0	n	o	n	9. 01
8.01 Disproportionate Share Adjustment	-]	_]			-
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Share percentage (see instructions)	40			1	2		1		40.5-
11. 00 Disproportionate share 34. 00 175, 944 0 135, 751 40, 193 175, 944 11. 00 adjustment (see instructions) 36. 00 953, 563 0 741, 267 212, 296 953, 563 11. 01	10. 00	Allowable disproportionate	33.00	0. 1194	0. 1194	0. 1194	0. 1194		10. 00
11.00 Disproportionate share 34.00 175,944 0 135,751 40,193 175,944 11.00 11.01 Uncompensated care payments 36.00 953,563 0 741,267 212,296 953,563 11.01 12.00 Total ESRD additional payment 46.00 0 0 0 0 0 0 13.00 Subtotal (see instructions) 47.00 7,084,673 0 5,485,680 1,598,993 7,084,673 13.00 14.00 Hospital specific payments 48.00 0 0 0 0 0 0 (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient 49.00 7,084,673 0 5,485,680 1,598,993 7,084,673 15.00 15.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 16.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 16.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 16.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 17.00 17.0									
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(see instructions) 13.00 Subtotal (see instructions) 47.00 7,084,673 0 5,485,680 1,598,993 7,084,673 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, Pt. I, Pt. I, Pt. I)				D beneficiary					
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Small rural hospitals only.) (see instructions)	1 7. 00		10.00	٩	O				00
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instructions) 16.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 capital (from Wkst. L, Pt. I,	15. 00		49. 00	7, 084, 673	0	5, 485, 680	1, 598, 993	7, 084, 673	15. 00
16.00 Payment for inpatient program 50.00 446,492 0 346,588 99,904 446,492 16.00 capital (from Wkst. L, Pt. I,									
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	10.00		50.00	440, 492	Ü	340, 388	99, 904	440, 492	10.00
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					-	From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Pre 5/27/2022 12:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
	T	0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	54.00	33, 060	0	21, 31	11, 742	33, 060	17. 00
17. 01 17. 02	new technologies Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	(0	0	18. 00
19. 00	SUBTOTAL			0	5, 853, 58	1, 710, 639	7, 564, 225	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	442, 757	0	342, 85	99, 904	442, 757	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	3, 735	0	3, 73	5 0	3, 735	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
22. 00		5. 00	0. 0000	0. 0000	0. 0000	0.0000		22. 00
23. 00	percentage (see instructions) 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. 0000	0. 0000	0.0000		24. 00
25. 00	1	11. 00	0	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	446, 492	0	346, 58	99, 904	446, 492	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 12880 753, 94		753, 942	27. 00 28. 00
29. 00		70. 97				220, 330	220, 330	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

From 01/01/2021 Part A Exhibit 5 Date/Time Prepared: 12/31/2021 5/27/2022 12:47 pm Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 4, 547, 775 4, 547, 775 4, 547, 775 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 1, 346, 504 1, 346, 504 1, 346, 504 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 C 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 60, 887 2 02 Outlier payments for discharges occurring 2 03 60, 887 60 887 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 0 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 C 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1194 0.1194 0.1194 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 175. 944 135, 751 40. 193 175.944 11.00 instructions) 11.01 Uncompensated care payments 36 00 953, 563 741, 267 212, 296 953, 563 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 12.00 instructions) 47.00 13 00 7, 084, 673 5, 485, 680 1, 598, 993 Subtotal (see instructions) 7, 084, 673 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 7, 084, 673 5, 485, 680 1, 598, 993 7, 084, 673 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 446, 492 346, 588 99, 904 446, 492 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 33,060 21, 318 11, 742 33,060 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 0 18.00 amount (see instructions) 19.00 **SUBTOTAL** 5, 853, 586 1, 710, 639 7, 564, 225 19. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0104	From 01/01/2021	Worksheet E Part A Exhibit 5 Date/Time Prepared:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CAL	LCULATION EXHIBIT 5	Provider CC	F	From 01/01/2021 To 12/31/2021	Part A Exhi bi Date/Ti me Pre 5/27/2022 12:	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	442, 757	342, 853	99, 904	442, 757	20. 00
20.01 Model 4 BPCI Capital DRG other than outl	ier 1.01	0	(0	0	20. 01
21.00 Capital DRG outlier payments	2.00	3, 735	3, 735	0	3, 735	
21.01 Model 4 BPCI Capital DRG outlier payment	s 2.01	0	(0	0	21. 01
22.00 Indirect medical education percentage (s instructions)	see 5.00	0. 0000	0. 0000	0.0000		22. 00
23.00 Indirect medical education adjustment (s	see 6.00	0	(0	0	23. 00
24.00 Allowable disproportionate share percent (see instructions)	age 10.00	0. 0000	0. 0000	0.0000		24. 00
25.00 Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	446, 492	346, 588	99, 904	446, 492	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00				0.00	,, ,,	27. 00
28.00 Low volume adjustment prior to October 1	70. 96	753, 942	753, 942	2	753, 942	28. 00
29.00 Low volume adjustment on or after Octobe		220, 330		220, 330		1
30.00 HVBP payment adjustment (see instruction	ns) 70. 93	-19, 078	-19, 078	0	-19, 078	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	. (0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-77, 427	-70, 364	-7, 063	-77, 427	31.00
31.01 HRR adjustment for HSP bonus payment (se instructions)	ee 70. 91	0	(0	0	31. 01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		(0	0	32. 00
100.00 Transfer HAC Reduction Program adjustmen Wkst. E, Pt. A.	nt to	N				100. 00

		Title XVIII	Hospi tal	5/27/2022 12: PPS	47 pm
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			24, 987	1.00
2. 00	Medical and other services (see First detrons) Medical and other services reimbursed under OPPS (see instructions)	s)		14, 543, 929	2.00
3. 00	OPPS payments	-)		11, 510, 366	3.00
4.00	Outlier payment (see instructions)			31, 860	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ns)		0.000	5. 00
6. 00 7. 00	Line 2 times line 5			0 0.00	6. 00 7. 00
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13. line 200		Ö	9. 00
10.00	Organ acqui si ti ons	•		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			24, 987	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			70, 035	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	59)		70,033	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	**)		70, 035	ł
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payme			0	15. 00
16. 00	Amounts that would have been realized from patients liable for pay	yment for services or	n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			70, 035	
19. 00	Excess of customary charges over reasonable cost (complete only it	fline 18 exceeds lir	ne 11) (see	45, 048	1
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only it	fline 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			24, 987	21. 00
22. 00	Interns and residents (see instructions)			24, 987	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			11, 542, 226	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	(for CALL occ inctru	unti ana)	0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			2, 117, 449 9, 449, 764	26. 00 27. 00
27.00	instructions)	the sum of fiftes 22	and 25] (3ee	7, 447, 704	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 5	50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			9, 449, 764	ł
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			519 9, 449, 245	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			7, 447, 243	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			41, 720	
35. 00	Adjusted reimbursable bad debts (see instructions)			27, 118	ł
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructi Subtotal (see instructions)	ons)		9, 476, 363	36. 00 37. 00
38. 00	,			9, 470, 303	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced of	devices (see instruct	i ons)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION			0 474 274	39. 99
40. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			9, 476, 374 0	40. 00 40. 01
40. 02	Demonstration payment adjustment amount after sequestration			ő	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			9, 429, 491	41. 00
41. 01	Interim payments-PARHM			_	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			46, 883	1
43. 01	Balance due provider/program-PARHM (see instructions)			.5, 500	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance w	with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			0	00 00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2021	Worksheet E Part B
	Component CCN: 15-S104	To 12/31/2021	Date/Time Prepared: 5/27/2022 12:47 pm
	Title XVIII	Subprovi der -	PPS

MART 8 _ WENTON AND OTHER WENTON SERVICES 1.00 Medical and other services (see Instructions) 2 _ 2,579 1.00 Medical and other services (see Instructions) 2 _ 2,579 1.00 Medical and other services (see Instructions) 2 _ 2,579 1.00 1.00 Medical and other services crimbursal under OPPS (see Instructions) 3.10 3.00			litle XVIII	Subprovi der - I PF	PPS	
Medical and other services (see instructions)						
Modical and other services (see instructions) 2,639 1,00		PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
3.00 Overline propriett (see instructions) 3.00 4.01	1.00				2, 639	1. 00
0.01 10 10 10 10 10 10 1			ons)			
0.011 cr reconcil 14 to a mount (see instructions) 0.000 5.00						
Inter-the hospital specific payment to cost ratio (see instructions)						
Line 2 times Line 5 0 0 0 0 0 0 0 0 0		,	ions)			
Transit foral corridor payment (see instructions) 0 8.00 0.00	6.00		,		o	6. 00
Acciding years in center pass through casts from West. D. Pt. IV, col. 13, line 200 0.00						
10.00 Grapam acquist sit ones 2.639 11.00 11.00 12.00 11			! 12 !: 200			
1.10 Total cock (sum of lines 1 and 10) (see Instructions) 2,639 1.00			col. 13, 11ne 200			
COMPUTATION OF LISSER OF COST OR CHARGES						
12.00 Ancillary service charges 6, 147 12.00 13.00 Organ acquist it on charges (from Wist. D-4, Pt. III., col. 4, line 69) 0, 13.00 0 13.00 13.00					,	
13.00 Organ acquisit ion charges (From Wikst. D-4, Pt. III., col. 4, line 69) 0, 13.00 0, 147 14.00 Total reasonable charges (sum of Ithes 12 and 13) 0, 147 14.00 14.00 0, 14.00						
14.00			2 40)			
Constraints Constraints			3 09)			
16.00 Amount's that would have been real ized from patients Itale For payment for services on a chargebasis 0 16.00 Natio of Iline 15 to Iline 16 (not to exceed 1.000000) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000					3,	
had such payment been made in accordance with 42 CFR §413.13(e)		, , , , , , , , , , , , , , , , , , , ,	•	•		
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 0.000000 17.00 0.10	16. 00		payment for services on	a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 6, 147 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 2.00 1.00	17 00				0.000000	17 00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 15.00 19.00 1						
20.00			if line 18 exceeds lin	ie 11) (see		
instructions					_	
2.639 21.00	20. 00		if line 11 exceeds lin	ie 18) (see	0	20.00
22.00 Interns and residents	21. 00				2. 639	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 318 24. 00		,				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT		, , ,	ctions)			
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0.25.00 0.00 Deductibles and Coinsurance amounts elating to amount on line 24 (for CAH, see instructions) 0.26.00 0.27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0.28.00 0.28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0.28.00 0.00 Subtotal (sum of lines 27 through 29) 0.29.00 0.10.00 Subtotal (sum of lines 27 through 29) 0.31.00 0.10 Primary payer payments 0.31.00 0.10 Primary payer payments 0.31.00 0.10 Direct sets (see instructions) 0.31.00 0.10 Direct sets (see instructions) 0.33.00 0.10 Direct sets (see instructions) 0.35.00 0.10 Direct sets (see instructions) 0.39.00 0.10 Direct sets (see instructions) 0.40.00 0.10 Direct sets (see instructions) 0.40.00 0.10 Direct sets (s	24. 00				318	24. 00
26. 00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 2, 907 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, 957 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 2, 957 30. 00 30. 00 Subtotal (sum of lines 27 through 29) 2, 957 30. 00 <td>25 00</td> <td></td> <td></td> <td></td> <td>0</td> <td>25 00</td>	25 00				0	25 00
Instructions		1	24 (for CAH, see instru	ıctions)		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 0 29.00 29.00 29.00 30.00 Subtotal (sum of lines 27 through 29) 2, 957 30.00 31.00 Primary payer payments 2, 957 30.00 31.00 Primary payer payments 2, 957 30.00 31.00 29.00 30.00 Primary payer payments 2, 957 32.00 31.00 31.00 31.00 32.00	27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	•	,	2, 957	27. 00
29.00 ESRD direct medical education costs (From Wkst. E-4, line 36) 29.00 31.00 31.00 Primary payer payments 2,957 30.00 31.00 Primary payer payments 2,957 30.00 31.00 AUDITION AUDITION 2,957 30.00 31.00 AUDITION 32.00 AUDITION 32.00 32.00 AUDITION 32.00 33.	20.00		- 50)			20.00
20, 90 Subtotal (sum of lines 27 through 29) 2, 957 30. 00 Primary payer payments 2, 957 30. 00 31. 00 Subtotal (line 30 minus line 31) 2, 957 32. 00 31. 00 32. 00 32. 00 33. 00 Composite rate ESRD (from West I. 1-5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 34. 00 34. 00 Allowable bad debts (see instructions) 0 35. 00 35. 00 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36. 00 37. 00 Subtotal (see instructions) 2, 957 37. 00 38. 00 39. 00 3			3 50)			
31.00 Subtotal (line 30 minus line 31) 2,957 32.00 3						
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 2,957 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.00 MSP-LCC demonstration payment adjustment (see instructions) 0 39.00 39.00 39.00 The RADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 39.90 39.90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.99 39.99 ACCELERATED DEPRECIATION 0 39.90		,				
33.00 Composite rate ESRD (from Wist. 1-5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 0 34.00 35.00 35.00 All owable bad debts (see instructions) 0 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 0 38.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 0 0 0 0 0 0 0 0 0	32. 00				2, 957	32. 00
34. 00	22 00	·	5)		0	22 00
35. 00						
37.00 Subtotal (see instructions) 2,957 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 0 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 0 40.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 0 OTHER ADJUSTME		, , , , , , , , , , , , , , , , , , ,				
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 98 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 90 39. 99 39. 90 39.			ctions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 91 oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 0 40.01 50.00						
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,957 40.00 40.01 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment amount after sequestration 0 40.02 40.03 41.00 Interim payments 1,548 41.00 Interim payments 41.01 Interim payments 41.01 10.00						
39. 97 Demonstration payment adjustment amount before sequestration 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 8 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 90 90 90 90 90 90 90		, , , , ,				
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 5ubtotal (see instructions) 2, 957 40. 00 40. 01 40. 01 40. 01 40. 01 40. 02 40. 03 40. 02 40. 03	39. 97				o	
40.00 Subtotal (see instructions) 2,957 40.00 40.01 Sequestration adj ustment (see instructions) 0 40.01 40.02 Demonstration payment adj ustment amount after sequestration 0 40.02 40.03 Sequestration adj ustment-PARHM pass-throughs 0 40.03 41.00 Interim payments 1,548 41.00 41.01 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement -PARHM (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 1,409 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00		·	d devices (see instruct	i ons)		
40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 1, 548 41. 00 41. 01 Interim payments-PARHM 41. 00 41. 01 42. 00 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 1, 409 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, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 92. 00 93. 00 Time Value of Money (see instructions) 0 93. 00						
40. 02 Demonstration payment adjustment amount after sequestration 9 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 1 Interim payments 1, 548 41. 00 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Time Value of Money (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier of Money (see instructions) 96. 00 Outlier of Money (see instructions) 97. 00 Outlier of Money (see instructions) 98. 00 Outlier of Money (see instructions) 99. 00 Outlier of Money (see instructions) 99. 00 Outlier of Money (see instructions)						
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41.01 Interim payments-PARHM	40. 03	1				40. 03
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42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions)					ام	
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44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					1, 409	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 pl.00 1 The rate used to calculate the Time Value of Money 1 me Value of Money (see instructions) 0 pl.00 1 me Value of Money (see instructions) 0 pl.00 1 me Value of Money (see instructions)						
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44. 00	,	e with CMS Pub. 15-2, c	chapter 1,	0	44. 00
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91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90. 00				0	90. 00
93.00 Time Value of Money (see instructions) 0 93.00					0	91. 00
74. 00 10 tai (30iii 01 111ic3 71 diiu 73)						
	74.00	Total (Sam of Times /1 and 70)			ΟĮ	74.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2021	Worksheet E
	Component CCN: 15-5832		
	Title XVIII	Skilled Nursing	

		Title XVIII	Skilled Nursing Facility	PPS	
			racrity	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			2, 355	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	tions)		0	2. 00 3. 00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)				4. 00
4. 01	Outlier reconciliation amount (see instructions)				4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru-	ctions)			5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00 8. 00
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	9.00
10. 00	Organ acquisitions	1 V, COI. 13, 11 He 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 355	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			7 440	12. 00
12. 00 13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		7, 400	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			7, 468	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			7, 468	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	5, 113	19. 00
20.00	instructions)	ly if lime 11 eyesede li	no 10) (ooo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT TIME IT exceeds IT	ne 18) (See	0	20. 00
21. 00	1			2, 355	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	5)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line		uctions)	_	26. 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	2, 355	27. 00
20 00	instructions) Direct graduate medical education payments (from Wkst. E. 4. L.)	ino EO)		0	28. 00
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)	THE 50)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2, 355	
31.00	Pri mary payer payments			0	31. 00
32. 00	,	250		2, 355	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	UES)	1	0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36. 00
37. 00				2, 355	37. 00
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		O	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	•		0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 355 0	40. 00 40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03
41. 00	Interim payments			1, 523	
41. 01	Interim payments-PARHM			0	41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			832	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordal \$115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)				90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money				91. 00 92. 00
93.00	1 · · · · · · · · · · · · · · · · · · ·				93.00
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems WIT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0104

					5/27/2022 12: 4	47 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		7, 388, 239		9, 429, 491	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		0		0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3.03			0		0	
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program					ļ
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	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. 99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		7, 388, 239		9, 429, 491	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					İ
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		380, 825		46, 883	6. 01
6. 02	SETTLEMENT TO PROGRAM		000, 020		0	6. 02
7. 00	Total Medicare program liability (see instructions)		7, 769, 064		9, 476, 374	
7.00	Total modical opingram traditity (see this tractions)		7,707,004	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	

Component CCN: 15-S104

Title XVIII Subprovi der -

Inpatient Part A			litle	XVIII	Subprovider - IPF	PPS	
1.00 Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 1.548 1.00 1.148, 320 1.548 1.00 1.148, 320 1.548 1.00 3.00			I npati en	t Part A		-t B	
1.00 Total InterIm payments paid to provider 1.00 2.00 3.00 4.00 1.548 1.00 1.148, 320 1.548 1.00 1.148, 320 1.548 1.00 3.00			mm/dd/yyyyy	Amount	mm/dd/yyyyy	Amount	
1.00							
Interim payments payable on individual bills, either submitted for to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00	Total interim payments paid to provider					1. 00
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00						2. 00
write "NONE" or enter a zero NOLE's 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 ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROGRAM ADJUSTMENT TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENT TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENTS TO PROGRAM ADJUSTMENT							
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		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 3.03 3.03 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.53 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.99) (transfer to West. E.or West. E.a.) line and column as appropriate) To Be CoMPLETE BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program 1.00 1.00 2.50 3.50 3.51 3.52 3.53 3.54 3.55 3.55 3.55 3.56 3.57 3.57 3.58 3.59 3.59 3.50 3.50 3.50 3.50 3.50 3.50 3.50 3.50							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 AJUSTMENTS TO PROVIDER 3.03 .03 .03 .05 .00 .00 .00 .00 .00 .00 .00 .00 .00	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider							
3.01							
3.02	2 01						2 01
3.03 3.04 3.05 Provider to Program 3.50 3.06 ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.53 3.94 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 5.00 Total interim payments (sum of lines 1, 2, and 3.99) To BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR FORTH NORE: or enter a zero. (1) Program to Provider TENTATI VE TO PROVIDER 5.00 Provider to Program TENTATI VE TO PROGRAM 5.50 S.50 S.50 S.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99 Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99) Butlotal (sum of lines 5.01-5.49 minus sum of lines 6.00 minus		ADJUSTMENTS TO PROVIDER				1 - 1	
3.05							
3.05						1 - 1	
Provider to Program						1 - 1	
ADJUSTMENTS TO PROGRAM	0.00	Provider to Program				Ü	0.00
3.52 3.53 3.53 3.53 3.53 3.54 3.50	3.50			0		0	3. 50
3.53 3.54 0 0 0 3.55	3.51			0		0	3. 51
3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0	3.52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3.53			0		0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program liabi	3.54			0		0	3. 54
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 1,148,320 1,548 4.00	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
Ctransfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1, 148, 320		1, 548	4.00
TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER 0 0 0 5.00 5.00							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	F 00						F 00
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER							
5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 5.51 5.52 0 0 0 5.55 5.52 5.59 0 0 0 5.55 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 5.55 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 1,409 6.07 6.02 SETTLEMENT TO PROGRAM 1 0 6.07 7.00 Total Medicare program liability (see instructions) 1,148,319 2,957 7.00 Contractor NMR Date (Mo/Day/Yr) 0 1.00 2.00	5. 01			0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATIVE TO PROGRAM 0 0 5.50	5.03			0		0	5. 03
5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 1,409 6.07 6.02 SETTLEMENT TO PROGRAM 1 0 6.00 6.00 7.00 Total Medicare program liability (see instructions) 1,148,319 Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00 Contractor Number (Mo/Day/Yr) 0 Contractor Number (Mo/Day/Yr) Contrac							
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 1,409 6.02	5.50	TENTATI VE TO PROGRAM					5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 1,409 6.00 6.02 SETTLEMENT TO PROGRAM 1 0 6.02 SETTLEMENT TO PROGRAM 1 1 0 6.02 7.957 7.00 Total Medicare program liability (see instructions) 1,148,319 Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00						- 1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		1 2 2 2 2 2 2					/ 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 1 1,148,319 1 2,957 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			_		1 400	6 01
7.00 Total Medicare program liability (see instructions) 1,148,319 2,957 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1 1		1	
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1 148 310			
Number (Mo/Day/Yr) 0 1.00 2.00		1.0 ca. moa. oa. o program rrabitity (300 moa. dottons)		1, 110, 317			,. 50
0 1.00 2.00							
8.00 Name of Contractor 8.00			()	1. 00		
	8.00	Name of Contractor					8. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | Part | To 12/31/2021 | Date/Time Prepared: | 5/27/2022 12:47 pm | Skilled Nursing | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PPS | PP Component CCN: 15-5832 Title XVIII Skilled Nursing

		litie	XVIII	Killed Nursing Facility	PPS	
		I npati en	t Part Δ		t B	
		Impatron	t rait A	i di		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		864, 217		1, 523	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			1	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER		Ö			3. 02
3. 03			Ö		l ől	3. 03
3. 04			ď		Ö	3. 04
3. 05			ď		ol	3. 05
	Provider to Program	L	-		_	
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3.51			C)	o	3. 51
3.52			C)	o	3. 52
3.53			C)	0	3. 53
3.54			C)	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		864, 217		1, 523	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	I				г оо
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		С		0	5. 01
5. 02	TEMMINE TO THOUSER		ď		l ol	5. 02
5. 03			C		0	5. 03
	Provider to Program	<u>'</u>				
5.50	TENTATI VE TO PROGRAM		C)	0	5.50
5.51			C)	0	5. 51
5.52			C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		_		000	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				832	6. 01 6. 02
			_		۱ ۱	
7. 00	Total Medicare program liability (see instructions)		864, 217	Contractor	2, 355 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor	`			2.00	8. 00
		1		1	'	

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0104 Period: V					
	From 01/01/2021 P To 12/31/2021 D					
			10 12/31/2021	Date/Time Pre 5/27/2022 12:		
		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.				1. 00 2. 00	
2. 00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost					
	reporting periods beginning on or after 10/01/2013, line 32)					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4. 00	
F 00	reporting periods beginning on or after 10/01/2013, line 32)				F 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				6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HII technology	Wkst. S-2, Pt. I		7. 00	
0.00	line 168				0.00	
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	
00.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				00.00	
	Initial/interim HIT payment adjustment (see instructions)				30.00	
31. 00	3,		,		31.00	
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00	

Не	alth Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CA	ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od:	Worksheet E-3
		C CON 15 C101	From 01/01/2021	
		Component CCN: 15-S104	10 12/31/2021	Date/Time Prepared: 5/27/2022 12:47 pm
		Title XVIII	Subprovi der -	PPS
			IPF	

		I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS	1	1.00	
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1	1, 255, 734	1. 00
2.00	Net IPF PPS Outlier Payments	'	917	2. 00
3.00	Net IPF PPS ECT Payments		0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before No	ovember	0.00	4. 00
	15, 2004. (see instructions)			
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displa	aced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment und	Jer 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			
5.00	New Teaching program adjustment. (see instructions)		0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of	a new	0. 00	6. 00
7. 00	teaching program" (see instuctions) Current year's unweighted L&R FTE count for residents within the new program growth period of	- a "now	0. 00	7. 00
7.00	teaching program" (see instuctions)	a new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9. 00	Average Daily Census (see instructions)		5. 569863	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	•	0.000000	10.00
11. 00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1	1, 256, 651	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	15. 00
16. 00	Subtotal (see instructions)	1	1, 256, 651	
17. 00	Pri mary payer payments		0	
18.00	Subtotal (line 16 less line 17).	1	1, 256, 651	
19.00	Deductibles		92, 008	
20.00	Subtotal (line 18 minus line 19) Coinsurance	'	1, 164, 643	
21. 00 22. 00	Subtotal (line 20 minus line 21)	1	16, 324 1, 148, 319	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	'	1, 140, 319	
24. 00	Adjusted reimbursable bad debts (see instructions)		0	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	1	1, 148, 319	
27. 00	Direct graduate medical education payments (see instructions)		0	
28. 00	Other pass through costs (see instructions)		o	28. 00
29. 00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30. 50
30. 98	Recovery of accelerated depreciation.		0	30. 98
30. 99	Demonstration payment adjustment amount before sequestration		0	30. 99
31. 00	Total amount payable to the provider (see instructions)	1	1, 148, 319	
31. 01	Sequestration adjustment (see instructions)		0	31. 01
31. 02	Demonstration payment adjustment amount after sequestration		0	31. 02
32.00		1	1, 148, 320	
33. 00	Tentative settlement (for contractor use only)		0	33. 00
34. 00 35. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	1	-1 0	34. 00 35. 00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter §115.2	1,	۷	35.00
	TO BE COMPLETED BY CONTRACTOR			
50. 00			917	50. 00
51. 00	Outlier reconciliation adjustment amount (see instructions)		717	51. 00
52. 00			0.00	
53. 00	Time Value of Money (see instructions)		0	
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE	COVID-19 PHE		
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2		0.000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99. 01

	4	Figure in Contains	LIOCDI TAL	1-11-	£ E CMC /	2552 40
_		Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E-3 Part VI Date/Time Pre 5/27/2022 12:4	pared:
_			Title XVIII	Skilled Nursing Facility	PPS	p
					1. 00	
_		PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTI SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)	HER HEALTH SERVICES FOR T	ITLE XVIII PART A	PPS SNF	
-	1. 00	Resource Utilization Group Payment (RUGS)			975, 888	1.00
2	2. 00	Routine service other pass through costs			0	2. 00
3	3. 00	Ancillary service other pass through costs			0	3. 00
4	4. 00	Subtotal (sum of lines 1 through 3)			975, 888	4.00
		COMPUTATION OF NET COST OF COVERED SERVICES				
Ę	5. 00	Medical and other services (Do not use this line as vaccine Part B. This line is now shaded.)	costs are included in lin	e 1 of W/S E,		5. 00
6	5. 00	Deducti bl e			0	6, 00
-	7. 00	Coi nsurance			111, 671	7. 00
8	3. 00	Allowable bad debts (see instructions)			0	8. 00
Ç	9. 00	Reimbursable bad debts for dual eligible beneficiaries (see	instructions)		0	9. 00
•	10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00
•	11. 00	Utilization review			0	11. 00
		Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	10 and 11)(see instruction	ns)	864, 217	12.00
•		Inpatient primary payer payments			0	13. 00
		OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14. 00
		Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	14. 50
		Recovery of accelerated depreciation.			0	14. 98
		Demonstration payment adjustment amount before sequestration			0	1
		Subtotal (see instructions			864, 217	1
		Sequestration adjustment (see instructions)			0	15. 01

15.02 Demonstration payment adjustment amount after sequestration 15.75 Sequestration for non-claims based amounts (see instructions)

18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

16.00 Interim payments
17.00 Tentative settlement (for contractor use only)

0 15. 02 0 15. 75

864, 217 0

0 18.00 0 19.00

16. 00 17. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: Worksheet E-3 From 01/01/2021 Part VII To 12/31/2021 Date/Ti me Prepared:

			Γο 12/31/2021	Date/Time Pre 5/27/2022 12:	
		Title XIX	Hospi tal	Cost	17 piii
		THE ALX	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		625, 458		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		625, 458	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		625, 458	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		1, 158, 613		8. 00
9.00	Ancillary service charges		1, 143, 777	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 302, 390	0	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)	0.000000	0.000000	15 00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 2, 302, 390	0. 000000 0	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 676, 932	0	1
17.00	line 4) (see instructions)	/ IT Title 16 exceeds	1, 070, 932	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	/if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	, IT TIME I EXCEEDS TIME		Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		625, 458	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of				1
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	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		625, 458	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		625, 458	0	
32.00	Deducti bl es		0	0	
33. 00			0	0	
34.00	Allowable bad debts (see instructions)		0	0	
35. 00 36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	22)	4 DE 4 E O	0	35. 00 36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	625, 458	0	
	Subtotal (line 36 ± line 37)		625, 458	0	
	Direct graduate medical education payments (from Wkst. E-4)		025, 456	U	39.00
40. 00			625, 458	0	
41. 00	Interim payments		741, 198	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-115, 740	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	-113, 740	0	1
.5. 55	chapter 1, §115.2			O	.5. 55
			'		

RECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0104	Peri od: From 01/01/2021	Worksheet E-4	
EDICAL EDUCATION COSTS			To 12/31/2021	Date/Time Prep 5/27/2022 12:4	
	Title	XVIII	Hospi tal	PPS	
				1. 00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				0.00	1 1 0
On Unweighted resident FTE count for allopathic and osteopath ending on or before December 31, 1996.	nic programs for	cost reporti	ng periods	0. 00	1.0
Unweighted FTE resident cap add-on for new programs per 42		(1) (see instr	ructions)	0.00	2.0
On Amount of reduction to Direct GME cap under section 422 of Direct GME cap reduction amount under ACA §5503 in accorda		8 §413.79 (m).	(see	0. 00 0. 00	3. 0 3. 0
instructions for cost reporting periods straddling 7/1/201	11)	• •			
OD Adjustment (plus or minus) to the FTE cap for allopathic a GME affiliation agreement (42 CFR §413.75(b) and § 413.79		programs due	to a Medicare	0.00	4.0
O1 ACA Section 5503 increase to the Direct GME FTE Cap (see i		cost reporti	ng periods	0. 00	4. 0
straddling 7/1/2011) 02 ACA Section 5506 number of additional direct GME FTE cap s	slots (see inst	ructions for	cost reporting	0. 00	4.0
periods straddling 7/1/2011)	•				
OD FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 4.02 plus applicable subscripts	l plus or minus	line 4 plus l	ines 4.01 and	0. 00	5.0
00 Unweighted resident FTE count for allopathic and osteopath	nic programs for	the current	year from your	0. 00	6.0
records (see instructions) 00 Enter the lesser of line 5 or line 6				0. 00	7.0
CO Effect the resser of time of of time of		Primary Care		Total	7.0
00 Weighted FTE count for physicians in an allopathic and ost	teonathi c	1.00	2.00	3. 00	8. 0
program for the current year.	георатті с	0.0	0.00	0.00	0.0
OD If line 6 is less than 5 enter the amount from line 8, oth multiply line 8 times the result of line 5 divided by the 6.		0.0	0.00	0. 00	9. 0
0. D. 00 Weighted dental and podiatric resident FTE count for the c	current year		0.00		10.0
0.01 Unweighted dental and podiatric resident FTE count for the	e current year		0.00		10.0
1.00 Total weighted FTE count 2.00 Total weighted resident FTE count for the prior cost repor	rting year (see	0.0			11. 0 12. 0
instructions) 3.00 Total weighted resident FTE count for the penultimate cost	t reporting	0.0	0.00		13. 0
year (see instructions) 4.00 Rolling average FTE count (sum of lines 11 through 13 divi	ded by 3).	0.0	0. 00		14. 0
5.00 Adjustment for residents in initial years of new programs	,	0.0			15.0
5.01 Unweighted adjustment for residents in initial years of ne 6.00 Adjustment for residents displaced by program or hospital		0.0			15. 0 16. 0
6.01 Unweighted adjustment for residents displaced by program of nospital		0.0			16.0
closure		0.0	0.00		17.0
7.00 Adjusted rolling average FTE count 3.00 Per resident amount		0.0			17. 0 18. 0
9.00 Approved amount for resident costs		<u> </u>	0 0	0	19.0
				1. 00	
0.00 Additional unweighted allopathic and osteopathic direct GN	ME FTE resident	cap slots red	ceived under 42		20. 0
Sec. 413.79(c)(4) 1.00 Direct GME FTE unweighted resident count over cap (see ins	structions)			0.00	21.0
2.00 Allowable additional direct GME FTE Resident Count (see in				0.00	
3.00 Enter the locality adjustment national average per resider	nt amount (see i	nstructions)		0.00	
4.00 Multiply line 22 time line 23				0	
5.00 Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed Care	0 Total	25. 0
		1. 00	2. 00	3. 00	
COMPUTATION OF PROGRAM PATIENT LOAD					
6.00 Inpatient Days (see instructions) (Title XIX - see S-2 Par 3.02, column 2)	rt IX, line	4, 05			26. 0
		11, 88			27. 0
7.00 Total Inpatient Days (see instructions)					28.0
7.00 Total Inpatient Days (see instructions) 3.00 Ratio of inpatient days to total inpatient days		0. 34129		n	29 N
7.00 Total Inpatient Days (see instructions)		0.34129	0 0.180427	0	29. 0 29. 0
7.00 Total Inpatient Days (see instructions) 3.00 Ratio of inpatient days to total inpatient days 9.00 Program direct GME amount		0. 34129		0	29. (30. (

	Financial Systems WITHAM MEMORIAL			u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0104	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/27/2022 12:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	OI CAL	
32. 00	1	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
00.00	and 94)		74 104)	0	00.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	0	
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ 11ne 33)		0.000000	
	Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line	24 v Line 2E)		0	35. 00 36. 00
36.00	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII			U	36.00
	Part A Reasonable Cost	ONLT			<u> </u>
37. 00				11, 125, 027	37. 00
38. 00	1			11, 123, 027	38.00
	Cost of physicians' services in a teaching hospital (see inst			0	39.00
	Primary payer payments (see instructions)	. 401. 51.5)		0	40.00
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		11, 125, 027	
	Part B Reasonable Cost	· · · · · · · · · · · · · · · · · · ·		, , , ,	
42.00	Reasonable cost (see instructions)			14, 574, 121	42. 00
43.00	Primary payer payments (see instructions)			519	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			14, 573, 602	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			25, 698, 629	45. 00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line 45)		0. 432904	46. 00
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 567096	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			
	Total program GME payment (line 31)			0	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			0	
50. 00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		0	50.00

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

Provider CCN: 15-0104

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 12:47 pm

OH y)					5/27/2022 12:	47 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS	71 541 405	il o	0	0	1.00
2.00	Cash on hand in banks Temporary investments	71, 541, 405 2, 982, 347		_	-	
3.00	Notes recei vabl e	2, 702, 547			0	3.00
4. 00	Accounts recei vabl e	27, 527, 645	Ö	0	0	
5.00	Other recei vable	-404, 430	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	3, 632, 380	0	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	5, 130, 000		0	0	
10.00	Due from other funds	3, 130, 000		_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	110, 409, 347	1	_	•	11.00
	FI XED ASSETS	1 110/1101/011				
12.00	Land	0	0	0	0	12. 00
13. 00	Land improvements	5, 948, 844	1	_		13. 00
14. 00	Accumulated depreciation	0	0	0	1	14.00
15.00	Buildings	528, 467	0	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	0		0	0	16. 00 17. 00
18. 00	Accumulated depreciation			_	0	18.00
19. 00	Fi xed equipment	0	Ö	_	o o	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Maj or movable equipment	213, 365, 878		0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-103, 369, 062	0	0	0	24. 00 25. 00
26. 00	Accumulated depreciation			_	0	26.00
27. 00	HIT designated Assets	0	o o	0	l o	27. 00
28. 00	Accumul ated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	116, 474, 127	' 0	0	0	30. 00
21 00	OTHER ASSETS) 0	0		21 00
31. 00 32. 00	Investments Deposits on Leases	0		_	1	31. 00 32. 00
33. 00	Due from owners/officers			_	0	33.00
34. 00	Other assets	30, 773, 415	1	_	0	34. 00
35.00	Total other assets (sum of lines 31-34)	30, 773, 415		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	257, 656, 889	0	0	0	36. 00
	CURRENT LIABILITIES				1	
37. 00	Accounts payable	915, 112			_	37. 00
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	12, 072, 541	0	0	0	38. 00 39. 00
40. 00	Notes and Loans payable (short term)	71, 439		0	0	
41. 00	Deferred income	71,437		0	0	41.00
42. 00	Accel erated payments	0		_		42. 00
43.00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	27, 004, 566	1	_	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44)	40, 063, 658	0	0	0	45. 00
44 00	LONG TERM LIABILITIES	1 0	0	0	1 0	14 00
46. 00 47. 00	Mortgage payable Notes payable	12, 226			1	
48. 00	Unsecured Loans	12, 220				
49. 00	Other long term liabilities	27, 174, 000				49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27, 186, 226	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	67, 249, 884	. 0	0	0	51.00
	CAPITAL ACCOUNTS		,			
52. 00	General fund balance	190, 407, 005				52.00
53.00	Specific purpose fund Donor created - endowment fund balance - restricted		0			53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted			0	•	55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				Ö	58. 00
	repl acement, and expansi on		1			
59. 00	Total fund balances (sum of lines 52 thru 58)	190, 407, 005	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	257, 656, 889	0	0	0	60.00
	<i>∨′/</i>	I	I	I	I	I

Provider CCN: 15-0104

| Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

					То	12/31/2021	Date/Time Prep 5/27/2022 12:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	. , G
				·				
		1.00	0.00	2.00		4 00	F 00	
1 00	Trund halanan at hankankan as anni ad	1.00	2. 00 185, 784, 770	3. 00		4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		4, 622, 235			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)		190, 407, 005			0		3. 00
4.00	Additions (credit adjustments) (specify)	0	190, 407, 003		0	U	0	4. 00
5.00	Additions (credit adjustments) (specify)				0		0	5. 00
6.00		0			0		0	6. 00
7. 00		0			0		ő	7. 00
8. 00		o			Ō		ol	8. 00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		190, 407, 005			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15.00		0			0		0	15.00
16. 00		0			0		0	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		190, 407, 005			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Eridowiiicht Tana	TTUTTE	Tana				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9. 00 10. 00	Total additions (sum of line 4.0)		U		0			9. 00 10. 00
11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0		U			12. 00
13. 00	beddetrons (debrt day detinents) (specify)		0					13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00		1	O				İ	17. 00
18.00	Total deductions (sum of lines 12-17)	o			0			18. 00
19. 00	Fund balance at end of period per balance	o			0			19. 00
	sheet (line 11 minus line 18)	1					l	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0104

		Т	o 12/31/2021	Date/Time Pre 5/27/2022 12:	
	Cost Center Description	Inpati ent	Outpati ent	Total	, p
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	14, 592, 099		14, 592, 099	1. 00
2.00	SUBPROVI DER - I PF	2, 818, 665		2, 818, 665	2. 00
3.00	SUBPROVI DER - I RF	0		0	3. 00
4.00	SUBPROVI DER	0		0	
5.00	Swing bed - SNF	0		0	
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY	2, 122, 311		2, 122, 311	
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)	19, 533, 075		19, 533, 075	10. 00
44.00	Intensive Care Type Inpatient Hospital Services	7 040 004		7 040 004	144.00
11.00	INTENSIVE CARE UNIT	7, 840, 924		7, 840, 924	11.00
12. 00 13. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT				12. 00 13. 00
14. 00					14.00
15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				15. 00
	Total intensive care type inpatient hospital services (sum of lines	7, 840, 924		7, 840, 924	
10.00	11-15)	7, 040, 924		7, 040, 924	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	27, 373, 999		27, 373, 999	17. 00
18. 00	Ancillary services	70, 951, 559		492, 210, 398	
19. 00	Outpatient services	70, 731, 337	14, 165	14, 165	
	RURAL HEALTH CLINIC	0	14, 103	14, 103	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	
22. 00	HOME HEALTH AGENCY		Š	Ü	22. 00
23. 00	AMBULANCE SERVICES	1, 082	4, 211, 827	4, 212, 909	23. 00
24. 00	CMHC	.,	., , =	., ,	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER (SPECIFY)	0	0	0	27. 00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	98, 326, 640	425, 484, 831	523, 811, 471	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		165, 004, 168		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	T	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 deductions (sum of lines 37-41)				41. 00 42. 00
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		165, 004, 168		42.00
75.00	to Wkst. G-3, line 4)		100,004,100		13.00

Heal th	Financial Systems WITHAM MEMORIA	L HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0104	Peri od:	Worksheet G-3	
			From 01/01/2021	D . (T' D	
			To 12/31/2021	Date/Time Prep 5/27/2022 12:	
				3/21/2022 12.	47 pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		523, 811, 471	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			362, 240, 459	
3.00	Net patient revenues (line 1 minus line 2)			161, 571, 012	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	2 43)		165, 004, 168	ı
5. 00	Net income from service to patients (line 3 minus line 4)			-3, 433, 156	•
	OTHER I NCOME			57 1557 155	
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			Ö	ı
8.00	Revenues from telephone and other miscellaneous communication	on services		0	
9. 00	Revenue from television and radio service			0	ı
	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			o	11. 00
	Parking Lot receipts			o	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			o	15. 00
	Revenue from sale of medical and surgical supplies to other	than patients		o	16. 00
	Revenue from sale of drugs to other than patients	, , , , , , , , , , , , , , , , , , ,		o	17. 00
	Revenue from sale of medical records and abstracts			o	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21. 00
	Rental of hospital space			0	22. 00
	Governmental appropriations			o	23. 00
	OTHER OPERATING INCOME			5, 256, 705	1
	NON-OPERATING INCOME			1, 884, 104	l
	COVID-19 PHE Funding			34, 627	
	O Total athorization (a) of lines (24)				25 00

7, 175, 436 25. 00 3, 742, 280

-879, 955 27. 00 -879, 955 28. 00 4, 622, 235 29. 00

26.00

24. 50 COVID-19 PHE Funding
25. 00 Total other income (sum of lines 6-24)
26. 00 Total (line 5 plus line 25)
27. 00 INTEREST EXPENSE
28. 00 Total other expenses (sum of line 27 and subscripts)
29. 00 Net income (or loss) for the period (line 26 minus line 28)

111 41-	Financial Contant	AL HOCDITAL	1-1:-	6 F CMC /	2552 40
Health Financial Systems WITHAM MEMORIAL HOSPITAL CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0104			Peri od:	eu of Form CMS-2552-10 Worksheet L	
CALCULATION OF CAPITAL PAINENT		Provider CCN. 15-0104	From 01/01/2021	Parts I-III	
			To 12/31/2021	Date/Time Pre	pared:
				5/27/2022 12: 4	47 pm
Title XVIII Hospital				PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			442, 757	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			3, 735	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			27. 23	
4.00	Number of interns & residents (see instructions)			0.00	
5. 00				0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			0. 00	7. 00
0.00	30) (see instructions)			0.00	0.00
8.00				0.00	
9. 00 10. 00				0.00	10.00
11. 00	3. (3. (3. (3. (3. (3. (3. (3. (3. (3. (0.00	
12. 00				446, 492	
12.00	Total prospective capital payments (see Thati detroits)			440, 472	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions))		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	11			0.00	
5.00			0		
6.00	Percentage adjustment for extraordinary circumstances (see			0.00	
7.00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2 x	(line 6)	0	
8. 00 9. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as app	alicable)		0	
10.00	Current year comparison of capital minimum payment level to		Loss Lino O)		
11. 00	Carryover of accumulated capital minimum payment level over	1 1 3 1	,		
	Worksheet L, Part III, line 14)		•		
12.00	Net comparison of capital minimum payment level to capital			0	
13.00			0		
14. 00	Carryover of accumulated capital minimum payment level over	capital payment for the f	following period	0	14. 00
45.00	(if line 12 is negative, enter the amount on this line)			_	45.00
15. 00	Current year allowable operating and capital payment (see i			0	
16.00	,	1		0	
17.00	Current year exception offset amount (see instructions)			ا	17. 00