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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0104 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2023 4:58 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, "L" for low, or "N" for no. [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] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR 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 01/01/2022 and ending 12/31/2022 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	Geo	rge Pogas	Y	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	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
PART III	- SETTLEMENT SUMMARY						
1.00 HOSPITAL		0	208, 617	85, 052	0	-313, 949	1. 00
2.00 SUBPROVI	DER - IPF	0	6, 360	1, 347		0	2.00
3.00 SUBPROVI	DER - IRF	0	0	0		0	3. 00
4. 00 SUBPROVI	DER (OTHER)						4. 00
5.00 SWING BE	D - SNF	0	0	0		0	5. 00
6.00 SWING BE	D - NF	0				0	6. 00
7.00 SKILLED	NURSING FACILITY	0	1	-359		0	7. 00
200. 00 TOTAL		0	214, 978	86, 040	0	-313, 949	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFIC		Provi d	er CCN:		Peri od: From 01/01/ To 12/31/	′2022 ′2022	Workshe Part I Date/Ti 5/30/20	me Pre	pared:
	1.00 Hospital and Hospital Health Care Co	mplex Add	2.00 Iress:		3. 00			4. 00			
1.00	Street: 2605 N. LEBANON STREET	mpr on nac	P0 Box:								1.00
2.00	City: LEBANON		State: IN	Zi p Code			ty: BOONE	-			2. 00
		Comp	oonent Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Syst O, or		
				Number	Number	Type	Certified	V '	XVIII	XIX	
			1. 00	2.00	3. 00	4.00	5. 00	6. 00		8. 00	
0.00	Hospital and Hospital-Based Componen			450404	0,000		07/04/40//				
3. 00	Hospi tal	WITHAM MI HOSPITAL	EMORI AL	150104	26900	1	07/01/1966	N	P	0	3. 00
4. 00	Subprovi der - IPF	WI THAM HO		15S104	26900	4	01/01/2000	N	Р	N	4. 00
15. 00	Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis	WITHAM H	OSPITAL ECU	155832	26900		05/07/2015	N	Р	N	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	0ther						From:		To		19. 00
							1. 00		2. (		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	022	12/31	/2022	20. 00 21. 00
						4.00	0.00		0.4		-
	Inpatient PPS Information					1. 00	2.00		3. (	00	
22. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin	stment, i r yes or 412.106(c r yes or Ps, inclu column 1 g period	n accordance w "N" for no. Is s)(2)(Pickle am "N" for no. iding supplemen , "Y" for yes occurring prio	ith 42 CFR this endment tal UCPs, or "N" for r to Octob	for no er	Y	N Y				22. 00
22. 02	1. Enter in column 2, "Y" for yes or cost reporting period occurring on o instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reporting.	r after ( requires ? (see ir e portior column 2,	october 1. (see a final UCP t estructions) En of the cost r "Y" for yes o	o be ter in col eporting r "N" for	umn	N	N				22. 02
22. 03	for the portion of the cost reporting period on or after October 1.							22. 03			
22. 04	yes or "N" for no.  1. 04 Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)  Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.							22.04			
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admiss of identi method us	ion, 2 if cens fying the days ed in the prio	us days, c in this c r cost	r 3		3 N				23. 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4:58 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on 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 adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 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 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) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 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) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 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 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

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)

63.00

Health Finan	cial Systems	WI THAM	MEMORIAL HOSPITA	I	In lie	eu of Form CMS-2	2552-10
	O HOSPITAL HEALTH CARE COMPL				Peri od:	Worksheet S-2	
					From 01/01/2022 To 12/31/2022		pared: 8 pm
			·	Unwei ghted	Unwei ghted	Ratio (col. 1/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				Si te	2.00	2.00	
Section	on 5504 of the ACA Base Yea	r FTF Residents in No	onnrovider Settin	1.00	2.00	3.00	
peri o	d that begins on or after J	uly 1, 2009 and befor	re June 30, 2010.				
in the	in column 1, if line 63 is e base year period, the num ent FTEs attributable to ro	ber of unweighted nor tations occurring in	n-primary care all nonprovider		0. 00	0. 000000	64. 00
	ngs. Enter in column 2 the ent FTEs that trained in yo						
	olumn 1 divided by (column						
		Program Name	Program Code		Unwei ghted	Ratio (col. 3/	
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1.00	2.00	3. 00	4.00	5. 00	
65.00 Enter	in column 1, if line 63	1.00	2.00	0.0			65. 00
is yestraine year passocient feet of the programm unweignon-procolum unweigneside your 15, the divide	In column 1, ITTINE 63 s, or your facility ed residents in the base period, the program name iated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code. Enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in hospital. Enter in column e ratio of (column 3 ed by (column 3 + column (see instructions)			Unwei ghted	Unwei ghted FTEs in	Ratio (col. 1/ (col. 1 + col.	65.00
				Nonprovi der		2))	
				Si te		,,	
				1. 00	2.00	3. 00	
	on 5504 of the ACA Current		n Nonprovider Set	tingsEffective	for cost reporti	ng peri ods	
	<u>ning on or after July 1, 20</u> in column 1 the number of		n, cono nocidont	0.0	0. 00	0. 000000	// 00
FTEs a Enter FTEs	attributable to rotations o in column 2 the number of that trained in your hospit mn 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0. 0	0. 00	0.000000	00.00
(22. 0.		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
				FTEs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1. 00	2.00	Si te 3. 00	4.00	5. 00	
67.00 Enter	in column 1, the program	1.00	2.00	0. (			67 00
name a your p which Enter code. numbed care b to romon-po column unweig reside your l 5, the	associated with each of primary care programs in you trained residents. in column 2, the program Enter in column 3, the rof unweighted primary FTE residents attributable tations occurring in all rovider settings. Enter in 4, the number of ghted primary care ent FTEs that trained in hospital. Enter in column e ratio of (column 3 ed by (column 3 + column (see instructions)						

Health Financial Systems WITHAM MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPITAL Provider CCN: 1		eriod: rom 01/01/202		2 epared:
				1.00	
68.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 For a cost reporting period beginning prior to October 1, 2022 MAC to apply the new DGME formula in accordance with the FY 20 (August 10, 2022)?	2, did you obtair	permissio	n from your	N	68. 00
			1.	00 2.00 3.00	
Inpatient Psychiatric Facility PPS		- LDE		,	70.00
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or one Enter "Y" for yes or "N" for no.  71.00 If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began (see instructions)  Inpatient Rehabilitation Facility PPS	d GME teaching pr er "Y" for yes or n residents in a er "Y" for yes or	rogram in t "N" for r new teach	the most inc. (see in ing.	Y N N O	70.00
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF),	or does it contai	n an IRF	1	V	75. 00
subprovider? Enter "Y" for yes and "N" for no.  76.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting)	2004? Enter "Y" ning program in a Column 3: If colu	for yes or accordance umn 2 is Y,	"N" for with 42	0	76. 00
				1.00	
Long Term Care Hospital PPS  80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a  81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.		reporting	period? Enter	- N N	80. 00 81. 00
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00 Did this facility establish a new Other subprovider (excluded				N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	,			N	87. 00
			Approved for Permanent Adjustment (Y/N)	Approved Permanent Adjustments	
88.00 Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions)  Column 2: Enter the number of approved permanent adjustments.	t to the TEFRA ta complete col. 2	arget 2 and line	1.00	2.00	0 88.00
		t. A Line No.	Effective Da	Permanent Adjustment Amount Per Discharge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A lin	ne number	1.00	2.00	3. 00	0 89.00
on which the per discharge permanent adjustment approval was I Column 2: Enter the effective date (i.e., the cost reporting peginning date) for the permanent adjustment to the TEFRA target per discharge.  Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	pased. period get amount	0.00			5, 57, 00
The first can got amount por an solitar go.			V	XI X	
Title V and XIX Services			1. 00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital	services? Enter	"Y" for	N	Y	90.00
yes or "N" for no in the applicable column.  91.00 Is this hospital reimbursed for title V and/or XIX through the		her in	N	Y	91. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certi fi cati on)?	'(see		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, an applicable column.		the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.		the	0. 00 N	0. 00 N	95. 00 96. 00
97.00   If line 96 is "Y", enter the reduction percentage in the appli	cable column.		0. 00	0.00	97. 00

117. 00

118. 00

"N" for no.

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-0104		/01/2022 /31/2022	Worksheet S- Part I Date/Time Pr 5/30/2023 4:	epared:
						1.00	
147.00 Was there a change in the statist	cal hasis? Enter "V" for	ves or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of						N N	148. 00
149.00 Was there a change to the simplif				or no.		N	149. 00
	<u> </u>	Part A	Part B		tle V	Title XIX	
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
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 - IRF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158. 00
159. 00 SNF		N	N N		N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
TOT. OUICINING			I IV		IN	IN	161.00
						1.00	
Multicampus			: :: 6:	6 CDC	· A = O	N.	1,15 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has on	e or more campu	uses in dit	rerent CBS	AS?	N	165. 00
Enter 1 For yes of 14 For he.	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 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						O. C	00 166. 00
						1.00	_
Health Information Technology (HI	T) incentive in the Americ	can Recovery and	d Reinvestm	ent Act		1.00	
167. 00 Is this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a meanin	gful user (line		"), enter	the		168. 00
reasonable cost incurred for the last 168.01 If this provider is a CAH and is			a avalific f	on o bonde	da i n		140.01
exception under §413.70(a)(6)(ii)					и р		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and				iter the	9. 9	99169.00
transition factor. (see instruction	ons)			Beg	i nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporti ng				170. 00
					1.00	2.00	
171.00 If line 167 is "Y", does this pro-	vider have any days for in	di vi dual s encol	led in		I. 00 N	2. 00	0 171. 00
section 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (:	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter	i on	IV		0171.00

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0104 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/30/2023 4:58 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 07/01/2022 07/01/2022 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS	-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S- Part II Date/Time Pr 5/30/2023 4:	epared:	
		Descri	pti on	Y/N	Y/N	JO 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		
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21. 00	
	records? If yes, see instructions.						
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)				
22.00	Capital Related Cost	Instructions		1		22. 00	
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost		23. 00	
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	porting period?		24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	e cost reporti	ng period? I	f yes, see		26. 00	
27. 00	.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.						
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	tered into dur	ing the cost	reporting		28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)		29. 00	
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matu	rity with new	debt? If yes	, see		30. 00	
31. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	, see		31. 00	
32. 00	Purchased Services  Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru-		d through co	ntractual		32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	lied pertainin	g to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34. 00	Were services furnished at the provider facility under an a If yes, see instructions.	rrangement wit	h provider-b	ased physicians?		34.00	
35. 00	If line 34 is yes, were there new agreements or amended exi- physicians during the cost reporting period? If yes, see in		ts with the	provi der-based		35. 00	
				Y/N	Date		
	Home Office Costs			1. 00	2. 00		
36 00	Home Office Costs Were home office costs claimed on the cost report?					36.00	
	If line 36 is yes, has a home office cost statement been pro	epared by the	home office?			37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					38. 00	
39. 00	If line 36 is yes, did the provider render services to othe see instructions.			,		39. 00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00	
		1.	00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TI NA		SEVERS		41. 00	
42. 00		BLUE & CO., LL	С			42. 00	
43. 00		317-713-7946		TSEVERS@BLUEANI	DCO. COM	43. 00	

Heal th	Financial Systems WITHAM MEMOI	RIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Peri od: From 01/01/2022	Worksheet S-2 Part II	
			To 12/31/2022		pared: 8 pm
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER			41. 00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				
43. 00	Enter the telephone number and email address of the cost				43. 00

| Period: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: 
 Heal th Financial
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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0104

					To	12/31/2022		
							5/30/2023 4:58 I/P Days / 0/P	5 PIII
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		34	12, 498	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 I RF Subprovi der							4. 00 5. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			34	12, 498	0.00	-	7. 00
7.00	beds) (see instructions)			34	12, 498	0.00	U	7.00
8. 00	INTENSIVE CARE UNIT	31. 00		16	5, 840	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00		10	3, 040	0.00	O	9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			50	18, 338	0.00	0	14.00
15.00	CAH visits				·		0	15.00
16.00	SUBPROVI DER - I PF	40. 00		10	3, 562		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00		0	0		0	17.00
18.00	SUBPROVI DER	42. 00		0	0		0	18.00
19. 00	SKILLED NURSING FACILITY	44. 00		18	6, 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	00.00						24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC							25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 00 26. 25
27. 00	Total (sum of lines 14-26)	69.00		78			U	27. 00
28. 00	Observation Bed Days			70			0	28. 00
29. 00	Ambulance Trips							29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	0			32. 00
32. 01	Total ancillary labor & delivery room			٦	Ĭ			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days			j				33.00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		0	34.00

| Period: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:58 pm

					-	5/30/2023 4:5	8 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 285	248	7, 134			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, 410	1, 702				2. 00
3. 00	HMO I PF Subprovi der	650	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	Ü			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	0.005	0	7 404			6.00
7. 00	Total Adults and Peds. (exclude observation	2, 285	248	7, 134			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	710	0	2, 473			8. 00
9. 00	CORONARY CARE UNIT	710	٩	2,4/3			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00							12. 00
13. 00	NURSERY		0	0			13. 00
14. 00	1	2, 995	248	9, 607	0.00	778. 20	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - IPF	1, 172	o	2, 065	0.00	0.00	
17.00	SUBPROVIDER - IRF	0	o	C	0.00	0.00	17. 00
18. 00	SUBPROVI DER		o	C	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY	2, 172	o	4, 085	0.00	0.00	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)			15			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	_	_	_			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		<b>l</b>	
27. 00	,			0.54/	0.00	778. 20	1
28. 00	Observation Bed Days	1 120	O	2, 546			28. 00
29. 00	The state of the s	1, 139		100			29. 00
30.00	Employee discount days (see instruction)			103 0			30.00
31.00	Employee discount days - IRF Labor & delivery days (see instructions)	0	89	142			31. 00 32. 00
32. 00 32. 01	Total ancillary labor & delivery room	١	89	142			32.00
32.01	outpatient days (see instructions)			U			32.01
33 00	LTCH non-covered days	0					33. 00
33. 01	,	0					33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	o	o	C			34. 00
2 30	The state of the s	١	٩١	· ·	I	ı	

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: 
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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0104

				To	12/31/2022	Date/Time Pre 5/30/2023 4:5	
		Full Time		Di sch	arges	7 307 2023 4. 3	Э рііі
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	679	40	2, 135	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)			474	414		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO I RF Subprovi der				O		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0		40	0.405	13.00
14.00	Total (see instructions)	0. 00	0	679	40	2, 135	14. 00
15.00	CAH visits	0.00	•	404		000	15.00
16.00	SUBPROVI DER - I PF	0.00	0	· ·	0	208	16.00
17. 00	SUBPROVIDER - I RF	0.00	0	0	0	0	17. 00
18.00	SUBPROVI DER	0.00	Ü	1	U	0	18.00
19.00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE			•			21. 00 22. 00
22. 00	HOME HEALTH AGENCY						23. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23.00
24. 00							
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
26. 00							26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 00
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	1						30.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00 32. 01
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33. 00
33. 00	LTCH site neutral days and discharges						33. 00
	Temporary Expansi on COVID-19 PHE Acute Care						34. 00
57.00	Tromporary Expansion Covid Traine Acute Care	I I		1			57.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0104

					To	12/31/2022	Date/Time Pre 5/30/2023 4:5	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
			Nopel tea	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
		1. 00	2.00	A-6) 3.00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	70, 656, 281	0	70, 656, 281	1, 163, 546. 00	60. 72	1.00
2. 00	instructions) Non-physician anesthetist Part					0.00		2.00
	A							
3. 00	Non-physician anesthetist Part		(		-	0.00		
4. 00	Physician-Part A - Administrative		C	0	0	0. 00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0	0	0	0. 00 0. 00	l .	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		C	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	972, 847 36, 543, 151			·	l .	
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract Labor: Direct Patient Care		7, 932, 305	0	7, 932, 305	82, 489. 00	96. 16	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	0	0	0.00	0. 00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		C	0	0	0.00	0.00	13. 00
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		C	О	0	0.00	0.00	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0	0	0. 00 0. 00	l .	1
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0. 00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		14, 535, 196	0	14, 535, 196			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		6, 731, 397	0	6, 731, 397 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21.00
22. 00	B Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		C	_	0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		(		0			25. 00
25. 50	Home office wage-related (core)		(		0			25. 50
25. 51	Related organization wage-related (core)		C		0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

					Т	o 12/31/2022	Date/Time Prep 5/30/2023 4:58	
		Wkst. A Line	Amount	Recl assi 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)							
	OVERHEAD COSTS - DI RECT SALARI E		2/1 225			10.010.00	, 50	
26. 00	Employee Benefits Department	4. 00	361, 335			· ·		
27. 00	Administrative & General	5. 00	7, 521, 048		7, 521, 048	i i		
28. 00	Administrative & General under		2, 589, 469	0	2, 589, 469	32, 964. 00	78. 55	28. 00
00.00	contract (see inst.)	, 00				0.00	0.00	00.00
29. 00	Maintenance & Repairs	6. 00	74 745	0	700 040	0.00		29. 00
30.00	Operation of Plant	7. 00	716, 715			i i		
31.00	Laundry & Linen Service	8. 00	46, 604		46, 604	i i		
32.00	Housekeepi ng	9. 00	522, 599	0	522, 599			
33. 00	Housekeeping under contract (see instructions)		0	0	0	0.00	0. 00	33. 00
34.00	Di etary	10. 00	883, 383	-464, 514	418, 869	54, 888. 00	7. 63	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	470, 691	470, 691	20, 639. 00	22. 81	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	551, 108	0	551, 108	32, 650. 00	16. 88	38. 00
39.00	Central Services and Supply	14. 00	0	0	0	0.00	0.00	39. 00
40.00	Pharmacy	15. 00	632, 839	0	632, 839	6, 033. 00	104. 90	40.00
41.00	Medical Records & Medical	16. 00	1, 166, 535	3, 501	1, 170, 036	41, 398. 00	28. 26	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared:

					'	0 12/31/2022	5/30/2023 4:58	
		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		73, 245, 750	0	73, 245, 750	1, 196, 510. 00	61. 22	1.00
	instructions)							
2.00	Excluded area salaries (see		37, 515, 998	9, 294	37, 525, 292	564, 742. 00	66. 45	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		35, 729, 752	-9, 294	35, 720, 458	631, 768. 00	56. 54	3.00
	minus line 2)							
4.00	Subtotal other wages & related		7, 932, 305	0	7, 932, 305	82, 489. 00	96. 16	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		14, 535, 196	0	14, 535, 196	0.00	40. 69	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		58, 197, 253	-9, 294	58, 187, 959	714, 257. 00	81. 47	6. 00
7.00	Total overhead cost (see		14, 991, 635	-68, 506	14, 923, 129	544, 436. 00	27. 41	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	Period: Worksheet S-3 From 01/01/2022 Part IV
		To 12/31/2022 Part TV

	To 12/31/20	022 Date/Time Pre 5/30/2023 4:5	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 225, 863	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)	8, 817, 833	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 994, 989	9. 00
10.00	Dental, Hearing and Vision Plan	397, 378	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	80, 067	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)	228, 081	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	666, 980	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	.   0	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	4, 563, 677	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	291, 725	19. 00
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. (s	see 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00		0	20.00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 266, 593	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Pre 5/30/2023 4:5	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				

			07 007 2020 11 0	0 0
	Cost Center Description	Contract Labor	Benefit Cost	
		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	7, 932, 305	21, 266, 593	1. 00
2.00	Hospi tal	7, 932, 305	21, 266, 593	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	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			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 FOHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17.00	RENAL DIALYSIS I			17. 00
18. 00	Other	0	0	18. 00

	Financial Systems WITHAM MEMORIAL HOSE			u of Form CMS-2				
JSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	vider CCN: 15-0104	Peri od: From 01/01/2022	Worksheet S-10	0			
			To 12/31/2022	Date/Time Pre	pared			
				5/30/2023 4:5	8 pm			
				1. 00				
	Uncompensated and indigent care cost computation		2)	0.0404/5				
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 colum	nn 8)	0. 213165	1.0			
00	Medicaid (see instructions for each line) Net revenue from Medicaid			-1, 155, 372	2.0			
00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. 0			
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medic	cai d?	N	4. (			
00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d		1, 724, 304	5. (			
00	Medi cai d charges			59, 697, 546				
00	Medicaid cost (line 1 times line 6)	aa 7 minua aum af li	noo 2 and E. if	12, 725, 427				
00	Difference between net revenue and costs for Medicaid program (line < zero then enter zero)	ne / minus sum of ii	nes 2 and 5; IT	12, 156, 495	8.0			
	Children's Health Insurance Program (CHIP) (see instructions for $\epsilon$	each line)			İ			
00	Net revenue from stand-alone CHIP	,		0	9. (			
	Stand-alone CHIP charges			0				
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	1			
2. 00	Difference between net revenue and costs for stand-alone CHIP (linenter zero)	ne 11 minus line 9;	if < zero then	0	12. (			
	Other state or local government indigent care program (see instruc	ctions for each line	;)					
3. 00	Net revenue from state or local indigent care program (Not include			0	13.			
4. 00	Charges for patients covered under state or local indigent care processing the control of the co	rogram (Not included	lin lines 6 or	0	14.			
	10)							
5. 00	State or local indigent care program cost (line 1 times line 14)	(1:	15 1:	0				
5. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	ent care program (11	ne 15 minus iine	U	16.			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/local indi	gent care program	ns (see				
	instructions for each line)			·				
	Private grants, donations, or endowment income restricted to fund				17.			
3. 00 9. 00	Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and Local in		ns (sum of lines	0 12, 156, 495				
7. 00	8, 12 and 16)	idi gerit care program	is (suii or rrites	12, 130, 473	17.			
		Uni nsured	Insured	Total (col. 1				
		pati ents		+ col . 2)				
	Uncomponented Cara (see instructions for each line)	1.00	2. 00	3. 00				
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ty 4, 939, 7	733 0	4, 939, 733	20 (			
3. 00	(see instructions)	1,707,		1,707,700				
1. 00	Cost of patients approved for charity care and uninsured discounts	s (see 1,052,9	978 0	1, 052, 978	21.			
	instructions)				00			
2. 00	Payments received from patients for amounts previously written of charity care	r as	0 0	0	22.			
3. 00	Cost of charity care (line 21 minus line 22)	1, 052, 9	978 0	1, 052, 978	23 (			
3. 00	sost of sharry sairs (fills 21 minus fills 22)	1,002,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1,002,770				
				1.00				
4. 00	Does the amount on line 20 column 2, include charges for patient of		n of stay limit	N	24. (			
5. 00	imposed on patients covered by Medicaid or other indigent care pro- If line 24 is yes, enter the charges for patient days beyond the		am's length of	0	25. (			
5. 00	stay limit Total bad debt expense for the entire hospital complex (see instr	ictions)		9, 103, 287	26.			
J. UU					1			
7. 00								
7. 00 7. 01								
	Non-Medicare bad debt expense (see instructions) 8,943,361 28.0							
7. 01 3. 00 9. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expens	se (see instructions	s)	1, 962, 386	29.			
7. 01 8. 00 9. 00 0. 00	Non-Medicare bad debt expense (see instructions)	·	s)		29. 30.			

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC		Period: From 01/01/2022 To 12/31/2022		
	Cost Center Description	Sal ari es	Other	Total (col. + col. 2)	Reclassificati ons (See A-6)	5/30/2023 4:5  Reclassified  Trial Balance  (col. 3 +-  col. 4)	8 piii
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		4, 701, 707	4, 701, 70			1. 00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 4, 599, 064	4, 599, 064	2.00
3. 00 4. 00	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	361, 335	16, 744, 801	17, 106, 13	6 492, 053	0 17, 598, 189	3. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	7, 521, 048	22, 980, 927	30, 501, 97			
7. 00	00700 OPERATION OF PLANT	716, 715	3, 227, 813				
8.00	00800 LAUNDRY & LINEN SERVICE	46, 604	595, 490			641, 533	
9.00	00900 HOUSEKEEPI NG	522, 599	324, 204			844, 426	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	883, 383	1, 399, 330	2, 282, 71	3 -854, 913 0 833, 092	1, 427, 800 833, 092	
13. 00	01300 NURSI NG ADMI NI STRATI ON	551, 108	79, 743	630, 85			1
15. 00	01500 PHARMACY	632, 839	9, 804, 189			'	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 166, 535	427, 245	1, 593, 78	0 -145	1, 593, 635	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	3, 540, 099	2, 918, 734	6, 458, 83	3 -365, 033	6, 093, 800	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 639, 095	1, 533, 135			2, 953, 876	1
40. 00	04000 SUBPROVI DER – I PF	1, 155, 264	138, 906			1, 262, 968	1
41. 00	04100 SUBPROVI DER - I RF	0	0		0 0	0	41. 00
42. 00	04200 SUBPROVI DER	0	0		0	0	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	972, 847	650, 590	1, 623, 43	7 -86, 668	1, 536, 769	43. 00 44. 00
44.00	ANCI LLARY SERVI CE COST CENTERS	772,041	030, 370	1, 023, 43	7 00,000	1, 550, 767	1 44.00
50.00	05000 OPERATING ROOM	2, 380, 164	6, 713, 457	9, 093, 62	1 -3, 485, 697	5, 607, 924	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 657, 876	4, 032, 330				1
55. 00 55. 01	05500   RADI OLOGY-THERAPEUTI C   05501   ULTRA SOUND	0 197, 878	968, 670	1, 166, 54	0 8 -138, 905	0 1, 027, 643	
57. 00	05700 CT SCAN	226, 671	837, 905	1, 166, 54		1, 000, 871	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	315, 019	373, 994	689, 01		671, 699	
59. 00	05900 CARDI AC CATHETERI ZATI ON	396, 837	1, 514, 835	1, 911, 67	2 -853, 075		
60.00	06000 LABORATORY	3, 326, 700	4, 858, 121	8, 184, 82			
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	282, 447 0	282, 44	7 -907	281, 540 0	1
66. 00	06600 PHYSI CAL THERAPY	1, 489, 163	180, 053	1, 669, 21	6 -7, 651	1, 661, 565	
67. 00	06700 OCCUPATI ONAL THERAPY	492, 973	43, 743			536, 499	
67. 01	06701 AUDI OLOGY	222, 889	180, 407	403, 29		383, 732	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	166, 168	13, 895	180, 06	3 0	180, 063 0	68. 00 69. 00
69. 01	06901 CARDI OLOGY	1, 488, 109	1, 010, 285	2, 498, 39	4 -509, 763		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-214, 807	-214, 80			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 1, 471, 589		
73. 00	O7300 DRUGS CHARGED TO PATIENTS   OUTPATIENT SERVICE COST CENTERS	0	0		0 8, 897, 070	8, 897, 070	73.00
90. 00	09000 CLINIC	0	0		0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	100, 869	13, 373	114, 24	2 -6, 819		1
90. 02	09002 CLI NI C	0	0		0 0	0	90. 02
90. 03 90. 04	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	3, 004	3, 00 77		3, 004	
90.04	09005 SURGERY CLINIC	0	772 1, 879	1, 87		10 1, 488	
90. 07	09007 UROLOGY CLINIC	52, 750	4, 229			56, 668	1
90. 09	09009 GASTROENTEROLOGY CLINIC	311	7, 425				
90. 11	09011 NEUROLOGY CLINIC	0	126, 185	126, 18		126, 185	
90. 12 90. 13	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	77, 623	12, 835 22, 552	12, 83 100, 17		6, 809 100, 534	
	09014 WOUND CARE	265, 419	437, 491	702, 91		644, 268	
91. 00	09100 EMERGENCY	2, 701, 504	5, 442, 988	8, 144, 49	2 -481, 372	7, 663, 120	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS  O9500 AMBULANCE SERVICES	2, 501, 982	495, 008	2, 996, 99	0 -107, 232	2, 889, 758	95. 00
75. 00	SPECIAL PURPOSE COST CENTERS	2,301,702	475, 000	2, 770, 77	107, 232	2,007,730	75.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	37, 770, 376	92, 889, 890	130, 660, 26	6 359, 886	131, 020, 152	118. 00
100.00	NONREI MBURSABLE COST CENTERS	ما	6		0 0	^	100.00
	1900  GIFT, FLOWER, COFFEE SHOP, & CANTEEN     1920  PHYSICIANS' PRIVATE OFFICES	0 32, 560, 333	0 11, 042, 811		0 4 -358, 891	0 43, 244, 253	190.00
	07950 THORNTOWN OFFICE BUILDING	0	0	.5, 555, 14	0 0		194. 00
194. 01	07951 CAFE/BOUTI QUE	27, 255	36, 380			63, 199	194. 01
	07952 OTHER NONREI MB	0	57, 446				194. 02
194. 03 200. 00	TOTAL (SUM OF LINES 118 through 199)	298, 317 70, 656, 281	2, 264, 784 106, 291, 311				
200.00	1.5 (55 5. 2E5 116 till 60gil 177)	. 5, 550, 201	. 55, 271, 511	, , , , , , , , , , ,	-,	1, , , , , , , , , , , , , , , , ,	1-00.00

Peri od: From 01/01/2022 To 12/31/2022

Worksheet A Date/Time Prepared: 5/30/2023 4:58 pm

			5/30/2023 4:5	8 pm
Cost Center Description		Net Expenses For Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-35, 418	4, 748, 447		1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	ol	4, 599, 064		2. 00
3.00 00300 OTHER CAPITAL RELATED COSTS	ol	0		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 064, 208	11, 533, 981		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-11, 583, 699	16, 545, 046		5. 00
7. 00 00700 OPERATION OF PLANT	-29, 587	3, 763, 052		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	641, 533		8. 00
9. 00   00900   HOUSEKEEPI NG	0	844, 426		9. 00
10. 00   01000   DI ETARY	-361, 035	1, 066, 765		10. 00
11. 00 01100 CAFETERI A	0	833, 092		11. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON		630, 062		13. 00
15. 00   O1500   NORSTING ADMINISTRATION 15. 00   O1500   PHARMACY	-71, 360	1, 402, 053		15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY				16. 00
	-1, 670	1, 591, 965		16.00
I NPATIENT ROUTI NE SERVI CE COST CENTERS	ما	4 002 000		30.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	0	6, 093, 800		
	0	2, 953, 876		31.00
40. 00   04000   SUBPROVI DER -   I PF	0	1, 262, 968		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	1 504 749		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	1, 536, 769		44. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	-4, 131	5, 603, 793		50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-2, 288	5, 240, 655		54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0		55. 00
55. 01   05501   ULTRA SOUND	0	1, 027, 643		55. 01
57.00  05700   CT   SCAN	0	1, 000, 871		57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	671, 699		58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	-6, 250	1, 052, 347		59. 00
60. 00   06000   LABORATORY	-158, 100	7, 770, 345		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	281, 540		63.00
64.00 06400 INTRAVENOUS THERAPY	O	0		64.00
66. 00   06600 PHYSI CAL THERAPY	O	1, 661, 565		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	536, 499		67. 00
67. 01   06701 AUDI OLOGY	-86, 003	297, 729		67. 01
68. 00 06800 SPEECH PATHOLOGY	o	180, 063		68. 00
69. 00 06900 ELECTROCARDI OLOGY	ol	0		69. 00
69. 01   06901 CARDI OLOGY	ol.	1, 988, 631		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	3, 280, 650		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	ol	1, 471, 589		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	8, 897, 070		73. 00
OUTPATIENT SERVICE COST CENTERS	<u>ا</u>	0,077,070		70.00
90. 00 09000 CLINIC	0	0		90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	l ol	107, 423		90. 01
90. 02   09002   CLI NI C	o o	0		90. 02
90. 03   09003   DERMATOLOGY CLINIC	-3, 004	o		90. 02
90. 04   09004 ENT CLINIC	-3,004	10		90. 04
90. 05   09005   SURGERY CLINIC	-1, 488	10		90.04
		24 042		
90. 07   09007   UROLOGY CLINIC 90. 09   09009   GASTROENTEROLOGY CLINIC	-21, 805 -7, 548	34, 863		90. 07 90. 09
90. 11   09011   NEUROLOGY   CLINIC	1	12/ 105		90. 09
	0	126, 185		90. 11
90. 12   09012   0PTHAMOLOGY CLINIC	-6, 809	100 534		
90. 13   09013   ALLERGY CLINIC	[ 0	100, 534		90. 13
90. 14   09014   WOUND CARE	-51	644, 217		90. 14
91. 00   09100   EMERGENCY	-2, 602, 200	5, 060, 920		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS		0.005 ==-		05.55
95. 00 09500 AMBULANCE SERVI CES	-9, 000	2, 880, 758		95. 00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-21, 055, 654	109, 964, 498		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	43, 244, 253		192. 00
194.00 07950 THORNTOWN OFFICE BUILDING	0	0		194. 00
194. 01 07951 CAFE/BOUTI QUE	O	63, 199		194. 01
194.02 07952 OTHER NONREIMB	O	56, 887		194. 02
194.03 07953 RETAIL PHARMACY	o	2, 563, 101		194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-21, 055, 654	155, 891, 938		200. 00
	·	'		

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 4:58 pm Provider CCN: 15-0104

					5/30/2023 4: 58	pm
		Increases				
	Cost Center	Li ne #	Salary	Other 5.00		
	2.00	3. 00	4.00	5. 00		
1. 00	A - INSURANCE RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	262, 329		1. 00
1.00	FIXT	1.00	U	202, 329		1.00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	o	580, 732		2. 00
2.00	TOTALS			843, 061		2.00
	B - CAFETERIA RECLASS					
1.00	CAFETERI A	11.00	470, 691	362, 401		1.00
	TOTALS		470, 691	362, 401		
	C - MME DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	4, 599, 064		1.00
	EQUI P					
2.00		0. 00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0. 00 0. 00	0	0		7. 00
8. 00 9. 00		0.00	0	0		8.00
10. 00	1	0.00	0	0		9. 00 10. 00
11. 00		0.00	0	0	•	11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0	•	15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	Ö		17. 00
18. 00		0.00	O	0		18. 00
19.00		0.00	O	0		19. 00
20.00		0.00	O	0		20.00
21.00		0.00	О	0		21. 00
22.00		0.00	О	0		22. 00
23.00		0.00	О	0		23. 00
24.00		0.00	O	0		24.00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0	4	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 38. 00		0. 00 0. 00	0	0		37. 00 38. 00
39. 00	1	0.00	0	0	· ·	39. 00
40. 00		0.00	0	0		40. 00
40.00	TOTALS — — — —			4, 599, 064	'	7U. UU
	D - DRUGS RECLASS		<u> </u>	7, 377, 004		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	8, 938, 451		1. 00
- <del>-</del>	TOTALS			8, 938, 451		- =
	E - IMPLANTABLES RECLASS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	1, 471, 589		1.00
	PATI ENT					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00	F	0.00	•	0		7. 00
	TOTALS	EC DECLACE	0	1, 471, 589		
1 00	F - CHARGEABLE MEDICAL SUPPLI		<u></u>	2 510 500		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 518, 502		1. 00
2. 00	PATI ENTS	0. 00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
4. 00 5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	o	0		8. 00
	1	0.00	٦١	٥,		

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm Provider CCN: 15-0104

						5/30/2023	4:58 pm
			Increases				
9.00 10.00 1		Cost Center	Li ne #	Sal ary	0ther		
10. 00   0. 00   0. 00   0. 00   0. 00   11. 00   12. 00   12. 00   13. 00   14. 00   0. 00   0. 00   0. 00   0. 00   14. 00   14. 00   15. 00   0. 00   0. 00   0. 00   0. 00   15. 00   16. 00   16. 00   16. 00   16. 00   17. 00   0. 00   0. 00   0. 00   18. 00   18. 00   18. 00   19. 00   0. 00   0. 00   0. 00   18. 00   18. 00   19. 00   0. 00   0. 00   0. 00   0. 00   18. 00   19. 00   0. 0		2. 00		4. 00			
11. 00   0.00   0.00   0.00   0.00   12. 00   13. 00   14. 00   14. 00   15. 00   0.00   0.00   0.00   0.00   0.00   14. 00   15. 00   16. 00   16. 00   17. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19. 00   0.00   0.00   0.00   0.00   19. 00				0	-		
12.00 13.00 14.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 19.00 19.00 19.00 19.00 20.00 20.00 21.00 22.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.00 27.00 28.00 26.00 27.00 28.00 28.00 29.00 20.00	10.00		0.00	0			10.00
13. 00	11. 00		0.00	0			11. 00
14 00   0 0 0 0 0 0 0 0 0 15 00 16 00 16 00 16 00 16 00 16 00 17 00 16 00 0 0 0 0 0 0 0 0 0 17 00 18 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00			0			12. 00
15. 00				0	-		4
16. 00     16. 00     16. 00     16. 00     17. 00     18. 00     19. 00				0			
17. 00	15.00			0			15. 00
18. 00     18. 00     0   0   0   0   0   0   0   18. 00   20. 00   20. 00   21. 00   22. 00   0. 00   0. 00   0. 00   0. 00   0. 00   22. 00   2				- 1			4
19, 00   0, 00   0, 00   0   0   0   0   0				-1			4
20. 00     0. 00   0				-1			4
21.00							
22.00				- 1			
23.00				- 1			
24. 00				- 1			
25. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 34. 00  TOTALS    TOTALS				- 1			1
26. 00 27. 00 27. 00 27. 00 28. 00 0				-			
27.00 28.00 28.00 0.00 0.00 0.00 0.00 0.00			l I	-1			
28. 00 29. 00 30. 00 0. 00 0. 00 0. 00 0. 00 31. 00 32. 00 33. 00 33. 00 34. 00  TOTALS  G - BONUS RECLASS  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l I				1
29.00				-1			•
30.00   31.00   0.00   0.00   0   0   0   31.00   32.00   33.0				-1			
31.00   32.00   30.00   0   0   0   0   0   0   32.00   33.00   0.00   0   0   0   0   0   0   0				۳			
32. 00 33. 00 34. 00 TOTALS G - BONUS RECLASS G - BONUS RECLASS TOTALS TOTALS TOTALS TOTALS G - BONUS RECLASS TOTALS				- 1			4
33.00   34.00			1	-	-		1
34.00   TOTALS			1	-1			1
TOTALS					-		4
1.00   OPERATI ON OF PLANT   7.00   3,328   0   1.00	34.00	TOTAL C					34.00
1. 00 OPERATI ON OF PLANT 7. 00 3, 328 0 2. 00 DI ETARY 10. 00 6, 177 0 3. 00 MEDI CAL RECORDS & LI BRARY 16. 00 3, 501 0 4. 00 ADULTS & PEDI ATRI CS 30. 00 18, 652 0 5. 00 INTENSI VE CARE UNIT 31. 00 19, 507 0 6. 00 SUBPROVI DER - I PF 40. 00 2, 912 0 7. 00 SKI LLED NURSI NG FACI LI TY 44. 00 5, 342 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 5, 128 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 2, 568 0 9. 00 11. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00 11. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 1, 660 0 11. 00 12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00 13. 00 LABORATORY 60. 00 2, 246 0 13. 00 14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00 15. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 10. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 10. 00 TOTALS				U	3, 518, 502		
2. 00 DI ETARY 10. 00 6, 177 0 2. 00 3. 00 MEDI CAL RECORDS & LI BRARY 16. 00 3, 501 0 3. 00 4. 00 ADULTS & PEDI ATRI CS 30. 00 18, 652 0 4. 00 5. 00 I NTENSI VE CARE UNI T 31. 00 19, 507 0 5. 00 7. 00 SUBPROVI DER - I PF 40. 00 2, 912 0 6. 00 7. 00 SKI LLED NURSI NG FACI LI TY 44. 00 5, 342 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 5, 128 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 2, 568 0 9. 00 10. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00 11. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 1, 660 0 (MRI) 12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00 13. 00 LABORATORY 60. 00 2, 246 0 13. 00 14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00 15. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 TOTALS	1 00		7 00	2 220	0		1 00
3. 00 MEDI CAL RECORDS & LI BRARY 16. 00 3, 501 0 4. 00 ADULTS & PEDI ATRI CS 30. 00 18, 652 0 5. 00 INTENSI VE CARE UNIT 31. 00 19, 507 0 5. 00 5. 00 SI BPROVI DER - I PF 40. 00 5, 342 0 7. 00 SKI LLED NURSI NG FACI LI TY 44. 00 5, 342 0 7. 00 8. 00 OPERATI NG ROOM 50. 00 5, 128 0 8. 00 99. 00 RADI OLOGY-DI AGNOSTI C 54. 00 2, 568 0 9. 00 10. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00 11. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 1, 660 0 (MRI )  12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00 14. 00 PHYSI CAL THERAPY 60. 00 2, 579 0 14. 00 15. 00 16. 00 ALBERGY CLI NI C 90. 13 1, 298 0 15. 00 16. 00 MBULANCE SERVI CES 95. 00 1, 040 0 0 TOTALS 81, 512 0 16. 00 TOTALS		•					4
4. 00 ADULTS & PEDIATRICS 30. 00 18, 652 0 5. 00 INTENSIVE CARE UNIT 31. 00 19, 507 0 5. 0		1					1
5. 00       INTENSIVE CARE UNIT       31. 00       19, 507       0       5. 00         6. 00       SUBPROVI DER - I PF       40. 00       2, 912       0       6. 00         7. 00       SKI LLED NURSI NG FACI LI TY       44. 00       5, 342       0       7. 00         8. 00       OPERATI NG ROOM       50. 00       5, 128       0       8. 00         9. 00       RADI OLOGY-DI AGNOSTI C       54. 00       2, 568       0       9. 00         10. 00       ULTRA SOUND       55. 01       1, 789       0       10. 00         11. 00       MAGNETI C RESONANCE I MAGI NG (MRI)       58. 00       1, 660       0       0         12. 00       CARDI AC CATHETERI ZATI ON       59. 00       3, 785       0       12. 00         13. 00       LABORATORY       60. 00       2, 246       0       13. 00         14. 00       PHYSI CAL THERAPY       66. 00       2, 579       0       14. 00         15. 00       ALLERGY CLI NI C       90. 13       1, 298       0       15. 00         16. 00       AMBULANCE SERVI CES       95. 00       1, 040       0       0       16. 00		I and the second					1
6. 00 SUBPROVI DER - I PF		•					1
7. 00 SKILLED NURSING FACILITY		•					1
8. 00 OPERATING ROOM 50. 00 5, 128 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 2, 568 0 9. 00 10. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00 11. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 1, 660 0 11. 00  12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00 13. 00 LABORATORY 60. 00 2, 246 0 13. 00 14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00 15. 00 ALLERGY CLI NI C 90. 13 1, 298 0 15. 00 16. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 16. 00  TOTALS 8. 00 15. 00 16. 00							1
9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 2, 568 0 10. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00  11. 00 MAGNETI C RESONANCE I MAGI NG (MRI)  12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00  13. 00 LABORATORY 60. 00 2, 246 0 13. 00  14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00  15. 00 ALLERGY CLI NI C 90. 13 1, 298 0 15. 00  16. 00 AMBULANCE SERVI CES 95. 00 16. 00  10. 00 2, 579 0 16. 00  10. 00 170TALS 1, 040 0 16. 00		•					1
10. 00 ULTRA SOUND 55. 01 1, 789 0 10. 00 11. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 1, 660 0 11. 00 (MRI) 12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00 13. 00 LABORATORY 60. 00 2, 246 0 13. 00 14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00 15. 00 ALLERGY CLI NI C 90. 13 1, 298 0 15. 00 16. 00 AMBULANCE SERVI CES 95. 00 16. 00 TOTALS 81, 512 0		•					1
11. 00 MAGNETI C RESONANCE I MAGI NG (MRI)  12. 00 CARDI AC CATHETERI ZATI ON 59. 00 3, 785 0 12. 00  13. 00 LABORATORY 60. 00 2, 246 0 13. 00  14. 00 PHYSI CAL THERAPY 66. 00 2, 579 0 14. 00  15. 00 ALLERGY CLI NI C 90. 13 1, 298 0 15. 00  16. 00 AMBULANCE SERVI CES 95. 00 1, 040 0  TOTALS 81, 512 0		•					1
12.00   CARDI AC CATHETERI ZATI ON   59.00   3,785   0   12.00     13.00   LABORATORY   60.00   2,246   0   13.00     14.00   PHYSI CAL THERAPY   66.00   2,579   0   14.00     15.00   ALLERGY CLI NI C   90.13   1,298   0   15.00     16.00   AMBULANCE SERVI CES   95.00   1,040   0     TOTALS   81,512   0		•					1
12. 00     CARDÍ AC CATHETERI ZATI ON     59. 00     3, 785     0     12. 00       13. 00     LABORATORY     60. 00     2, 246     0     13. 00       14. 00     PHYSI CAL THERAPY     66. 00     2, 579     0     14. 00       15. 00     ALLERGY CLINIC     90. 13     1, 298     0     15. 00       16. 00     AMBULANCE SERVI CES     95. 00     1, 040     0     0       TOTALS     81, 512     0	11.00		33.00	1, 500	Ö		1 50
13. 00     LABORATORY     60. 00     2, 246     0       14. 00     PHYSI CAL THERAPY     66. 00     2, 579     0       15. 00     ALLERGY CLINIC     90. 13     1, 298     0       16. 00     AMBULANCE SERVICES     95. 00     1, 040     0       TOTALS     81, 512     0	12. 00	1. /	59.00	3, 785	0		12. 00
14. 00     PHYSI CAL THERAPY     66. 00     2, 579     0       15. 00     ALLERGY CLINIC     90. 13     1, 298     0       16. 00     AMBULANCE SERVICES     95. 00     1, 040     0       TOTALS     81, 512     0		•					4
15. 00 ALLERGY CLINI C 90. 13 1, 298 0 15. 00 16. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 16. 00 TOTALS 81, 512 0		•					4
16. 00 AMBULANCE SERVI CES 95. 00 1, 040 0 16. 00 TOTALS 81, 512 0		•					1
TOTALS 81, 512 0		•			-		4
			<del>                                     </del>				
	500.00	Grand Total: Increases			19, 733, 068		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0104

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm

						30/2023 4: 58 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00 A - INSURANCE RECLASS	7. 00	8. 00	9. 00	10. 00	
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	ol	843, 061	12	1. 00
2. 00	ADMINISTRATIVE & GENERAL	0.00	Ö	0+3, 001	0	2. 00
	TOTALS — — — —			843, 061		
	B - CAFETERIA RECLASS					
1. 00	DI ETARY	10. 00	470, 691	362, 401		1. 00
	TOTALS		470, 691	362, 401		
1. 00	C - MME DEPRECIATION RECLASS NEW CAP REL COSTS-BLDG &	1.00	O	180, 171	9	1. 00
1.00	FIXT	1.00	٩	100, 171	(	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	6, 509	O	2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 512, 230	0	3. 00
4.00	OPERATION OF PLANT	7. 00	0	155, 173	l	4. 00
5.00	LAUNDRY & LINEN SERVICE	8. 00	0	445		5. 00
6. 00 7. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	2, 146 26, 779	I	6. 00 7. 00
8. 00	NURSING ADMINISTRATION	13. 00	0	26, 779 789		8. 00
9. 00	PHARMACY	15. 00	o	4, 776		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16.00	O	3, 429		10.00
11.00	ADULTS & PEDIATRICS	30.00	O	103, 025		11. 00
12. 00	INTENSIVE CARE UNIT	31.00	0	78, 899		12.00
13.00	SUBPROVI DER - I PF	40.00	0	12, 188	I	13.00
14. 00 15. 00	SKILLED NURSING FACILITY OPERATING ROOM	44. 00 50. 00	0	49, 838	I	14. 00 15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	473, 057 386, 709		16. 00
17. 00	ULTRA SOUND	55. 01	0	129, 711		17. 00
18. 00	CT SCAN	57. 00	o	51, 462		18. 00
19.00	MAGNETIC RESONANCE IMAGING	58. 00	0	13, 743	O	19. 00
	(MRI)					
20.00	CARDI AC CATHETERI ZATI ON	59.00	0	155, 174	I	20.00
21. 00 22. 00	LABORATORY  BLOOD STODING DROCESSING 8	60. 00 63. 00	0	230, 626 897		21. 00 22. 00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	۷	897	0	22.00
23. 00	PHYSI CAL THERAPY	66.00	0	8, 429	o	23. 00
24.00	OCCUPATI ONAL THERAPY	67. 00	0	213	O	24. 00
25.00	AUDI OLOGY	67. 01	0	19, 476		25. 00
26. 00	CARDI OLOGY	69. 01	0	491, 400		26. 00
27. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	567	0	27. 00
28. 00	PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	670	o	28. 00
29. 00	OTHER OUTPATIENT SERVICE	90. 01	0	2, 860		29. 00
27.00	COST CENTER	70.0.		2,000		27.00
30.00	ENT CLINIC	90. 04	0	762	0	30.00
31. 00	SURGERY CLINIC	90. 05	0	391		31.00
32. 00	UROLOGY CLINIC	90. 07	0	293		32.00
33. 00 34. 00	OPTHAMOLOGY CLINIC ALLERGY CLINIC	90. 12 90. 13	0	6, 026 645	l	33. 00 34. 00
35. 00	WOUND CARE	90. 13	o	20, 359		35. 00
36. 00	EMERGENCY	91.00	o	110, 833		36.00
37.00	AMBULANCE SERVICES	95.00	0	84, 984	O	37. 00
38. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	272, 387		38. 00
39. 00	CAFE/BOUTI QUE	194. 01	0	434		39.00
40. 00	OTHER NONREIMB	1 <u>94.</u> 02	0	<u>5</u> 59 4, 599, 064		40. 00
	D - DRUGS RECLASS		UU	4, 599, 064		
1.00	PHARMACY	15. 00	0	8, 938, 451	0	1. 00
	TOTALS			8, 938, 451		
	E - IMPLANTABLES RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	0	348		1.00
2.00	OPERATING ROOM	50.00	0	1, 127, 912		2.00
3. 00 4. 00	RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON	54. 00 59. 00	0	19, 812 244, 591		3. 00 4. 00
5. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	22, 478		5. 00
0.00	PATI ENTS	,	٦	22,		0.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	40, 698		6. 00
7.00	WOUND CARE	<u>90.</u> 14	•	1 <u>5, 7</u> 50		7. 00
	TOTALS	FC DECLACE	0	1, 471, 589		
1 00	F - CHARGEABLE MEDICAL SUPPLI		6	/50		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	658 17, 939		1. 00 2. 00
3. 00	OPERATION OF PLANT	7.00	0	17, 939		3.00
4. 00	LAUNDRY & LINEN SERVICE	8.00	o	116		4. 00
5.00	HOUSEKEEPI NG	9. 00	Ö	231		5. 00
6.00	DI ETARY	10.00	О	1, 219	O	6. 00
	·		·		<u> </u>	

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 4:58 pm Provider CCN: 15-0104

						5/30/2023 4:	58 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10. 00		
7.00	PHARMACY	15. 00	0	20, 388	0		7. 00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	217	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	280, 660	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	158, 614	0		10.00
11.00	SUBPROVI DER - I PF	40.00	o	21, 926	0		11. 00
12.00	SKILLED NURSING FACILITY	44.00	o	42, 172	0		12.00
13.00	OPERATING ROOM	50.00	o	1, 889, 856	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	o	43, 310	0		14.00
15.00	ULTRA SOUND	55. 01	o	10, 983	0		15. 00
16. 00	CT SCAN	57. 00	o	12, 243			16. 00
17. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	5, 231			17. 00
10 00	(MRI)	FO 00		457 005	0		10.00
18.00	CARDI AC CATHETERI ZATI ON LABORATORY	59.00	0	457, 095		l .	18. 00
19.00		60.00	- 1	27, 996	-	l .	19. 00
20. 00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	10	0		20.00
21.00	PHYSI CAL THERAPY	66.00	0	1, 801	0		21. 00
22.00	OCCUPATI ONAL THERAPY	67.00	0	4	0		22. 00
23.00	AUDI OLOGY	67. 01	0	88	0		23. 00
24.00	CARDI OLOGY	69. 01	O	18, 363	0		24. 00
25.00	DRUGS CHARGED TO PATIENTS	73.00	O	13	0		25. 00
26. 00	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	0	3, 959	0		26. 00
27. 00	UROLOGY CLINIC	90. 07	0	18	0		27. 00
28. 00	GASTROENTEROLOGY CLINIC	90.09	ő	188		l .	28. 00
29. 00	ALLERGY CLINIC	90. 13	Ö	294		l .	29. 00
30. 00	WOUND CARE	90. 14	0	22, 533	-		30.00
31. 00	EMERGENCY	91.00	o	370, 539		l .	31. 00
32. 00	AMBULANCE SERVICES	95.00	0	23, 288		l .	32. 00
33. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0		-	l .	33. 00
		•		86, 504	0	l .	1
34. 00	CAFE/BOUTI QUE	1 <u>94.</u> 01	0				34. 00
	G - BONUS RECLASS		U	3, 518, 502			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	81, 512	0	0		1. 00
2.00		0.00	0	0		l .	2. 00
3.00		0.00	o	0			3. 00
4. 00		0.00	Ö	0		l .	4. 00
5. 00		0.00	o	0	0	l .	5. 00
6. 00		0.00	o	0	_	l .	6. 00
7. 00		0.00	ő	0		l .	7. 00
8. 00		0.00	0	0	0	l .	8. 00
9. 00		0.00	0	0	-	l .	9. 00
10. 00		0.00	0	0	0		10. 00
11. 00		0.00	0	0	0	l .	11. 00
12. 00		0.00	0	0	_	l .	12. 00
			0	0	0		1
13.00		0.00		ŭ	_	l .	13.00
14.00		0.00	0	0	0		14.00
15. 00		0.00	0	0		l .	15. 00
16. 00		<u> </u>	0	0	0		16. 00
F00	TOTALS		81, 512	0			
500.00	Grand Total: Decreases	ı	552, 203	19, 733, 068			500. 00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provi der CCN: 15-0104

Peri od: Worksheet A-7 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022

5/30/2023 4:58 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 895, 261 0 1.00 15, 027 0 15, 027 2.00 Land Improvements 3, 053, 583 0 2.00 132, 522, 490 0 3.00 3.00 Buildings and Fixtures 511, 653 511, 653 0 0 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 4, 992, 623 178, 049 0 178, 049 0 5.00 75, 850, 765 0 6.00 Movable Equipment 645, 251 645, 251 0 6.00 0 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 219, 314, 722 1, 349, 980 1, 349, 980 0 8.00 9.00 Reconciling Items 0 0 9.00 219, 314, 722 Total (line 8 minus line 9) 1, 349, 980 10.00 10.00 0 1, 349, 980 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 895, 261 0 1.00 2.00 Land Improvements 3, 068, 610 0 2.00 3.00 Buildings and Fixtures 0 3.00 133, 034, 143 0 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 5, 170, 672 0 5.00 Movable Equipment 0 6.00 76, 496, 016 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 220, 664, 702 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 220, 664, 702 0 10.00

Heal th	Financial Systems	WITHAM MEMORI	AI HOSPITAI		In lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part II	pared:
			SL	JMMARY OF CAP	PI TAL	373072023 4.30	5 piii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 701, 707	0		0 0	0	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 701, 707	0		0 0	0	3. 00
		SUMMARY O	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				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4, 701, 707		·		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
	1			I			

0 0 0

4, 701, 707

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2022 To 12/31/2022	5/30/2023 4: 5	
		COM	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPIT				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FLXT	144, 168, 686		144, 168, 68	6 0. 653338	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	76, 496, 016		76, 496, 01			2.00
3.00	Total (sum of lines 1-2)	220, 664, 702		220, 664, 70			3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE			ı	0 4 501 507	0	1 00
1.00	NEW CAP REL COSTS BLDG & FLXT	0	}		0 4, 521, 536		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1		0 4, 599, 064		2.00
3. 00	Total (sum of lines 1-2)	U		JMMARY OF CAPI	9, 120, 600	0	3. 00
			31	JIVIIVIARY OF CAPT	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-35, 418		1	0	4, 748, 447	1. 00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	-	1	0	4, 599, 064	2. 00
3.00	Total (sum of lines 1-2)	-35, 418	262, 329	1	0 0	9, 347, 511	3. 00

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0104 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 REL COSTS-BLDG & FLXT (chapter IFT XT 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3 00 Investment income - other 0 0 00 (chapter 2) 4 00 Trade, quantity, and time 0.00 di scounts (chapter 8) Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 suppliers (chapter 8) 7.00 Tel ephone services (pay В -4.066 ADMINISTRATIVE & GENERAL 5.00 stations excluded) (chapter 21) 8.00 Tel evision and radio service 0 0.00 0 (chapter 21) Parking Lot (chapter 21) 9.00 0.00 -2, 760, 100 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0 0.00 (chapter 23) 12.00 Related organization A-8-1 0 transactions (chapter 10) 13.00 Laundry and linen service 0.00 14.00 Cafeteria-employees and guests В -307, 185 DI ETARY 10.00 15.00 Rental of quarters to employee 0.00 and others 16.00 Sale of medical and surgical 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 pati ents -668 MEDICAL RECORDS & LIBRARY Sale of medical records and 18.00 В 16 00 abstracts 19.00 Nursing and allied health 0.00 education (tuition, fees, books, etc.) 20.00 В -1, 501 DI ETARY 10.00

1. 00 2.00 3 00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18 00 19.00 Vending machines Income from imposition of 20.00 21.00 0 00 21 00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory 0 \*\*\* Cost Center Deleted \*\*\* 23.00 65 00 23 00 A - 8 - 3therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 25.00 Utilization review -114.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FI XT Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 27.00 27.00 2.00 COSTS-MVBLE EQUIP EQUI P 0 \*\*\* Cost Center Deleted \*\*\* 28.00 Non-physician Anesthetist 19.00 28 00 Physicians' assistant 29.00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14)

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0104

				To	12/31/2022	Date/Time Prep 5/30/2023 4:58	
				Expense Classification on To/From Which the Amount is		07 007 2020 1. 00	piii
				10/FI OIII WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
32. 00	CAH HIT Adjustment for	1.00	2.00	3.00	4. 00	5. 00 0	32. 00
	Depreciation and Interest		_				
33. 00	HOSPI TAL ADMI NI STRAT SPONSORSHI PS/DO	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01 33. 02	BANK FEES HEARING AID COSTS	A A		OPERATING ROOM AUDIOLOGY	50. 00 67. 01	0	33. 01 33. 02
33. 03	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 03
33. 04	(3) LOBBYING EXPENSE-IHA DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	
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
33. 07	COSTS SELF INSURANCE CLAIMS PAID	В	-5 351 914	EMPLOYEE BENEFITS DEPARTMENT	4. 00	12	33. 07
33. 08	HAF FEE	A	-10, 317, 628	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	WIT EXTENDED CARE UNIT OTHER OPERATI	A		SKILLED NURSING FACILITY	44. 00	0	
33. 10	WIT PHYSICIAN CLINIC LB MISC REVENUE	A	0	OTHER OUTPATIENT SERVICE COST CENTER	90. 01	0	33. 10
33. 11	WIT CLINICAL LAB LB OTHER OPERATING	А	-200	LABORATORY	60. 00	0	33. 11
33. 12	WIT PHARMACY LB OTHER OPERATING REVE	А	-51, 358	PHARMACY	15. 00	0	33. 12
33. 13	WIT EDUCATION COVID VACCINE ADMINI	А	-86, 547	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	WIT EDUCATION OTHER OPERATING REVE	А	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	WIT PLANT OPERATIONS LB ELECTRIC CAR	A	-290	OPERATION OF PLANT	7. 00	0	33. 15
33. 16	WIT PLANT OPERATIONS LB OTHER OPERAT	A	-29, 297	OPERATION OF PLANT	7. 00	0	33. 16
33. 17	WIT FINANCE ACCOUNTING REVENUE SHARE	А	-11, 837	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	WIT ADMIN HOSPITAL UNRESTRICTED CONT	А	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	WIT ADMIN HOSPITAL INVEST IN	А	-586, 545	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	WIT HR EMPLOYEE BENEFITS EMP REINSUR	А	0	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
33. 21	WIT AMBULANCE EDUCATION REIMBURSEM	А	-5, 500	AMBULANCE SERVICES	95.00	0	33. 21
33. 22	WIT DERMATOLOGY CLINIC RENTAL REVENU	А	-3, 004	DERMATOLOGY CLINIC	90. 03	0	33. 22
33. 23	WIT EAR NOSE THROAT CLIN RENTAL REVE	А	0	ENT CLINIC	90. 04	0	33. 23
33. 24	WIT SURGERY CLINIC RENTAL REVENUE	А	-1, 488	SURGERY CLINIC	90. 05	0	33. 24
33. 25	WIT UROLOGY CLINIC RENTAL REVENUE	А	-21, 805	UROLOGY CLINIC	90. 07	0	33. 25
33. 26	WIT GASTROENTEROLOGY CLI RENTAL REVE	А	-7, 548	GASTROENTEROLOGY CLINIC	90. 09	0	33. 26
33. 27	WIT DIALYSIS CENTER RENTAL REVENUE	А	-51	WOUND CARE	90. 14	0	33. 27
33. 28	WIT EYE INSTITUTE RENTAL REVENUE	А	-6, 809	OPTHAMOLOGY CLINIC	90. 12	0	33. 28
33. 29	WIT CARDIAC CATHETERIZAT	В	-6, 250	CARDIAC CATHETERIZATION	59. 00	0	33. 29
33. 30	PURCHASING WIT PHARMACY LB PURCHASING DISCOUNTS	В	-20, 002	PHARMACY	15. 00	0	33. 30
33. 31	WIT CENTRAL SUPPLY PURCHASING DISCOU	В		MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	33. 31
33. 32	WIT HEALTH INFORMATION M PHYSICIAN Q	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 32
33. 33	WIT DIETARY HOME DELIVERED MEALS	В	-30, 854	DI ETARY	10.00	0	33. 33
33. 34 33. 35	WIT DIETARY HEAD START WIT DIETARY CICOA MEAL	B B		DI ETARY DI ETARY	10. 00 10. 00	0	33. 34 33. 35
33. 36	VOUCHERS WIT FINANCE MATERIALS MG	В		ADMINISTRATIVE & GENERAL	5. 00	0	
	PURCHASI NG						
33. 3 <i>1</i>	WIT FINANCE MATERIALS MG PURCHASING	В	-57, 525	ADMINISTRATIVE & GENERAL	5. 00	0	33. 37

From 01/01/2022 To 12/31/2022 Date/Time Prepared:

					5/30/2023 4:5	ma 8
			Expense Classification or			ļ
			10/110m which the amount is	to be Aujusteu		
Cost Center Description	Rasis/Code (2)	Amount	Cost Center	line #	Wkst A_7 Ref	
·	1.00	2. 00	3.00	4. 00	5. 00	
	В	2	ADMINISTRATIVE & GENERAL	5. 00	0	33. 38
WIT FINANCE HOSPITAL BIL	В	-6, 456	ADMINISTRATIVE & GENERAL	5. 00	11	33. 39
WIT ADMIN HOSPITAL LAND LEASE	В	-20, 484	ADMINISTRATIVE & GENERAL	5.00	10	33. 40
WIT ADMIN HOSPITAL MANAGEMENT	В	-28, 947	ADMINISTRATIVE & GENERAL	5.00	0	33. 41
WIT ADMIN HOSPITAL OTHER	В	-17, 408	ADMINISTRATIVE & GENERAL	5. 00	0	33. 42
WIT ADMIN HOSPITAL INTEREST ON	В	-184, 813	ADMINISTRATIVE & GENERAL	5. 00	11	33. 43
WIT HR EMPLOYEE BENEFITS	А	-532, 408	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33. 44
WIT HR WELLNESS PROGRAM OTHER	В	-65, 191	EMPLOYEE BENEFITS DEPARTMEN	Т 4. 00	0	33. 45
WIT INSURANCE INSURANCE CLAIM	В	-13, 556	ADMINISTRATIVE & GENERAL	5. 00	12	33. 46
VOL VOLUNTEERS VOLUNTEER MISC	В	-14, 840	ADMINISTRATIVE & GENERAL	5. 00	0	33. 47
VOL VOLUNTEERS INTEREST ON	В	-103	ADMINISTRATIVE & GENERAL	5. 00	11	33. 48
BCH 2015 BOND INTEREST ON	В	-35, 243	l .	1.00	11	33. 49
BCH 2017 BOND INTEREST ON	В	-175	NEW CAP REL COSTS-BLDG &	1.00	11	33. 50
WIT AMBULANCE OTHER OPERATING	В	-3, 500		95.00	0	33. 51
WIT OPERATING ROOM OTHER	В	-4, 131	OPERATING ROOM	50.00	0	33. 52
WIT RADIOLOGY LB PURCHASING	В	-2, 281	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 53
WIT RADIOLOGY LB OTHER	В	-7	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 54
WIT QUALITY SERVICES ACUTE BC	А	-10, 632	ADMINISTRATIVE & GENERAL	5. 00	0	33. 55
WIT QUALITY SERVICES SHO	А	-71	ADMINISTRATIVE & GENERAL	5. 00	0	33. 56
WIT DIETARY OTHER OPERATING	В	-196	DI ETARY	10.00	0	33. 57
WIT FINANCE HOSPITAL BIL	В	-180	ADMINISTRATIVE & GENERAL	5. 00	0	33. 58
WIT FINANCE HOSPITAL BIL MISC	В	-460	ADMINISTRATIVE & GENERAL	5. 00	0	33. 59
WIT FINANCE INFORMATION	В	-28, 624	ADMINISTRATIVE & GENERAL	5. 00	0	33. 60
WIT ADMIN HOSPITAL PURCHASING	В	-710	ADMINISTRATIVE & GENERAL	5. 00	0	33. 61
WIT ADMIN HOSPITAL SETTLEMENT	В	-142	ADMINISTRATIVE & GENERAL	5. 00	0	33. 62
WIT HR EMPLOYEE BENEFITS PLAN	А	-20, 530	EMPLOYEE BENEFITS DEPARTMEN	Т 4. 00	0	33. 63
WIT INSURANCE REFUND-PCF	В	-5, 467	ADMINISTRATIVE & GENERAL	5. 00	0	33. 64
RECRUITING OFFSET-EH&W	A		i e			
	A		i e			33. 66 33. 67
			i e			1
	A			95. 00	0	33. 69
(Transfer to Worksheet A,		-21, 055, 654	l .			50. 00
	WIT FINANCE HOSPITAL BIL CASH (SHORT WIT FINANCE HOSPITAL BIL INTEREST IN WIT ADMIN HOSPITAL LAND LEASE REVENU WIT ADMIN HOSPITAL MANAGEMENT FEE RE WIT ADMIN HOSPITAL OTHER OPERATING R WIT ADMIN HOSPITAL INTEREST ON INVES WIT HR EMPLOYEE BENEFITS EMPLOYEE DR WIT HR WELLNESS PROGRAM OTHER OPERAT WIT INSURANCE INSURANCE CLAIM PROC VOL VOLUNTEERS VOLUNTEER MISC REV VOL VOLUNTEERS INTEREST ON INVESTME BCH 2015 BOND INTEREST ON INVESTME BCH 2017 BOND INTEREST ON INVESTME BCH 2017 BOND INTEREST ON INVESTME WIT AMBULANCE OTHER OPERATING REVE WIT OPERATING ROOM OTHER OPERATING REVE WIT OPERATING REVE WIT OUALITY SERVICES ACUTE BC MDCD S WIT QUALITY SERVICES ACUTE BC MDCD S WIT QUALITY SERVICES SHO ANTHEM SHAR WIT FINANCE HOSPITAL BIL MISC REVEWUT OUALITY SERVICES SHO ANTHEM SHAR WIT FINANCE HOSPITAL BIL MISC REVEWUT ADMIN HOSPITAL BIL MISC REVEWU WIT ADMIN HOSPITAL BIL MISC REVEWU WIT ADMIN HOSPITAL BIL MISC REVEWU WIT FINANCE HOSPITAL BIL MISC REVEWU WIT FINANCE HOSPITAL BIL MISC REVEWU WIT ADMIN HOSPITAL SETTLEMENT REVENU WIT FINANCE REFUND-PCF (PATIENT RECRUITING OFFSET-EH&W RECRUITING OFFSET-EH&W RECRUITING OFFSET-EH&W RECRUITING OFFSET-EH&W RECRUITING OFFSET-AMBULANCE TOTAL (Sum of FIINES 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	WIT FINANCE HOSPITAL BIL CASH (SHORT WIT FINANCE HOSPITAL BIL INTEREST IN WIT ADMIN HOSPITAL LAND LEASE REVENU WIT ADMIN HOSPITAL LAND LEASE REVENU WIT ADMIN HOSPITAL MANAGEMENT FEE RE WIT ADMIN HOSPITAL OTHER OPERATING R WIT ADMIN HOSPITAL INTEREST ON INVES WIT HE EMPLOYEE BENEFITS A EMPLOYEE DR WIT HR EMPLOYEE BENEFITS WIT HR WELLNESS PROGRAM OTHER OPERAT WIT INSURANCE INSURANCE CLAIM PROC VOL VOLUNTEERS VOLUNTEER MISC REV VOL VOLUNTEERS INTEREST ON INVESTME BCH 2015 BOND INTEREST ON INVESTME BCH 2017 BOND INTEREST ON INVESTME BCH 2017 BOND INTEREST ON B INVESTME BCH 2017 BOND OTHER BCH 2017 BOND	1.00   2.00	Cost Center Description Basis/Code (2) Amount Cost Center 3.00 3.00 WIT FINANCE HOSPITAL BIL CASH (SHORT WIT FINANCE HOSPITAL BIL CASH (SHORT WIT ADMIN HOSPITAL LAND LEASE REVENU) WIT ADMIN HOSPITAL LAND LEASE REVENU WIT ADMIN HOSPITAL LAND LEASE B -20, 484 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL CHEER B -20, 484 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL INTEREST ON B -28, 947 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL OTHER B -17, 408 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL INTEREST ON B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL INTEREST ON B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL INTEREST ON B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL INTEREST ON B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL SERVE WILL FINE WIT ADMIN HOSPITAL BIL MISC B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL BIL MISC B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL BIL MISC B -184, 813 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL BIL MISC B -184, 814 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL BIL MISC B -194, 844 ADMIN ISTRATIVE & GENERAL FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B -184, 814 ADMIN ISTRATIVE & GENERAL FINE WIT FINANCE HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT FINANCE HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT FIRM FINE WIT ADMIN HOSPITAL BIL MISC B FIRM FINE WIT FIRM FINE WIT FIRM FINE WIT ADMIN HOSPITAL SERVICES SHO AND FIRM FINE WIT FIRM FINE W	COST Center Description   Rasis/Code (2)   Arount   Cost Center   Line #	To/From Which the Amount is to be Adjusted

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

<sup>(2)</sup> 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.

Peri od: Worksheet A-8-2 From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/30/2023 4:58 pm Cost Center/Physician Identifier Wkst. A Line # Professi onal RCE Amount Total Provi der Physi ci an/Prov Remuneration Component Component ider Component Hours 7.00 1. 00 2.00 3.00 4.00 5. 00 6. 00 60. 00 LABORATORY 1.00 157, 900 157, 900 1. 00 260, 300 0 0 0 0 0 0 0 0 0 2.00 91. 00 EMERGENCY 2, 602, 200 2, 602, 200 211, 500 2.00 0 0 0 0 0 0 0 3.00 0.00 3.00 0.00 4.00 0 0 0 4.00 0.00 0 5.00 0 5.00 0 0.00 0 6.00 6.00 0 7.00 0.00 0 7. 00 0 8.00 0.00 8.00 0 0.00 9.00 9. 00 10.00 0.00 10.00

200.00			2, 760, 100	2, 760, 10	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RC	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	
1.00	60. 00	LABORATORY	0		0	0	0	1. 00
2.00	91. 00	EMERGENCY	0		0	0	0	2. 00
3.00	0.00		0		0	0	0	3. 00
4.00	0. 00		0		0	0	0	4. 00
5.00	0.00		0		0	0	0	5. 00
6.00	0.00		0		0	0	0	6. 00
7.00	0. 00		0		0	0	0	7. 00
8.00	0. 00		0		0	0	0	8. 00
9.00	0.00		0		0	0	0	9. 00
10.00	0.00		0		0	0	0	10. 00
200.00			0		0	0	0	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					

			Share of col. 14				
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00	
1.00	60. 00	LABORATORY	0	0	0	157, 900	1.00
2.00	91. 00	EMERGENCY	0	0	0	2, 602, 200	2.00
3.00	0. 00		0	0	0	0	3.00
4.00	0. 00		0	0	0	0	4.00
5.00	0. 00		0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	6.00
7.00	0. 00		0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	8.00
9. 00	0.00		0	0	0	0	9.00
10. 00	0. 00		0	0	0	0	10.00
200. 00			0	0	0	2, 760, 100	200.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2023 | To 12/ Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104

Cost Center Description						To	12/31/2022	Date/Time Pre 5/30/2023 4:5	
PRINCE   PRINCE   COST CRITERS   FIXE   EQUIP   SERVET					CAPI TAL REI	ATED COSTS		37 307 2023 4. 3	o piii
PRINCE   PRINCE   COST CRITERS   FIXE   EQUIP   SERVET									
All location   Column   Colu			Cost Center Description					Subtotal	
Common   C					TIXI	LQUII			
D									
CHERNEL SERVICE COST CERTIESS   1, 74, 748, 447					4.00	2.22	4.00	4.0	
1.00		CENED	AL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
2 00 00000 NEW CAP REL COSTS-MARLE EQUIP	1.00			4, 748, 447	4, 748, 447				1.00
5.00   0.0000   ADMINI STRATIVE & CEMERAL   16, 546, 046   367, 147   355, 597   1, 238, 506   18, 506, 206   5.00   0.00000   ADMINISTRATIVE & CEMERAL   1.00000   1.00000   ADMINISTRATIVE & CEMERAL   1.000000   1.000000   ADMINISTRATIVE & CEMERAL   1.000000   1.000000   ADMINISTRATIVE & CEMERAL   1.000000   1.0000000   ADMINISTRATIVE & CEMERAL   1.0000000   0.000000   0.000000000   0.000000   0.000000   0.00000000		1			.,				
7.00 007000   CPERATI MO OF PLANT		1							1
8.00   0000000000000000000000000000000						· ·			1
9.00   00000    FLARY   1.006, 765   98, 126   99, 126   97, 100   100, 100   10000   101000   101000   101000   101000   101000   101									
11-10 0 01100 CAFETERIA 833.0P2 0 0 0 77.510 710.0P2 11.0 11.0 01100 PARAMACY 11.0 011		1		1	-				1
13.00   01300   MINST INE AGMIN ISTRATION   6.30, Oc2   0   0   90, 752   720, E11   13.00   15.00   101500   MINST INE AGMIN ISTRATION   1, 190, 1905   30, 292   293   101, 211   1, 156, 896   15.00   10.00   IDCOL RECERCIOS & LEBRARY   1, 201, 693   30, 292   293   101, 211   1, 156, 896   15.00   10.00   IDCOL RECERCIOS & LEBRARY   1, 201, 693   30, 292   293   101, 211   1, 156, 896   15.00   10.00   IDCOL RECERCIOS & LEBRARY   1, 200, 90, 900   30, 292   200, 200, 200, 200, 200, 200, 200, 2		1		1	98, 126	95, 039			
15.00   01500   PIARMIACY   1. 402,058   30,292   29,339   104,211   1,565,895   15.00   300,000   1.000   1.000   1.000   1.000   1. 591,965   1. 591,965   1. 591,965				1	-	-			
10.00					-				
MATIENT ROUTH & SERVICE COST CENTERS   0,093,800   318,280   308,267   586,027   7,306,374   30,00   3100   MTERISTY CARE UNIT   2,953,876   87,409   84,659   273,125   3,399,069   31,00   41,00   40,00   40,00   40,00   40,00   40,00   40,00   41,00									
31 0.0   03100   INTERSIVE CARE UNIT   2,953,876   87,409   88,659   273,125   3,399,609   31.00   04.		I NPAT	IENT ROUTINE SERVICE COST CENTERS						
40,00   04000   SUBPROVIDER - I PF		1							
41.00   04100   SUBPROVIDER - IRF		1							
42.00   04200   SUBPROVI DER   0   0   0   0   0   0   42.00   04.00				1, 202, 700	00,078	70, 730	190, 719		1
44.00	42.00	04200	SUBPROVI DER	o	0	0	o	0	1
ANCILLARY SERVICE COST CENTERS				0	_	0	0	_	
50.00	44. 00			1, 536, 769	75, 785	73, 401	161, 080	1, 847, 035	44. 00
54.00   0.500   RADI OLOCY-DIA CHOSTIC   5, 240, 655   310, 671   300, 898   273, 429   6, 125, 653   54.00   55.01   5550   0.550	50.00			5 603 793	339 495	328 815	392 791	6 664 894	50 00
55.01   05501   ULTRA SOUND   1, 027, 643   0   0   32, 880   1, 060, 523   55, 01									1
57.00   05700   CT SCAN   1.000.871   0   0   37.326   1.038.197   57.00		1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0		
58. 00   05800   MACNETI C RESONANCE I NACING (WRI )					0	0			
59.00   0.6900   CARDIA AC CATHETER ZATION   1,052,347   22,465   21,759   65,971   1,162,542   59.00		1			26 652	Ĭ			
60.00   06000   LABORATORY   7,770, 345   156, 867   151, 922   548, 184   8, 627, 328   60.00   64.00   06.00   06.00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									1
64.00   06400   INTRAVENOUS THERAPY   1.661.565   140,229   135,817   245,648   2.183,259   6.00   6.00   06700   06	60.00	1		7, 770, 345	156, 867	151, 932	548, 184	8, 627, 328	60.00
66.00   06600   PHYSI CAL THERAPY   1,661,565   140,229   135,817   245,648   2,183,259   66.00   67.00   670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   0670,00   06800   06800   06800   06800   06800   069000   069000   069000   069000   069000   069000   069000   0690000   0690000   06900000   069000000   06900000000   069000000000   0690000000000				281, 540	0	-	0		
67. 00   06700   06700   06700   06701   0617, 678   07. 00   07. 01   06701   06101   06101   07. 01   06701   06101   07. 01   06101   07. 01   06101   07. 01				1 661 565	140 220	ŭ	245 648	_	1
67.01		1		1	140, 227				1
69, 00   06900   CARDIOLOGY   0   0   0   0   0   0   0   0   0		06701	AUDI OLOGY	1	13, 951	13, 512			
69.01   06901   CARDIOLOGY				180, 063	0	0	27, 363		
71.00				1 000 621	14 451	12 006	245 050	_	
72. 00   07300   IMPL. DEV. CHARGED TO PATIENT   1, 471, 589   0   0   0   0   1, 471, 589   72. 00				· · · · · · · · · · · · · · · · · · ·		•	_		
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTER   OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE SERVICES   OUTPATIENT SERVICE SERVICES   OUTPATIENT SERVICE SERVICES   OUTPATIENT SERVICE SERVICES   OUTPATIENT SERVICES   OUTPATIENT SERVICE SERVICES   OUTPATIENT SERVICES   OUTPATIEN					0	0	o		
90. 00   09000   CLI NI C   0   09000   0   0   0   0   0   0   0	73. 00			8, 897, 070	0	0	0	8, 897, 070	73. 00
90. 01   99.001   09001   OTHER OUTPATIENT SERVICE COST CENTER   107,423   59,710   57,831   16,610   241,574   90.01   90.02   09002   CLINIC   0   0   0   0   0   0   0   0   0	00 00	001PA	CLINIC		0		ما	0	1 00 00
90. 02   09002   CLINIC					U	U	٧		ı
90. 04   09004   SURCERY CLINIC   0   0   0   0   0   0   0   0   0				0	0	0	0		1
90. 05   09005   09005   09007		1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0		1
90. 07   09007   UROLOGY CLINIC   34,863   0   0   0   8,686   43,549   90. 07   90.09   90009   GASTROENTEROLOGY CLINIC   0   0   0   0   51   51   90. 09   90. 11   09011   NEUROLOGY CLINIC   126,185   0   0   0   0   0   126,185   90. 11   90. 12   90. 12   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   0   0   0   0   0   90. 12   90. 13   90. 13   ALLERGY CLINIC   100,534   13,951   13,512   12,996   140,993   90. 13   90. 14   09014   WOUND CARE   644,217   117,795   114,089   43,707   919,808   90. 14   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.00   0				10	0	0	0		
90. 09   09009   GASTROENTEROLOGY CLINIC   0   0   0   0   51   51   90. 09   90. 11   09011   NEUROLOGY CLINIC   126, 185   0   0   0   0   126, 185   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0   0   0   0   0   0   0   90. 13   09013   ALLERGY CLINIC   100, 534   13, 951   13, 512   12, 996   140, 993   90. 13   90. 14   09014   WOUND CARE   644, 217   117, 795   114, 089   43, 707   919, 808   90. 14   91. 00   09100   EMERGENCY   5, 060, 920   383, 785   371, 712   444, 862   6, 261, 279   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART)   0   92. 00   95. 00   09500   ABBULANCE SERVI CES   2, 880, 758   74, 364   72, 024   412, 178   3, 439, 324   95. 00   SUBTOTALS (SUM OF LINES 1 through 117)   109, 964, 498   3, 176, 048   3, 076, 132   6, 173, 643   101, 453, 810   18. 00   NONRE MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP, & CANTEEN   0   9, 749   9, 442   0   19, 191   190. 00   192. 00   19200   PHYSI CLANS* PRI VATE OFFI CES   43, 244, 253   1, 366, 570   1, 323, 579   5, 361, 745   51, 296, 147   192. 00   194. 00   07950   THORNTOWN OFFI CE BUI LDI NG   0   0   0   0   0   0   194. 00   194. 01   07951   CAFE/BOUTI OUE   63, 199   22, 122   21, 426   4, 488   111, 235   194. 01   194. 02   07952   OTHER NONREI MB   56, 887   167, 709   162, 433   0   387, 029   194. 02   194. 03   07953   RETAI L PHARMACY   2, 563, 101   6, 249   6, 052   49, 124   2, 624, 526   194. 02   194. 03   07953   RETAI L PHARMACY   2, 563, 101   6, 249   6, 052   49, 124   2, 624, 526   194. 02   190. 00   00   00   00   00   00   00   0				34. 863	0	0	8. 686		
90. 12		1	l e e e e e e e e e e e e e e e e e e e	0	0	Ö			1
90. 13		1		126, 185	0	0	О		1
90. 14   09014   WOUND CARE   644, 217   117, 795   114, 089   43, 707   919, 808   90. 14   91. 00   09100   EMERGENCY   5, 060, 920   383, 785   371, 712   444, 862   6, 261, 279   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   92. 00   O9200   ABBURANCE SERVI CES   2, 880, 758   74, 364   72, 024   412, 178   3, 439, 324   95. 00   O9500   ABBURANCE SERVI CES   SPECIAL PURPOSE COST CENTERS		1		100 534	13.051	12 512	12.004		1
91. 00   09100   EMERGENCY   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   092.00   OBSERVATI ON BEDS (NON-DI STI NCT PART)   095.00   AMBULANCE SERVI CES   2,880,758   74,364   72,024   412,178   3,439,324   95.00   OBSERVATI ON BURSABLE COST CENTERS   095.00   AMBULANCE SERVI CES   2,880,758   74,364   72,024   412,178   3,439,324   95.00   OBSERVATION BURSABLE COST CENTERS   095.00   095.00   OBSERVATION BURSABLE COST CENTERS   095.00   OBSERVATION BURSABLE COST CENTERS						13,512			
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   07HER REI MBURSABLE COST CENTERS   09500   AMBULANCE SERVI CES   2,880,758   74,364   72,024   412,178   3,439,324   95.00   09500   AMBULANCE SERVI CES   2,880,758   74,364   72,024   412,178   3,439,324   95.00   09500   AMBULANCE SERVI CES   2,880,758   74,364   72,024   412,178   3,439,324   95.00   0   0   0   0   0   0   0   0   0									
95. 00 09500 AMBULANCE SERVICES 2, 880, 758 74, 364 72, 024 412, 178 3, 439, 324 95. 00 SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 109, 964, 498 3, 176, 048 3, 076, 132 6, 173, 643 101, 453, 810 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9, 749 9, 442 0 19, 191 190. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 43, 244, 253 1, 366, 570 1, 323, 579 5, 361, 745 51, 296, 147 192. 00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTI QUE 63, 199 22, 122 21, 426 4, 488 111, 235 194. 01 194. 02 07952 OTHER NONREI MB 56, 887 167, 709 162, 433 0 387, 029 194. 02 194. 03 07953 RETAIL PHARMACY 2, 563, 101 6, 249 6, 052 49, 124 2, 624, 526 194. 03 200. 00 Cross Foot Adjustments	92. 00							0	92. 00
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   109,964,498   3,176,048   3,076,132   6,173,643   101,453,810   118.00   NONREI MBURSABLE COST CENTERS	05 00	OTHER	RELIMBURSABLE COST CENTERS	2 000 750	74 2/4	72.024	410 170	2 420 224	0F 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 109, 964, 498 3, 176, 048 3, 076, 132 6, 173, 643 101, 453, 810 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 9, 749 9, 442 0 199, 199, 199, 199, 199, 199, 199, 19	95.00			2, 880, 758	74, 364	72, 024	412, 178	3, 439, 324	95.00
NONRE   MBURSABLE   COST CENTERS   190.00   19000   GI FT   FLOWER, COFFEE SHOP, & CANTEEN   0   9,749   9,442   0   19,191   190.00   192.00   1	118. 00			109, 964, 498	3, 176, 048	3, 076, 132	6, 173, 643	101, 453, 810	118. 00
192.00     19200     PHYSI CI ANS' PRI VATE OFFI CES     43, 244, 253     1, 366, 570     1, 323, 579     5, 361, 745     51, 296, 147     192.00       194.00     194.01     07951     CAFE/BOUTI QUE     63, 199     22, 122     21, 426     4, 488     111, 235     194.01       194.02     07952     OTHER NONREI MB     56, 887     167, 709     162, 433     0     387, 029     194.02       194.03     07953     RETAI L PHARMACY     2, 563, 101     6, 249     6, 052     49, 124     2, 624, 526     194.03       200.00     Cross Foot Adjustments     0     200.00		NONRE	IMBURSABLE COST CENTERS						
194. 00     07950     THORNTOWN OFFICE BUILDING     0     0     0     0     194. 00       194. 01     07951     CAFE/BOUTI QUE     63, 199     22, 122     21, 426     4, 488     111, 235     194. 01       194. 02     07952     OTHER NONREI MB     56, 887     167, 709     162, 433     0     387, 029     194. 02       194. 03     07953     RETAI L PHARMACY     2, 563, 101     6, 249     6, 052     49, 124     2, 624, 526     194. 03       200. 00     Cross Foot Adj ustments     0     200. 00							0		
194. 01 07951     CAFE/BOUTI QUE     63, 199     22, 122     21, 426     4, 488     111, 235 194. 01       194. 02 07952     OTHER NONREI MB     56, 887     167, 709     162, 433     0 387, 029 194. 02       194. 03 07953     RETAI L PHARMACY     2, 563, 101     6, 249     6, 052     49, 124     2, 624, 526 194. 03       200. 00     Cross Foot Adjustments     0 200. 00				43, 244, 253			5, 361, 745 ol		
194. 02 07952     OTHER NONREI MB     56, 887     167, 709     162, 433     0     387, 029 194. 02       194. 03 07953     RETAI L PHARMACY     2, 563, 101     6, 249     6, 052     49, 124     2, 624, 526 194. 03       200. 00     Cross Foot Adjustments     0     200. 00				63, 199	-		4, 488		
200. 00   Cross Foot Adjustments   0   200. 00	194. 02	07952	OTHER NONREIMB	56, 887	167, 709	162, 433	О	387, 029	194. 02
		1		2, 563, 101	6, 249	6, 052	49, 124		
201.00    nogative cost centers         0  0  0  0 201.00		1			0	0	0		
		1	mogative oost omiters	ı l	0	١	Ч	0	1201.00

Health Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022	Part     Date/Time Pre	pared:
					5/30/2023 4:5	
		CAPITAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
202.00 TOTAL (sum lines 118 through 201)	155, 891, 938	4, 748, 447	4, 599, 06	11, 589, 000	155, 891, 938	202. 00

Provider CCN: 15-0104

				To	12/31/2022	Date/Time Pre 5/30/2023 4:5	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	S piii
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	0.00	9.00	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	00400 EMPLOYEE BENEFITS DEPARTMENT	40 50/ 00/					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	18, 506, 296	E 00E E41				5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	603, 718 87, 450	5, 085, 562	736, 657			7. 00 8. 00
9. 00	00900 HOUSEKEEPING	136, 963	55, 067		1, 208, 808		9.00
10.00	01000 DI ETARY	179, 008	123, 263		80, 663		1
11. 00	01100 CAFETERI A	122, 661	(	.	26, 894	0	1
13.00	01300 NURSING ADMINISTRATION	97, 096	(	0	12, 161	0	13. 00
15. 00	01500 PHARMACY	210, 931	38, 052	0	24, 555		
16. 00	01600 MEDI CAL RECORDS & LI BRARY	253, 085	60, 11	1 0	53, 788	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	004 100	200 01	14 (25	400 (10	722 (04	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	984, 190 457, 865	399, 815 109, 801		408, 610 108, 511	723, 604 280, 960	
40. 00	04000 SUBPROVI DER - I PF	222, 354	125, 716		129, 035	244, 111	1
41. 00	04100 SUBPROVI DER - I RF	0	120, 710	0,002	0	0	1
42.00	04200 SUBPROVI DER	0	(	o	0	0	1
43.00	04300 NURSERY	o	(	0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	248, 801	95, 200	4, 407	0	463, 165	44. 00
	ANCILLARY SERVICE COST CENTERS	007 704	107.17		0.4.000		
50. 00 54. 00	05000 OPERATING ROOM	897, 781 825, 144	426, 466		24, 088 108, 979	0	1
55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	825, 144	390, 258	0 39, 378	108, 979	0	
55. 01	05501 ULTRA SOUND	142, 856	(	15, 040	7, 016	0	
57. 00	05700 CT SCAN	139, 848	(	94, 975	10, 758	ő	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	104, 572	33, 480		10, 290	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	156, 598	28, 220	29, 222	0	0	59. 00
60.00	06000 LABORATORY	1, 162, 127	197, 052		46, 071	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	37, 924	(	_, _, .	0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	47/ 45/	6, 182	0	0	
66.00	06600 PHYSI CAL THERAPY	294, 092	176, 152		16, 604	0	
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	83, 203 48, 748	17, 525	5, 240 1, 322	7, 951 5, 847	0	
68. 00	06800 SPEECH PATHOLOGY	27, 941	17, 523	1, 322	3, 508		
69. 00	06900 ELECTROCARDI OLOGY	27, 741	(	1, 300	3, 300	o o	
69. 01	06901 CARDI OLOGY	304, 715	18, 153	41, 154	35, 313	Ö	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	441, 913	. (		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	198, 227	(	19, 488	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 198, 462	7, 850	48, 603	25, 491	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS				0		00.00
90.00	09000 CLINIC	0 32, 541	75, 00 <i>6</i>	1	(2.475	0	
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	32, 541	75,000		62, 675 0	0	1
90. 02	09003 DERMATOLOGY CLINIC		(		0	0	
90. 04	09004 ENT CLINIC	1	(	ol o	0	Ő	
	09005 SURGERY CLINIC	O	(	o o	0	0	
90. 07	09007 UROLOGY CLINIC	5, 866	(	228	0	0	
90. 09	09009 GASTROENTEROLOGY CLINIC	7	(	0	0	0	
90. 11	09011 NEUROLOGY CLINIC	16, 997	(	0	0	0	1
90. 12	09012 OPTHAMOLOGY CLINIC	10,000	17 52	0	0	0	1
90. 13 90. 14	09013 ALLERGY CLINIC 09014 WOUND CARE	18, 992 123, 901	17, 525 147, 97		0	0	1
91. 00	09100 EMERGENCY	843, 413	482, 102		0	0	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	043, 413	402, 102	30, 147	J		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					/2.00
95.00	09500 AMBULANCE SERVI CES	463, 287	93, 414	7, 149	0	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		11, 173, 278	3, 118, 199	736, 657	1, 208, 808	1, 711, 840	118. 00
400	NONREI MBURSABLE COST CENTERS	2	10.5	.1 =		-	100 00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2, 585	12, 246		0		190.00
	19200   PHYSICIANS' PRIVATE OFFICES   07950   THORNTOWN OFFICE BUILDING	6, 909, 783	1, 716, 656	0	0		192. 00 194. 00
	07950 THORNTOWN OFFICE BUILDING	14, 984	27, 789	1	0		194. 00
	207952 OTHER NONREIMB	52, 134	210, 672		0		194. 01
	07953 RETAIL PHARMACY	353, 532	2.0, 3/2	ol ő	0		194. 03
200.00	Cross Foot Adjustments						200. 00
201.00		0	(	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	18, 506, 296	5, 085, 562	736, 657	1, 208, 808	1, 711, 840	202. 00

Provider CCN: 15-0104

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:58 pm	

			10	12/31/2022	5/30/2023 4:5	
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	O piii
	11. 00	13. 00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS			10100			
1. 00	1, 060, 157 20, 512 41, 024 83, 128	850, 583 0 0	1, 880, 457 0	2, 328, 948		1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	337 123	<u> </u>	<u> </u>	2, 020, 7.10		10.00
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 43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	279, 615 22, 671 35, 626 0 0 0 0	155, 722 68, 149 58, 874 0 0 0 60, 538	73 88 12 37 0 0	572, 319 118, 997 141, 664 0 0 0 0	10, 874, 947 4, 576, 816 2, 613, 119 37 0 0 2, 719, 146	40. 00 41. 00 42. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	24, 831	127, 500	3, 145	205, 412	8, 469, 333	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C 55. 01   05501   ULTRA SOUND	30, 229 0 3, 239	127, 500 17, 653 0	10, 168 0 803	549, 654 0 59, 499	8, 117, 316 0 1, 288, 976	54. 00 55. 00 55. 01
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	4, 318 10, 796	0	19, 118 7, 572	67, 998 36, 833	1, 375, 212 1, 003, 883	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 740	23, 528	7, 572	30, 833	1, 400, 110	
60. 00   06000   LABORATORY	88, 526	0	5	56, 665	10, 299, 349	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	О	0	0	321, 468	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	6, 182	
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	44, 263 18, 353	61, 973 28, 069	113	110, 498 48, 166	2, 898, 224 808, 660	
67. 00   06700 OCCUPATIONAL THERAPY	19, 433	13, 334	0	48, 100 0	468, 105	
68. 00 06800 SPEECH PATHOLOGY	20, 512	7, 277	0	Ö	268, 044	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	Ö	0	69. 00
69. 01   06901   CARDI OLOGY	44, 263	72, 306	2, 266	106, 248	2, 886, 546	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 671	0	0	0	3, 765, 033	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 689, 304	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	739, 843	0	10, 917, 319	73. 00
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC	O	ol	0	٥١	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	36, 706	3, 766	0	237, 995	690, 263	
90. 02   09002   CLINI C	0	0	0	0	0	90. 02
90. 03 09003 DERMATOLOGY CLINIC	0	О	0	О	0	
90. 04   09004   ENT CLINIC	0	0	0	0	11	
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, 578	0	0	49, 643 7, 636	1
90. 11   09011   NEUROLOGY   CLI NI C	0	7, 376	25, 705	0	168, 887	
90. 12   09012   OPTHAMOLOGY   CLI NI C	0	o	0	Ö	0	90. 12
90. 13   09013   ALLERGY   CLI NI C	0	3, 613	28	O	181, 662	90. 13
90. 14   09014   WOUND CARE	0	15, 553	4, 855	0	1, 221, 866	
91. 00   09100   EMERGENCY	69, 094	95, 677	14, 888	0	7, 824, 600	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	140, 347	ol	2, 255	ol	4, 145, 776	95. 00
SPECIAL PURPOSE COST CENTERS	140, 547	<u> </u>	2, 200	<u> </u>	4, 143, 770	75.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 060, 157	821, 110	830, 974	2, 311, 948	91, 057, 473	
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	26, 335	0 611, 463	17, 000	34, 022 60, 577, 384	190.00
192.00 19200 PHYSICIANS PRIVATE OFFICES  194.00 07950 THORNTOWN OFFICE BUILDING	0	20, 335 N	011, 403 N	17,000		194. 00
194. 01 07951 CAFE/BOUTI QUE	o o	ol	0	ol O	154, 008	
194. 02 07952 OTHER NONREIMB	o	3, 138	0	Ö	652, 973	
194. 03 07953 RETAIL PHARMACY	o	o	438, 020	o	3, 416, 078	
200.00 Cross Foot Adjustments						200.00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	0 1, 060, 157	0 850, 583	0 1, 880, 457	0 2, 328, 948	0 155, 891, 938	201. 00 202. 00
, , , , , , , , , , , , , , , , , , ,	., 550, 107	330, 330	., 555, 167	_, 525, , 10		, 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4:58 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 10, 874, 947 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 4, 576, 816 31.00 04000 SUBPROVIDER - IPF 40 00 2, 613, 119 40 00 04100 SUBPROVIDER - IRF 41.00 37 41.00 04200 SUBPROVI DER 0 0 42.00 42.00 0 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 2, 719, 146 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 8, 469, 333 8, 117, 316 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000000 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55 00 55.01 05501 ULTRA SOUND 1, 288, 976 55.01 05700 CT SCAN 57.00 1, 375, 212 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 1,003,883 58.00 05900 CARDIAC CATHETERIZATION 1, 400, 110 59.00 59.00 60.00 06000 LABORATORY 10, 299, 349 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 321, 468 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 6, 182 64.00 06600 PHYSI CAL THERAPY 2, 898, 224 66.00 66 00 808, 660 06700 OCCUPATIONAL THERAPY 67.00 67.00 06701 AUDI OLOGY 67.01 468, 105 67.01 06800 SPEECH PATHOLOGY 68.00 68.00 268, 044 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 06901 CARDI OLOGY 2, 886, 546 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 765, 033 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 689, 304 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 10, 917, 319 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 00000000000000 09001 OTHER OUTPATIENT SERVICE COST CENTER 90.01 690, 263 90.01 90.02 09002 CLI NI C 90.02 90. 03 09003 DERMATOLOGY CLINIC 0 90.03 09004 ENT CLINIC 90 04 11 90 04 90.05 09005 SURGERY CLINIC Ω 90.05 09007 UROLOGY CLINIC 90.07 49,643 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 7.636 90.09 09011 NEUROLOGY CLINIC 90.11 168, 887 90.11 90.12 09012 OPTHAMOLOGY CLINIC 90.12 09013 ALLERGY CLINIC 90. 13 181, 662 90.13 90 14 09014 WOUND CARE 1 221 866 90 14 91.00 09100 EMERGENCY 7,824,600 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 4, 145, 776 95.00 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 91, 057, 473 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190 00 34 022 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 60, 577, 384 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 194.00 194. 01 07951 CAFE/BOUTI QUE 0 0 0 0 154, 008 194. 01 194.02 07952 OTHER NONREIMB 652, 973 194. 02 194. 03 07953 RETAIL PHARMACY 194. 03 3, 416, 078 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 155, 891, 938 202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/202 | To 12/31/2022 | To 12/31/202 | To 12/31/ Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

				Io	12/31/2022	Date/lime Pre 5/30/2023 4:5	
			CAPI TAL REI	ATED COSTS		10,00,2020 110	, p
	Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FIXT	EQUI P		BENEFITS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
GE	NERAL SERVICE COST CENTERS						
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0200 NEW CAP REL COSTS-MVBLE EQUIP		27.040	27 270	FF 010	FF 010	2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL	0	27, 949 367, 147		55, 019 722, 744	55, 019 5, 881	4. 00 5. 00
	0700 OPERATION OF PLANT		304, 907		600, 221	563	7. 00
1	0800 LAUNDRY & LINEN SERVICE	0	0		0	36	8. 00
	9900 HOUSEKEEPI NG	0	43, 837		86, 295	409	9. 00
	1000 DI ETARY	0	98, 126		193, 165	328	10.00
	I 100 CAFETERIA I 300 NURSING ADMINISTRATION	0	0		0	368 431	11. 00 13. 00
	1500 PHARMACY	0	30, 292	1	59, 631	495	15. 00
	1600 MEDICAL RECORDS & LIBRARY	0	47, 852		94, 199	915	16. 00
	IPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	0	318, 280		626, 547	2, 783	30.00
	B100 INTENSIVE CARE UNIT HO00 SUBPROVIDER - IPF	0	87, 409 100, 078		172, 068 197, 008	1, 297 906	31. 00 40. 00
	1100 SUBPROVI DER – I RF		100, 078	70, 730	177, 000	0	41.00
	1200 SUBPROVI DER	0	0	O	0	0	42. 00
	1300 NURSERY	0	0	0	0	0	43. 00
	1400 SKILLED NURSING FACILITY	0	75, 785	73, 401	149, 186	765	44. 00
	ICILLARY SERVICE COST CENTERS  5000 OPERATING ROOM	l ol	339, 495	328, 815	668, 310	1, 865	50. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	310, 671		611, 569	1, 298	54.00
	5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
	5501 ULTRA SOUND	0	0	0	0	156	55. 01
	5700 CT SCAN	0	0	0	0 52 444	177	57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI) 5900 CARDIAC CATHETERIZATION	0	26, 652 22, 465		52, 466 44, 224	248 313	58. 00 59. 00
	5000 LABORATORY	0	156, 867		308, 799	2, 603	60.00
	300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
	5400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
	6600 PHYSICAL THERAPY 6700 OCCUPATIONAL THERAPY	0	140, 229	135, 817	276, 046	1, 167 386	66. 00 67. 00
	5700 OCCUPATIONAL THERAPT		13, 951	1	27, 463	174	67. 00
	5800 SPEECH PATHOLOGY	0	0	0	0	130	68. 00
	5900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	5901 CARDI OLOGY	0	14, 451	13, 996	28, 447	1, 164	69. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	o	0		Ö	0	73. 00
OL	JTPATIENT SERVICE COST CENTERS						
	9000 CLINIC	0	0		0		90.00
	POO1 OTHER OUTPATIENT SERVICE COST CENTER POO2 CLINIC	0	59, 710 0	·	117, 541 0	79 0	90. 01 90. 02
	2003 DERMATOLOGY CLINIC	o	0	Ö	Ö	0	90. 03
	POO4 ENT CLINIC	0	0	0	0	0	90. 04
	9005 SURGERY CLINIC	0	0	0	0	0	90. 05
	POO7 UROLOGY CLINIC POO9 GASTROENTEROLOGY CLINIC	0	0	0	0	41	90. 07 90. 09
	PO11 NEUROLOGY CLINIC		0		0	0	90. 09
	PO12 OPTHAMOLOGY CLINIC	0	0	Ö	0	0	90. 12
	PO13 ALLERGY CLINIC	0	13, 951		27, 463	62	90. 13
	9014 WOUND CARE	0	117, 795		231, 884	208	1
	2100 EMERGENCY 2200 OBSERVATION BEDS (NON-DISTINCT PART)	O	383, 785	371, 712	755, 497 0	2, 113	91. 00 92. 00
	THER REIMBURSABLE COST CENTERS				o <sub>l</sub>		72.00
95.00 09	9500 AMBULANCE SERVICES	0	74, 364	72, 024	146, 388	1, 957	95. 00
	PECIAL PURPOSE COST CENTERS	TI					
	SUBTOTALS (SUM OF LINES 1 through 117)  DNREIMBURSABLE COST CENTERS	0	3, 176, 048		6, 252, 180	29, 318	]118. 00 ]
	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9, 749		19, 191		190. 00
	P200 PHYSICIANS' PRIVATE OFFICES P50 THORNTOWN OFFICE BUILDING	0	1, 366, 570 0		2, 690, 149	25, 447	192. 00 194. 00
	7950 THORNTOWN OFFICE BUILDING		22, 122		43, 548		194. 00
	7952 OTHER NONREI MB		167, 709		330, 142		194. 02
	7953 RETAIL PHARMACY	0	6, 249		12, 301	233	194. 03
200.00	Cross Foot Adjustments		^		0	_	200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	0 4, 748, 447	0 4, 599, 064	0 9, 347, 511		201. 00 202. 00
202.00	1.577.2 (56 11165 116 till bugir 201)	<u> </u>	1, , 10, 447	1, 5,7,004	., 517, 511	55, 617	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0104

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/30/2023 4:58 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 00 728.625 5 00 7.00 00700 OPERATION OF PLANT 23,772 624, 556 7.00 00800 LAUNDRY & LINEN SERVICE 3, 443 3, 479 8.00 8.00 9.00 00900 HOUSEKEEPI NG 5, 393 6.763 98.860 9.00 C 01000 DI ETARY 7.049 222, 277 10.00 10.00 15, 138 0 6.597 2, 199 01100 CAFETERI A 4,830 0 11.00 11.00 0 13 00 01300 NURSING ADMINISTRATION 3,823 0 995 0 13.00 01500 PHARMACY 15 00 8 306 4,673 0 2 008 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 9,965 4, 399 0 16.00 7, 382 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38, 753 49, 101 93, 957 207 33.416 30.00 03100 INTENSIVE CARE UNIT 18.029 8.874 31.00 13, 485 50 36, 482 31.00 04000 SUBPROVIDER - IPF 40.00 8,755 15, 439 23 10, 553 31, 697 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 04200 SUBPROVI DER 42.00 0 0 0 0 42.00 0 04300 NURSERY O 43.00 Λ r 0 Λ 43.00 04400 SKILLED NURSING FACILITY 60, 141 44.00 44.00 9,797 11,691 20 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 35, 351 52, 374 442 1.970 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 32, 490 47, 927 276 8, 913 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C C 0 55.00 05501 ULTRA SOUND 5,625 70 574 55.01 55.01 0 05700 CT SCAN 5, 507 57 00 440 880 Λ 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 4, 118 4, 112 111 842 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 6, 166 3, 466 136 0 59.00 06000 LABORATORY 45.759 60.00 24, 200 629 3.768 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1, 493 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 29 0 64.00 06600 PHYSI CAL THERAPY 66.00 11,580 21, 633 52 1, 358 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 3 276 24 650 0 67 00 1, 919 06701 AUDI OLOGY 67.01 2, 152 6 478 0 67.01 06800 SPEECH PATHOLOGY 1, 100 287 0 68.00 68.00 6 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 0 06901 CARDI OLOGY 11.998 69.01 2, 229 191 2, 888 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 401 92 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 7,805 90 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 47, 190 964 225 2,085 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, 281 9, 211 0 0 90.01 5, 126 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 90.05 90.05 0 0 0 09007 UROLOGY CLINIC 1 90 07 90 07 231 Ω 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 90.09 09011 NEUROLOGY CLINIC 90.11 669 0 90.11 0 09012 OPTHAMOLOGY CLINIC 0 90. 12 90.12 0 0 90 13 09013 ALLERGY CLINIC 748 2 152 2 0 0 90 13 09014 WOUND CARE 4,879 18, 172 45 0 90.14 90.14 0 91 00 09100 EMERGENCY 33, 210 59, 207 270 O O 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 18, 242 09500 AMBULANCE SERVICES 95.00 11, 472 33 0 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 439.953 382, 943 3, 479 98, 860 222, 277 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 102 1, 504 0 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 272,007 210, 823 0 0 0 192, 00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 0 194.00 194. 01 07951 CAFE/BOUTI QUE 590 3, 413 0 0 0 194. 01 o 194. 02 07952 OTHER NONREIMB 2,053 25, 873 0 0 194. 02 194. 03 07953 RETAIL PHARMACY 0 194, 03 13,920 0 0 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 728.625 624, 556 3.479 98, 860 222, 277 202. 00

Provider CCN: 15-0104

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:58 pm

Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	5/30/2023 4:5 Subtotal	8 pm
oost deliter bescription	ONI ETEKTA	ADMI NI STRATI ON	THANMACT	RECORDS & LI BRARY	Subtotal	
	11.00	13.00	15. 00	16. 00	24. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00   O0100   NEW CAP REL COSTS-BLDG & FIXT 2.00   O0200   NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY						9.00
10. 00   01000  DI ETARY 11. 00   01100  CAFETERI A	7, 397	,				10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	143					13. 00
15. 00 01500 PHARMACY	286	1	75, 399			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	580	0	0	117, 440		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	1 051	007	2	20.040	07/ 5/5	20.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	1, 951 158	1 1	3	28, 860 6, 001	876, 565 256, 880	
40. 00   04000   SUBPROVI DER - I PF	249		0	7, 144	272, 147	
41. 00   04100   SUBPROVI DER -   I RF	C	1 1	1	0	1	1
42. 00   04200   SUBPROVI DER	C	o	0	O	0	42. 00
43. 00   04300   NURSERY	C	1	0	0	0	
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	C	384	0	0	231, 984	44. 00
50. 00   05000   OPERATING ROOM	173	808	126	10, 358	771, 777	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	211		408	27, 717	730, 921	1
55. 00   05500 RADI OLOGY-THERAPEUTI C	C		0	0	0	1
55. 01   05501   ULTRA SOUND	23	1	32	3, 000	9, 480	1
57. 00   05700   CT   SCAN	30		767	3, 429	11, 230	1
58.00   O5800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   O5900   CARDIAC CATHETERIZATION	75 0		304	1, 857	64, 133 54, 454	1
60. 00   06000   LABORATORY	618		0	2, 857	389, 233	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	1 1	0	0	1, 502	
64. 00 06400 I NTRAVENOUS THERAPY	C	o	0	0	29	64. 00
66. 00   06600   PHYSI CAL THERAPY	309		5	5, 572	318, 115	1
67. 00 06700 OCCUPATI ONAL THERAPY	128		0	2, 429	7, 071	1
67. 01   06701   AUDI OLOGY 68. 00   06800   SPEECH PATHOLOGY	13 <i>6</i> 143	1 1	0	O O	32, 413 1, 712	1
69. 00   06900   SPEECH FAMIOLOGY	143	1	0	0	1, 712	1
69. 01   06901   CARDI OLOGY	309	1	91	5, 358	53, 133	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	158	0	0	0	17, 651	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	C		0	0	7, 895	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	С	0	29, 663	0]	80, 127	73. 00
90. 00 09000 CLI NI C	C	0	0	ol	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	256		0	12, 001	145, 519	1
90. 02 09002 CLI NI C	C	o	0	0	0	90. 02
90. 03   09003   DERMATOLOGY CLINIC	C	1	0	0	0	
90. 04   09004 ENT CLINIC	C	1	0	0	0	1
90. 05   09005   SURGERY CLINIC 90. 07   09007   UROLOGY CLINIC	C	1 1	0	0	0 273	1
90. 09 09009 GASTROENTEROLOGY CLINIC	C		0	0	48	1
90. 11   09011   NEUROLOGY   CLI NI C	C	o	1, 031	0	1, 700	1
90. 12   09012   0PTHAMOLOGY   CLI NI C	C	1	0	0	0	90. 12
90. 13   09013   ALLERGY   CLI NI C	C		1	0	30, 451	1
90. 14   09014   WOUND CARE 91. 00   09100   EMERGENCY	482		195 597	0	255, 482 851, 982	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	402	000	377		031, 702	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	979	0	90	0	179, 161	95. 00
SPECIAL PURPOSE COST CENTERS  118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 397	, E 20E	22 210	114 500	F (F2 0(0	110 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	1, 391	5, 205	33, 318	116, 583	5, 653, 069	] 118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	C	0	0	0	20, 797	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	C		24, 518	857	3, 223, 968	192. 00
194. 00 07950 THORNTOWN OFFICE BUILDING	C	1	0	0		194. 00
194. 01 07951 CAFE/BOUTI QUE 194. 02 07952 OTHER NONREI MB	C		0	0	47, 572 358, 088	194. 01
194. 02 07952 0THER_NONRETMB 194. 03 07953  RETALL_PHARMACY	(	20	17, 563	0		194. 02
200.00 Cross Foot Adjustments		1	17,000	Ĭ		200. 00
201.00 Negative Cost Centers	C		0	О	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	7, 397	5, 392	75, 399	117, 440	9, 347, 511	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/30/2023 4:58 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 876, 565 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 256, 880 31.00 04000 SUBPROVIDER - IPF 40 00 272.147 40 00 04100 SUBPROVIDER - IRF 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 0 43.00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 231, 984 44 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 771, 777 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000000000 730, 921 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55 00 Ω 55.01 05501 ULTRA SOUND 9, 480 55.01 05700 CT SCAN 57.00 11, 230 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 64. 133 58.00 05900 CARDIAC CATHETERIZATION 59.00 54, 454 59.00 60.00 06000 LABORATORY 389, 233 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 502 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 29 64.00 06600 PHYSI CAL THERAPY 66.00 318, 115 66.00 06700 OCCUPATIONAL THERAPY 7, 071 67.00 67.00 06701 AUDI OLOGY 67.01 32, 413 67.01 06800 SPEECH PATHOLOGY 68.00 68.00 1, 712 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 06901 CARDI OLOGY 53, 133 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 17, 651 71.00 7, 895 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 80, 127 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 00000000000000 09001 OTHER OUTPATIENT SERVICE COST CENTER 90.01 145, 519 90.01 90.02 09002 CLI NI C 90.02 90. 03 09003 DERMATOLOGY CLINIC 0 90.03 09004 ENT CLINIC 90 04 0 90 04 90.05 09005 SURGERY CLINIC 0 90.05 09007 UROLOGY CLINIC 90.07 273 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 90.09 48 09011 NEUROLOGY CLINIC 90.11 1,700 90.11 90.12 09012 OPTHAMOLOGY CLINIC C 90.12 09013 ALLERGY CLINIC 90. 13 30, 451 90.13 90 14 09014 WOUND CARE 255 482 90.14 09100 EMERGENCY 91.00 851, 982 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 179, 161 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 5, 653, 069 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190 00 20 797 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 3, 223, 968 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 194.00 194. 01 07951 CAFE/BOUTI QUE 0 0 47.572 194. 01 194.02 07952 OTHER NONREIMB 358, 088 194. 02 194. 03 07953 RETAIL PHARMACY 194. 03 44, 017 0 200.00 Cross Foot Adjustments 0 200. 00 201.00 Negative Cost Centers Ω 201. 00 202.00 TOTAL (sum lines 118 through 201) 9, 347, 511 202.00

		TION - STATISTICAL BASIS	WI IIIAW WEWOKIA	Provider CO	CN: 15-0104 F	Peri od:	Worksheet B-1	
						From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			CAPITAL RELA	ATED COCTO			5/30/2023 4:5	8 pm
			CAPITAL RELA	AIED COSIS				
		Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation		
			FIXT (SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT		& GENERAL (ACCUM.	
			FEET)	FEET)	(GROSS		COST)	
			1.00	,	SALARI ES)		,	
	GENER	AL SERVICE COST CENTERS	1.00	2. 00	4. 00	5A	5. 00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	303, 947					1.00
2.00		NEW CAP REL COSTS-MVBLE EQUIP		303, 947				2. 00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	1, 789 23, 501	1, 789 23, 501			137, 385, 642	4. 00 5. 00
7. 00		OPERATION OF PLANT	19, 517	19, 517			4, 481, 844	1
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	46, 604	1 0	649, 207	8. 00
9.00	00900	HOUSEKEEPI NG DI ETARY	2, 806	2, 806			1, 016, 778	
10. 00 11. 00		CAFETERIA	6, 281 0	6, 281 0			1, 328, 906 910, 602	
13. 00		NURSI NG ADMI NI STRATI ON	o	0	1		720, 814	
15.00		PHARMACY	1, 939	1, 939			1, 565, 895	
16. 00		MEDICAL RECORDS & LIBRARY IENT ROUTINE SERVICE COST CENTERS	3, 063	3, 063	1, 170, 036	5 0	1, 878, 836	16.00
30.00	03000	ADULTS & PEDIATRICS	20, 373	20, 373	3, 558, 75	0	7, 306, 374	30.00
31.00		INTENSIVE CARE UNIT	5, 595	5, 595			3, 399, 069	1
40. 00 41. 00	1	SUBPROVIDER - IPF SUBPROVIDER - IRF	6, 406	6, 406 0	1, 158, 176	0	1, 650, 695 0	1
42. 00		SUBPROVI DER	Ö	0		o o	0	
43.00		NURSERY	0	0	(	0	0	
44. 00		SKILLED NURSING FACILITY LARY SERVICE COST CENTERS	4, 851	4, 851	978, 189	9 0	1, 847, 035	44. 00
50. 00		OPERATING ROOM	21, 731	21, 731	2, 385, 292	2 0	6, 664, 894	50.00
54.00		RADI OLOGY-DI AGNOSTI C	19, 886	19, 886		0	6, 125, 653	54.00
55. 00		RADI OLOGY-THERAPEUTI C	0	0	100 (4	0 0	1 0/0 533	
55. 01 57. 00		ULTRA SOUND CT SCAN	0	0	199, 667 226, 67		1, 060, 523 1, 038, 197	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 706	1, 706			776, 313	
59. 00		CARDI AC CATHETERI ZATI ON	1, 438	1, 438			1, 162, 542	
60. 00 63. 00	1	LABORATORY BLOOD STORING, PROCESSING & TRANS.	10, 041	10, 041	3, 328, 946		8, 627, 328 281, 540	
64. 00		I NTRAVENOUS THERAPY	0	0			201, 340	
66. 00		PHYSI CAL THERAPY	8, 976	8, 976			2, 183, 259	
67. 00 67. 01		OCCUPATI ONAL THERAPY AUDI OLOGY	0 893	0 893	492, 973 222, 889		617, 678 361, 896	
68. 00		SPEECH PATHOLOGY	0	0			207, 426	
69. 00		ELECTROCARDI OLOGY	0	0	(	0	0	
69. 01 71. 00		CARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	925	925	1, 488, 109	0 0	2, 262, 128 3, 280, 650	
		IMPL. DEV. CHARGED TO PATIENT	0	0			1, 471, 589	
73. 00		DRUGS CHARGED TO PATIENTS	0	0	(	0	8, 897, 070	73. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	ol	0	1 (		0	90.00
90. 00		OTHER OUTPATIENT SERVICE COST CENTER	3, 822	3, 822	100, 869	9 0	241, 574	
90. 02		CLI NI C	0	0	. (	0	0	90. 02
90. 03 90. 04		DERMATOLOGY CLINIC ENT CLINIC	0	0	(	0	0	
90. 04		SURGERY CLINIC	0	0			10 0	1
90. 07	09007	UROLOGY CLINIC	0	0	52, 750	0	43, 549	90. 07
90. 09	1	GASTROENTEROLOGY CLINIC	0	0	31.		51	
90. 11 90. 12		NEUROLOGY CLINIC OPTHAMOLOGY CLINIC	0	0	(	0	126, 185 0	1
90. 13	1	ALLERGY CLINIC	893	893	78, 92 <sup>2</sup>	i o	140, 993	1
90. 14	1	WOUND CARE	7, 540	7, 540			919, 808	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	24, 566	24, 566	2, 701, 504	0	6, 261, 279	91.00
<del>9</del> 2.00		REIMBURSABLE COST CENTERS			l .			72.00
95. 00	09500	AMBULANCE SERVICES	4, 760	4, 760	2, 503, 022	0	3, 439, 324	95. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	203, 298	203, 298	37, 490, 553	-18, 506, 296	92 047 E14	110 00
110.00		IMBURSABLE COST CENTERS	203, 290	203, 290	37, 490, 550	- 10, 300, 290	82, 947, 514	1110.00
	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624				190. 00
		PHYSICIANS' PRIVATE OFFICES	87, 474	87, 474	32, 560, 333		51, 296, 147	
		THORNTOWN OFFICE BUILDING CAFE/BOUTIQUE	1, 416	1, 416	27, 255	0 0	111, 235	194. 00 194. 01
194. 02	07952	OTHER NONREIMB	10, 735	10, 735		0	387, 029	194. 02
		RETAIL PHARMACY	400	400	298, 317	0	2, 624, 526	
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
	1	1 3			1	1	l .	

Heal th	Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
COST AL	LOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		& GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
		1.00	2. 00	4.00	5A	5. 00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 748, 447	4, 599, 064	11, 589, 00	00	18, 506, 296	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 622615	15. 131138	0. 16467	2	0. 134703	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			55, 01	9	728, 625	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00078	2	0. 005304	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems	WITHAM MEMORI				u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CO		eriod: rom 01/01/2022	Worksheet B-1	
				,		Date/Time Pre	
		ODEDATION OF	LAUNDDV 0	HOUGEKEEDING	DIETADY	5/30/2023 4:5	8 pm
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (HOURS OF	DI ETARY (MEALS	CAFETERIA (MEALS	
		(SQUARE	(GROSS	SERVICE)	SERVED)	SERVED)	
		FEET)	CHARGES)	02	02.11723)	0225)	
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	1		Г			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	259, 140					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	427, 168, 359				8. 00
9.00	00900 HOUSEKEEPI NG	2, 806	0	129, 223			9. 00
10.00	01000 DI ETARY	6, 281	0	8, 623		000	10.00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	0	0	2, 875 1, 300		982 19	
15. 00	01500 PHARMACY	1, 939	0	2, 625		38	
	01600 MEDICAL RECORDS & LIBRARY	3, 063	0	5, 750		77	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	20, 373	25, 869, 461			259	1
31. 00	03100 I NTENSI VE CARE UNI T	5, 595	6, 205, 801	11, 600		21	
40. 00 41. 00	04000   SUBPROVI DER - I PF   04100   SUBPROVI DER - I RF	6, 406	2, 916, 918	13, 794	6, 459	33	40.00
42. 00	04200 SUBPROVI DER	0	0		0	0	1
43. 00	04300 NURSERY	0	Ö	Ö	o	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	4, 851	2, 554, 570	0	12, 255	0	44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 731	55, 197, 809			23	1
54.00	05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C	19, 886	34, 537, 877 0	11, 650 0	1	28 0	1
55. 00 55. 01	05501 ULTRA SOUND	0	8, 718, 757	750		3	55. 00 55. 01
57. 00	05700 CT SCAN	o o	55, 058, 097	1, 150		4	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 706	13, 928, 648		1	10	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 438	16, 940, 415			0	
60.00	06000 LABORATORY	10, 041	70, 600, 501		1	82	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 161, 523			0	
64. 00 66. 00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	8, 976	3, 583, 608 6, 533, 105			41	
67. 00	06700 OCCUPATI ONAL THERAPY	0, 770	3, 037, 658			17	67. 00
67. 01	06701 AUDI OLOGY	893	766, 296			18	
68. 00	06800 SPEECH PATHOLOGY	0	800, 193	375	0	19	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
69. 01 71. 00	06901   CARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	925	23, 857, 320			41	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	11, 477, 860 11, 297, 436		_	21 0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	400	28, 175, 513			0	1
	OUTPATIENT SERVICE COST CENTERS			·			
	09000 CLI NI C	0	0			0	
	09001 OTHER OUTPATIENT SERVICE COST CENTER	3, 822	0	6, 700		34	
90. 02 90. 03	09002   CLI NI C   09003   DERMATOLOGY   CLI NI C	0	0	0	-	0	
90. 03	09004 ENT CLINIC	0	0			0	
90. 05	09005 SURGERY CLINIC	0	0	Ö	_	0	1
90. 07	09007 UROLOGY CLINIC	0	132, 087	0	0	0	1
90. 09	09009 GASTROENTEROLOGY CLINIC	0	0	0		0	
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	
90. 12 90. 13	O9012 OPTHAMOLOGY CLINIC   O9013 ALLERGY CLINIC	893	296, 430	0	0	0	
90. 13	09014 WOUND CARE	7, 540	5, 668, 141	0	0	0	
	09100 EMERGENCY	24, 566	33, 708, 197	Ö	o	64	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS			T			
95. 00	09500 AMBULANCE SERVI CES	4, 760	4, 144, 138	0	0	130	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	158, 891	427, 168, 359	129, 223	45, 294	002	118. 00
110.00	NONREI MBURSABLE COST CENTERS	130, 071	427, 100, 339	127, 223	45, 274	702	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	87, 474	0	0	0		192. 00
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194. 00
	07951 CAFE/BOUTI QUE	1, 416	0	0	0		194. 01
	07952 OTHER NONREIMB 07953 RETAIL PHARMACY	10, 735	0		0		194. 02 194. 03
200.00						O	200.00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B,	5, 085, 562	736, 657	1, 208, 808	1, 711, 840	1, 060, 157	202. 00
202.00	Part I)	10 (047)	0 001705	0.254424	27 702040	1 070 500/40	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	19. 624767	0. 001725	9. 354434	37. 793968	1, 079. 589613	1203.00

Health Fina	ncial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der Co	Provider CCN: 15-0104		Worksheet B-1		
					To 12/31/2022	Date/Time Pre 5/30/2023 4:5		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS		
		(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)		
		FEET)	CHARGES)					
		7. 00	8. 00	9. 00	10.00	11. 00		
204.00	Cost to be allocated (per Wkst. B,	624, 556	3, 479	98, 86	0 222, 277	7, 397	204. 00	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	2. 410110	0. 000008	0. 76503	4. 907427	7. 532587	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)							

| Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0104

				To 12/31/2022	Date/Time Pr 5/30/2023 4:	
Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		5/30/2023 4.	. 56 piii
	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						1.00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT 2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT						5. 00 7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY						9. 00 10. 00
11. 00   01100   CAFETERI A						11. 00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 15. 00   01500   PHARMACY	415, 525 0	9, 231, 291				13. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LI BRARY	0	9, 231, 291	41, 100			16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	7/ 072	250	10 10			
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	76, 072 33, 292	358 433	10, 100 2, 100			30. 00 31. 00
40. 00 04000 SUBPROVI DER - I PF	28, 761	61	2, 500			40. 00
41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER	0	182 0	(	1		41. 00 42. 00
43. 00 04300 NURSERY	Ö	Ö	Ó			43. 00
44.00 O4400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	29, 574	0	(	)		44. 00
50. 00 05000 OPERATING ROOM	62, 286	15, 440	3, 625			50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	8, 624 0	49, 917 0	9, 700			54. 00 55. 00
55. 00   05500   RADI OLOGI - THERAPEUTI C	0	3, 943	1, 050			55. 00
57. 00 05700 CT SCAN	0	93, 853	1, 200			57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	0 11, 494	37, 171 0	650 (			58. 00 59. 00
60. 00   06000   LABORATORY	0	25	1, 000			60.00
63.00   06300   BLOOD STORING, PROCESSING & TRANS. 64.00   06400   INTRAVENOUS THERAPY	0	0	(			63. 00 64. 00
66. 00 06600 PHYSI CAL THERAPY	30, 275	554	1, 950			66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 67. 01   06701   AUDI OLOGY	13, 712 6, 514	0	850 (			67. 00 67. 01
68. 00 06800 SPEECH PATHOLOGY	3, 555	ő	(	ó		68. 00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI OLOGY	0 35, 323	0 11, 123	1, 875			69. 00 69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 07.			71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	0	0	(			72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	3, 631, 944		بار 		73. 00
90. 00 09000 CLINIC	0	0				90.00
90. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER 90. 02   09002   CLINIC	1, 840	0	4, 200	)		90. 01 90. 02
90. 03 09003 DERMATOLOGY CLINIC	0	O	(			90. 03
90. 04   09004   ENT CLINIC 90. 05   09005   SURGERY CLINIC	0	0	(			90. 04 90. 05
90. 07   09007   UROLOGY CLI NI C	o	ő	Ó	ó		90. 07
90. 09   09009   GASTROENTEROLOGY   CLINIC 90. 11   09011   NEUROLOGY   CLINIC	3, 702	0 126, 185	-			90. 09 90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	o	0	(	ó		90. 12
90. 13   09013   ALLERGY   CLI NI C 90. 14   09014   WOUND   CARE	1, 765 7, 598	137 23, 832	(			90. 13 90. 14
91. 00   09100   EMERGENCY	46, 740	73, 085				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	11, 072	(			95. 00
SPECIAL PURPOSE COST CENTERS			10.004			<b>=</b>
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	401, 127	4, 079, 315	40, 800	)		118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING	12, 865	3, 001, 710	300			192. 00 194. 00
194. 01 07951 CAFE/BOUTI QUE	0	o	(			194. 01
194. 02 07952 OTHER NONRELMB	1, 533	2 150 244	(			194. 02 194. 03
194.03 07953 RETAIL PHARMACY 200.00  Cross Foot Adjustments	0	2, 150, 266	(	,		200. 00
201.00 Negative Cost Centers	050 500	1 000 457	2 222 23			201. 00
202.00   Cost to be allocated (per Wkst. B, Part I)	850, 583	1, 880, 457	2, 328, 948	3		202. 00
	<u> </u>	<u> </u>				<u> </u>

Heal th Fi	nancial Systems	WITHAM MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALL	DCATION - STATISTICAL BASIS		Provi der CC		Peri od: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL			
		ADMI NI STRATI ON	(COSTED	RECORDS &			
			REQUIS.)	LI BRARY			
		(DI RECT		(TIME			
		NRSING HRS)		SPENT)			
		13.00	15. 00	16.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 047008	0. 203705	56. 66540	1		203. 00
204.00	Cost to be allocated (per Wkst. B,	5, 392	75, 399	117, 44	.0		204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 012976	0. 008168	2. 85742	1		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)						

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0104

					0 12/31/2022	5/30/2023 4:5	
			Title	xVIII	Hospi tal	PPS	
	·				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	10, 874, 947		10, 874, 947		10, 874, 947	
31. 00	03100 INTENSIVE CARE UNIT	4, 576, 816		4, 576, 816		4, 576, 816	
40.00	04000 SUBPROVI DER - I PF	2, 613, 119		2, 613, 119		2, 613, 119	
41. 00	04100 SUBPROVI DER - I RF	37		37	0	37	
42.00	04200 SUBPROVI DER	0		(	-	0	
43.00	04300 NURSERY	0		(	′	0	
44. 00	04400 SKILLED NURSING FACILITY	2, 719, 146		2, 719, 146	0	2, 719, 146	44. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	8, 469, 333		8, 469, 333		8, 469, 333	
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 117, 316		8, 117, 316		8, 117, 316	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		(	1	0	55. 00
55. 01	05501 ULTRA SOUND	1, 288, 976		1, 288, 976		1, 288, 976	
57. 00	05700 CT SCAN	1, 375, 212		1, 375, 212		1, 375, 212	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 003, 883		1, 003, 883		1, 003, 883	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 400, 110		1, 400, 110		1, 400, 110	
60.00	06000 LABORATORY	10, 299, 349		10, 299, 349		10, 299, 349	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	321, 468		321, 468		321, 468	
64. 00	06400 I NTRAVENOUS THERAPY	6, 182		6, 182		6, 182	
66. 00	06600 PHYSI CAL THERAPY	2, 898, 224	0			2, 898, 224	
67. 00	06700 OCCUPATI ONAL THERAPY	808, 660	0			808, 660	
67. 01	06701 AUDI OLOGY	468, 105	0	,		468, 105	
68. 00	06800 SPEECH PATHOLOGY	268, 044	0	268, 044		268, 044	
69. 00	06900 ELECTROCARDI OLOGY	0		(	-	0	
69. 01	06901 CARDI OLOGY	2, 886, 546		2, 886, 546		2, 886, 546	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 765, 033		3, 765, 033		3, 765, 033	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 689, 304		1, 689, 304		1, 689, 304	
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 917, 319		10, 917, 319	0	10, 917, 319	73. 00
	OUTPATIENT SERVICE COST CENTERS			1		_	
90.00	09000 CLI NI C	0		(		0	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	690, 263		690, 263		690, 263	
90. 02	09002 CLINIC	0		(		0	
90. 03	09003 DERMATOLOGY CLINIC	0		(		0	
90.04	09004 ENT CLINIC	11		1		11	90. 04
90.05	09005 SURGERY CLINIC	0		(0.44	′	0	
90. 07	09007 UROLOGY CLINIC	49, 643		49, 643		49, 643	
90.09	09009 GASTROENTEROLOGY CLINIC	7, 636		7, 636		7, 636	
90. 11	09011 NEUROLOGY CLINIC	168, 887		168, 887		168, 887	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0		104 ((	-	0	90. 12
90. 13	09013 ALLERGY CLINIC	181, 662		181, 662		181, 662	1
90. 14	09014 WOUND CARE	1, 221, 866		1, 221, 866		1, 221, 866	
91.00	09100 EMERGENCY	7, 824, 600		7, 824, 600		7, 824, 600	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 860, 278		2, 860, 278	5	2, 860, 278	92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	A 14E 77/		A 14E 77	0	A 14E 77/	05 00
95.00	09500 AMBULANCE SERVICES	4, 145, 776	^	4, 145, 776		4, 145, 776	
200.00	1 /	93, 917, 751	0			93, 917, 751	
201. 00 202. 00	1 1	2, 860, 278 91, 057, 473	0	2, 860, 278 91, 057, 473		2, 860, 278 91, 057, 473	
202.00	p potar (see mistructions)	71,007,473	U	71,007,473	ار. ا	71,007,473	1202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:58 pm	Provider CCN: 15-0104

						5/30/2023 4:5	8 pm
			Title	XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col.	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	17, 721, 972		17, 721, 97	2		30.00
31.00	03100 INTENSIVE CARE UNIT	6, 205, 801		6, 205, 80	1		31.00
40.00	04000 SUBPROVI DER - I PF	2, 916, 918		2, 916, 91	8		40.00
41.00	04100 SUBPROVI DER - I RF	0			o		41.00
42.00	04200 SUBPROVI DER	0			o		42. 00
43.00	04300 NURSERY	0			o		43.00
44.00	04400 SKILLED NURSING FACILITY	2, 554, 570		2, 554, 57	o		44. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 748, 970	48, 448, 839	55, 197, 80	9 0. 153436	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 908, 239	32, 629, 638	34, 537, 87	7 0. 235026	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0. 000000	0.000000	55. 00
55. 01	05501 ULTRA SOUND	721, 719	7, 997, 038	8, 718, 75	7 0. 147839	0.000000	55. 01
57.00	05700 CT SCAN	8, 071, 618	46, 986, 479	55, 058, 09	7 0. 024977	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	926, 868	13, 001, 780	13, 928, 64	8 0. 072073	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 311, 373	11, 629, 042	16, 940, 41	5 0. 082649	0.000000	59. 00
60.00	06000 LABORATORY	14, 345, 367	56, 255, 134		0. 145882	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	641, 599	519, 924	1, 161, 52	3 0. 276764	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	1, 328, 159	2, 255, 449	3, 583, 60	8 0. 001725	0. 000000	64.00
66. 00	06600 PHYSI CAL THERAPY	2, 337, 594	4, 195, 511			0. 000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 132, 398	905, 260			0. 000000	
67. 01	06701 AUDI OLOGY	O	766, 296			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	176, 554	623, 639			0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	
69. 01	06901 CARDI OLOGY	7, 040, 747	16, 816, 573	23, 857, 32		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 285, 174	8, 192, 686			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 978, 896	9, 318, 540			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 349, 061	17, 826, 452			0. 000000	
70.00	OUTPATIENT SERVICE COST CENTERS	10/01//001	1770207102	20/1/0/01	0,00,170	0.00000	70.00
90.00	09000 CLI NI C	0	0		0. 000000	0.000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER		0		0. 000000	0. 000000	
90. 02	09002 CLI NI C	0	0		0. 000000	0. 000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0		0. 000000	0. 000000	
90. 04	09004 ENT CLINIC	0	0		0. 000000	0. 000000	
90. 05	09005 SURGERY CLINIC	0	0	•	0. 000000	0. 000000	
90. 07	09007 UROLOGY CLINIC		132, 087			0. 000000	
90. 09	09009 GASTROENTEROLOGY CLINIC		.02,007	102,00	0. 000000	0. 000000	
90. 11	09011 NEUROLOGY CLINIC		0		0. 000000	0. 000000	
90. 12	09012 OPTHAMOLOGY CLINIC		0		0. 000000	0. 000000	
90. 13	09013 ALLERGY CLINIC		296. 430			0. 000000	
90. 14	09014 WOUND CARE	15, 322	5, 652, 819			0. 000000	
91. 00	09100 EMERGENCY	4, 523, 300	29, 184, 897				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	294, 759	7, 852, 730			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	274, 737	7,002,730	0, 177, 40	7, 0. 331003	0.000000	1 /2.00
95. 00	09500 AMBULANCE SERVICES	0	4, 144, 138	4, 144, 13	8 1. 000395	0. 000000	95 00
200.00		101, 536, 978	325, 631, 381			3.000000	200.00
201.00	,	101,000,770	520, 001, 001	127, 100, 00			201.00
202.00		101, 536, 978	325, 631, 381	427, 168, 35	9		202.00
202.00	1.2.2. (333 1.131 431 3.13)	10.7000,770	-20,00.,001	1 .2., .55, 66	-1	ı	1-32. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:58 pm Health Financial Systems

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

			T: +1 o V/// / /	Hooni tol	PPS
	Coot Contan Decement on	DDC Innotiont	Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
	INDATIONE DOUTING CODVICE COST CENTERS	11.00			
30. 00	O3000 ADULTS & PEDIATRICS	T I			30.00
31. 00					31.00
	03100   NTENSI VE CARE UNI T				
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
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.150407			F0.00
50.00	05000 OPERATING ROOM	0. 153436			50.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 235026			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000			55. 00
55. 01	05501 ULTRA SOUND	0. 147839			55. 01
57. 00	05700 CT SCAN	0. 024977			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 072073			58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 082649			59.00
60.00	06000 LABORATORY	0. 145882			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 276764			63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 001725			64. 00
66. 00	06600 PHYSI CAL THERAPY	0. 443621			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 266212			67. 00
67. 01	06701 AUDI OLOGY	0. 610867			67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 334974			68.00
69.00	06900 ELECTROCARDI OLOGY	0.000000			69.00
69. 01	06901 CARDI OLOGY	0. 120992			69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 328026			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 149530			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 387475			73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
90.00	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000 0. 000000			90. 00
90. 01	09001 OTHER OUTPATTENT SERVICE COST CENTER	0. 000000			90.01
90. 02		1			
90. 03	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0. 000000 0. 000000			90. 03
90. 04	09004 ENT CLINIC	0. 000000			90.04
90. 05	09007 UROLOGY CLINIC	0. 375836			90.05
90.07	09007 DROLOGY CLINIC	0. 375836			90.07
90. 09	09011 NEUROLOGY CLINIC	0. 000000			90. 09
90. 11	09011 NEUROLOGY CLINIC	0. 000000			90.11
90. 12	09012 OPTHAMOLOGY CLINIC	1			90. 12
90. 13	09014 WOUND CARE	0. 612833 0. 215567			90. 13
90. 14	09100 EMERGENCY	0. 215567			91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 232128			92.00
72. UU	OTHER REIMBURSABLE COST CENTERS	0. 301003			92.00
95. 00	09500 AMBULANCE SERVICES	1. 000395			95. 00
200.00		1.000373			200. 00
200.00					201. 00
201.00					202.00
202.00	Total (300 Histi dott ons)	1			1202.00

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0104

Cost Center Description						0 12/31/2022	5/30/2023 4:5	
NINATEEN ROUTH SERVICE COST CENTERS   Part 1, col.   Part 1, col				Ti tl	e XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS   Adj   Disall ownce   Part 1, col   2,00   3,00   4,00   5,00						Costs		
Part   Col.		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		·	(from Wkst. B,	Adj .		Di sal I owance		
IMPATI ENT ROUTINE SERVICE COST CENTERS   1,00   2,00   3,00   4,00   5,00			Part I, col.	·				
INPART ENT ROUTH NE SERVICE COST CENTERS   10, 874, 947   10, 874, 947   0, 10, 874, 947   31, 00   31.00   03100   AULTS & PEDIATRICS   14, 576, 816   4, 576, 816   0, 4, 576, 816   31, 00   04100   03100   INTENSIVE CARE UNIT   4, 576, 816   4, 576, 816   0, 4, 576, 816   31, 00   04100   03100   INTENSIVE CARE UNIT   4, 576, 816   31, 00   041			26)					
30. 00   30000   ADULTS & PEDIATRICS   10, 874, 947   10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 874, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 10, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947   0, 947, 947, 947   0, 947, 947, 947   0, 947, 947, 947, 947, 947, 947, 947, 947			1.00	2.00	3. 00	4. 00	5. 00	
13.1 0.0   03100   INTENSIVE CARE UNIT								
40.00   04000   SUBPROVI DER - I PF   2, 613, 119   0, 00   0   0   0, 00   0   0   0   0					· · ·			
11.00   04100   SUBPROVI DER   1   1   1   0   0   0   0   0   0   0								
42 00   04200   SUBROVI DER   0   0   0   0   0   0   22 00								
43. 00   04300   NURSERY   0   0   0   0   0   0   43. 00   ANCI LLARY SERVICE COST CENTERS    144. 00   A4000   OSCHOLLER NURSING FACILITY   2,719,146   2,719,146   0,2,719,146   0,2,719,146			1		•			
A			-1			-		
ANCILLARY SERVICE COST CENTERS			1			,	_	
50.00	44. 00		2, 719, 146		2, 719, 146	0	2, 719, 146	44. 00
54 00   05400   RADI DLOCY-DI AGNOSTIC   8, 117, 316   0   0, 173, 316   54, 00   0   0   0   0   0   55, 00   05500   08500   RADI DLOCY-THERAPEUTIC   0   0   0   0   0   0   55, 00   05500   RADI DLOCY-THERAPEUTIC   0   0   0   0   0   0   55, 00   05500   RADI DLOCY-THERAPEUTIC   1, 288, 976   1, 288, 976   0   10, 299, 349   0			TI		1			
55. 00   05500   RADIOLOGY-THERAPEUTIC   0   1, 288, 976   0   55. 00   55. 00   55. 00   0			1					
1.288.976   1.288.976   1.288.976   1.288.976   1.288.976   5.5 01			1					
57.00   05700   05700   05700   05700   050000   050000   050000   050000   050000   050000   050000   050000   0500			-1			_		1
SB 00   OSBOO   MAGNETI C RESONANCE I MAGING (MRI )								
59. 00   050								
60.00   06000   LABORATORY   10, 299, 349   10, 299, 349   321, 468   0 321, 468   63. 00								
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   321, 468   321, 468   0   63.01   06400   06400   INTRAVENOUS THERAPY   6, 182   6, 182   0   6, 182   0   0, 61.82   06.00   06600   PHYSI CAL THERAPY   2, 898, 224   0   2,								
64.00   06400   INTRAVENOUS THERAPY   6,182   6,182   0   6,182   64.00   66.00   06600   PHYSI CAL THERAPY   2,898,224   0   2,898,224   0   2,898,224   0   2,898,224   60.00   67.01   0670								
66.00   06600   PHYSICAL THERAPY   2,898,224   0   2,898,224   0   2,898,224   66.00   67.01   06701   OCCUPATI ONAL THERAPY   808,660   0   808,660   0   808,660   67.01   67.01   06701   AUDI OLOGY   468,105   0   468,105   0   468,105   0   68.00   06800   SPEECH PATHOLOGY   268,044   0   268,044   0   268,044   0   268,044   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   69.01   06901   CARDI OLOGY   2,886,546   2,886,546   0   2,886,546   0   2,886,546   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3,765,033   3,765,033   0   3,765,033   71.00   72.00   072.00   IMPL. DEV. CHARGED TO PATI ENTS   10,917,319   10,917,319   0   10,917,319   73.00   07300   DRUGS CHARGED TO PATI ENTS   10,917,319   10,917,319   0   10,917,319   73.00   07300   DRUGS CHARGED TO PATI ENTS   10,917,319   10,917,319   0   10,917,319   73.00   07000   CLINIC   0   0   0   0   0   0   0   70.01   09000   CLINIC   0   0   0   0   0   0   70.02   09000   CLINIC   0   0   0   0   0   70.03   09003   DERMATOLOGY CLINIC   0   0   0   0   0   70.04   09004   ENT CLINIC   11   11   11   0   11   90.04   70.05   09005   SURGERY CLINIC   49,643   49,643   0   49,643   90.07   70.07   09007   UROLOGY CLINIC   7,636   7,636   7,636   0   7,636   90.07   70.08   09001   DERMATOLOGY CLINIC   168,887   0   168,887   0   168,887   0   10,21,21,866   0   1,221						,		
67. 00   06700   06CUPATI ONAL THERAPY   808, 660   0   808, 660   0   808, 660   67. 00   67. 01   06701   AUDI OLOGY   268, 044   0   268, 044   0   268, 044   0   268, 044   0   69. 00   06800   SPEECH PATHOLOGY   268, 044   0   268, 044   0   0   0   0   0   0   69. 01   06901   CARDI OLOGY   2   286, 546   0   2   286, 546   0   2   286, 546   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 765, 033   3, 765, 033   0   3, 765, 033   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   1, 689, 304   1, 689, 304   0   1, 689, 304   72. 00   73. 00   70300   DRUSS CHARGED TO PATIENTS   10, 917, 319   10, 917, 319   0   10, 917, 319    00. 00   09000   CLI NI C   0   0   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   79. 01   09001   07HER OUTPATIENT SERVI CE COST CENTER   690, 263   690, 263   690, 263   0   690, 263   90. 01   79. 02   09002   CLI NI C   0   0   0   0   0   0   79. 03   09003   DERMATOLOGY CLI NI C   0   0   0   0   0   0   79. 04   09004   ENT CLI NI C   11   11   11   11   0   11   90. 04   79. 05   09005   SURGERY CLI NI C   0   0   0   0   0   0   79. 07   09007   UROLOGY CLI NI C   49, 643   49, 643   49, 643   0   49, 643   90. 07   79. 09   09009   GASTROENTEROLOGY CLI NI C   168, 887   168, 887   0   168, 887   0   168, 887   79. 10   09011   NEUROLOGY CLI NI C   0   0   0   0   0   79. 11   09011   NEUROLOGY CLI NI C   181, 662   181, 662   0   181, 662   0   181, 662   79. 10   09012   OPTHAMOLOGY CLI NI C   181, 662   181, 662   0   181, 662   0   181, 662   0   79. 10   09101   EMERGENCY   7, 824, 600   7,				0				
67. 01   06701   AUDI OLOGY   468, 105   0   468, 105   0   468, 105   0   268, 044   0   0   69, 00   0   0   0   0   0   0   0   0   0								
68. 00   06800   SPECH PATHOLOGY   268,044   0   268,044   0   0   268,044   68. 00   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   0   069. 00   06900   060000   060000   060000   060000   060000   060000   0600000   06000000   0600000000								
69.00   06900   ELECTROCARDIOLOGY				0	,			
69. 01   06901   CARDI OLOGY   2, 886, 546   2, 886, 546   0 2, 886, 546   0 0 3, 765, 033   0 3, 765, 033   71. 00   70. 00   07. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3, 765, 033   3, 765, 033   0 3, 765, 033   71. 00   72. 00   72. 00   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   1, 689, 304   1, 689, 304   0   1, 689, 304   72. 00   73. 00   07. 00   07. 00   0   0   0   0, 917, 319   0   0. 00   0   0   0, 917, 319   0   0. 00   0   0. 00   0   0   0   0			1	0				
71. 00			١			_	_	
72. 00 07200   IMPL. DEV. CHARGED TO PATIENT								1
73. 00   07300   DRUGS CHARGED TO PATIENTS   10, 917, 319   10, 917, 319   0   10, 917, 319   73. 00								1
90. 00   09000   CLI NI C   0   0   0   0   0   0   0   0   0								
90. 00	70.00		10,717,017		10,717,01	, <u>_</u>	10, 717, 017	70.00
90. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   690, 263   690, 263   0   690, 263   90. 01   90. 02   09002   CLI NI C	90.00		0			0	0	90.00
90. 02						-		
90. 03	90. 02		1 1					
90. 04   09004   09004   ENT CLINIC   11   0   11   90. 04   90. 05   09005   SURGERY CLINIC   0   0   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   49, 643   49, 643   49, 643   0   49, 643   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   7, 636   7, 636   0   0   0   0   0   0   0   0   0	90. 03		o			0	0	
90. 07   09007   UROLOGY CLINIC   49,643   49,643   0 49,643   90.07   90. 09   09009   GASTROENTEROLOGY CLINIC   7,636   7,636   0 7,636   90.09   90. 11   09011   NEUROLOGY CLINIC   168,887   168,887   0 168,887   90.11   90. 12   09012   OPTHAMOLOGY CLINIC   0 0 0 0 0 0 90.12   90. 13   09013   ALLERGY CLINIC   181,662   181,662   0 181,662   90.13   90. 14   09014   WOUND CARE   1,221,866   1,221,866   0 1,221,866   90.14   91. 00   09100   EMERGENCY   7,824,600   7,824,600   0 7,824,600   91.00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   2,860,278   2,860,278   2,860,278   95. 00   09500   AMBULANCE SERVICES   4,145,776   4,145,776   0 4,145,776   95.00   200. 00   Subtotal (see instructions)   93,917,751   0 93,917,751   0 93,917,751   200.00   201. 00   Less Observation Beds   2,860,278   2,860,278   2,860,278   201.00			11		1	0	11	90. 04
90. 09	90. 05	09005 SURGERY CLINIC	o			0	0	90. 05
90. 11	90. 07	09007 UROLOGY CLINIC	49, 643		49, 643	0	49, 643	90. 07
90. 12	90. 09	09009 GASTROENTEROLOGY CLINIC	7, 636		7, 636	0	7, 636	90. 09
90. 13   09013   ALLERGY CLINIC   181, 662   181, 662   0   181, 662   90. 13   90. 14   09014	90. 11	09011 NEUROLOGY CLINIC	168, 887		168, 887	0	168, 887	90. 11
90. 14	90. 12	09012 OPTHAMOLOGY CLINIC	o			0	0	90. 12
91. 00   09100   EMERGENCY   7, 824, 600   7, 824, 600   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   2, 860, 278   2, 860, 278   92. 00   000	90. 13	09013 ALLERGY CLINIC	181, 662		181, 662	0	181, 662	90. 13
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   2,860,278   2,860,278   2,860,278   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   4,145,776   4,145,776   0   4,145,776   0   93,917,751   0   93,917,751   0   93,917,751   0   93,917,751   200. 00   201. 00   Less Observation Beds   2,860,278   2,860,278   201. 00	90. 14	09014 WOUND CARE	1, 221, 866		1, 221, 866	0	1, 221, 866	90. 14
OTHER REIMBURSABLE COST CENTERS           95. 00         09500 AMBULANCE SERVICES         4, 145, 776         0 4, 145, 776         0 4, 145, 776         95. 00           200. 00         Subtotal (see instructions)         93, 917, 751         0 93, 917, 751         0 93, 917, 751         200. 00           201. 00         Less Observation Beds         2, 860, 278         2, 860, 278         2, 860, 278         201. 00	91.00	09100 EMERGENCY	7, 824, 600		7, 824, 600	0	7, 824, 600	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 860, 278		2, 860, 278	3	2, 860, 278	92.00
200. 00     Subtotal (see i nstructions)     93, 917, 751     0     93, 917, 751     0     93, 917, 751     0     93, 917, 751     200. 00       201. 00     Less Observation Beds     2, 860, 278     2, 860, 278     2, 860, 278     2, 860, 278								
201.00 Less Observation Beds 2, 860, 278 2, 860, 278 2, 860, 278 2, 860, 278								
		,		0				
202.00   Total (see instructions)   91,057,473  0  91,057,473  0  91,057,473  0  91,057,473								
	202.00	Total (see instructions)	91, 057, 473	0	91, 057, 473	8  0	91, 057, 473	202. 00

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0104

Cost Center Description						10 12/31/2022	5/30/2023 4:5	
Inpati ent   Outpati ent   Outpati ent   Total (col.   6   Cost or Other   Ratio   Inpati ent   Ratio     Inpati ent   Ratio				Ti tl	e XIX	Hospi tal		о р
Inpati ent   Outpati ent   Outpati ent   Total (col.   6   Cost or Other   Ratio   Inpati ent   Ratio     Inpati ent   Ratio								
INPATIENT ROUTINE SERVICE COST CENTERS   17, 721, 972   17, 721, 972   30.00   33000   ADULTS & PEDI ATRICS   17, 721, 972   17, 721, 972   31.00   3310   03100   INTENSIVE CARE UNIT   6, 205, 801   6, 205, 801   41.00		Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
INPATI ENT ROUTINE SERVICE COST CENTERS   17, 721, 972					+ col. 7)	Ratio		
INPART ENT ROUTH NE SERVICE COST CENTERS   17, 721, 972   30.00   30.00   30.00   30.10   30.10   31.00   30.10   31.00   30.10   31.00   30.10   30.10   31.00   30.10   30								
0.00   0.3000   ADULTS & PEDIATRICS   17, 721, 972   17, 721, 972   30 00			6. 00	7. 00	8. 00	9. 00	10. 00	
31.00   03100   INTENSIVE CARE UNIT   6, 205, 801   6, 205, 801   40.00   400.00			47 704 070		1			
40. 00   04000   SUBPROVI DER - I PF   2, 916, 918   2, 916, 918   0   41. 00   41			1					1
11 00   04100   SUBPROVI DER   1 IF   0   0   0   42.00   42			1 ' ' 1					
42 00   04-200   SUBPROVI DER   0			2, 916, 918		2, 916, 91			
43.00   04300   NURSERY   0   0   0   0   43.00   0   0   0   0   0   0   0   0   0			0			-		
44. 00   04400   SKILLED NURSING FACILITY   2,554,570   2,554,570   44. 00   08400		l e e e e e e e e e e e e e e e e e e e	0			-		1
ANCILLARY SERVICE COST CENTERS			0					1
50.00			2, 554, 570		2, 554, 57	<u>O</u>		44.00
54 00   05400   RADI OLOCY-DIAGNOSTIC   1,908,239   32,629   638   34,537,877   0,235026   0,000000   55,000   055000   05500   055000   05500   055000   05			/ 740 070	40, 440, 020	FF 107 00	0.152427	0.000000	F0 00
55. 00   05.00   RADIO LOGY-THERAPEUTIC   0   7.97, 08   8.718, 75   0.147839   0.000000   55. 00								1
55. 01   0.5501   ULTRA SOUND   7.21, 71.9   7, 997, 0.38   8, 718, 757   0.147839   0.000000   55. 01			1	32, 629, 638	34, 537, 87			1
57.00   05700   05700   05700   05700   05600   05600   05600   05700   058.00   05800   05800   05800   05800   05800   05800   05900   05900   05900   05900   05800   059000   059000   059000   059000   059000   059000   059000   0590			١	7 007 020	0 710 75			1
S8.00   05900   MAGNETI C RESONANCE I MAGI NG (MRI )   926, 868   13, 001, 780   13, 928, 648   0, 072073   0, 000000   58, 00   059			1 ' 1					
59.00   05900   CARDI AC CATHETERI ZATI ON   5, 311, 373   11, 629, 042   16, 940, 415   0.082649   0.000000   59, 00   60.00   60.00   60.00   60.00   CABORATORY   14, 345, 367   56, 255, 134   70, 600, 501   0.145882   0.000000   60.00   63.00   63.00   0.6300   BLOOD STORI NG, PROCESSING & TRANS.   641, 599   519, 924   1, 161, 523   0.276764   0.000000   64.00   64.00   64.00   64.00   CARDINARY   1, 328, 1599   2, 255, 449   3, 583, 608   0.001725   0.000000   64.00   66.00			1					
60.00   06000   LABORATORY   14, 345, 367   56, 255, 134   70, 600, 501   0.145882   0.000000   60. 00			1					1
63.0   06300   BLOOD STORING, PROCESSING & TRANS.   641,599   519,924   1,161,523   0,276764   0,000000   63.00   64.00   06400   INTRAVENOUS THERAPY   1,328,159   2,255,449   3,583,608   0.001725   0.000000   64.00   66.00   06600   PHYSI CAL THERAPY   2,337,594   4,195,511   6,533,105   0,443621   0.000000   66.00   67.00   06700   OCCUPATI ONAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.01   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.00   68.00   06600   PHYSI CAL THERAPY   2,132,398   905,260   3,037,658   0.266212   0.000000   67.00   68.00   06600   PECCHARGED TO PATIENTS   3,240,041   17,616,554   623,639   800,193   0.334974   0.000000   0.000000   0.000000   69.01   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   1,978,896   9,318,540   11,297,436   0.149530   0.000000   71.00   69.01   07200   INPLE DEV. CHARGED TO PATIENTS   1,978,896   9,318,540   11,297,436   0.149530   0.000000   72.00   69.01   07200   INPLE OLD CALL THERAPY   1,978,896   9,318,540   11,297,436   0.149530   0.000000   72.00   69.01   07200   INPLE OLD CALL THERAPY   1,978,896   9,318,540   11,297,436   0.149530   0.000000   72.00   69.01   07200   INPLE OLD CALL THERAPY   1,978,896   9,318,540   11,297,436   0.149530   0.000000   72.00   69.01   07200   INPLE OLD CAL								
64.00   06400   INTRAVENOUS THERAPY   1, 328, 159   2, 255, 449   3, 583, 608   0. 001725   0. 000000   64.00   66.00   06600   PHYSI CAL THERAPY   2, 337, 594   4, 195, 511   6, 533, 105   0. 443621   0. 000000   67.00   67.01   06701   06701   06701   000000   06700   0. 000000   0. 000000   0. 000000   0. 000000   67.01   06701   06701   06701   06800   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   69.01   06900   ELECTROCARDI OLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0. 120992   0. 000000   69.01   71.00   07010   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3, 285, 174   8, 192, 686   11, 477, 860   0. 328026   0. 000000   71.00   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   90.01   79.01   09000   CLI NI C   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		· ·	1					1
66.00   06600   PHYSI CAL THERAPY   2, 337, 594   4, 195, 511   6, 533, 105   0. 443621   0. 000000   66. 00   67.00   06700   0CCUPATI ONAL THERAPY   2, 132, 398   905, 260   3, 037, 658   0. 266212   0. 000000   67. 01   68.00   06800   06800   SPEECH PATHOLOGY   0   766, 296   0. 610867   0. 000000   67. 01   68.00   06900   CARDIOLOGY   0   0   0. 000000   0. 000000   0. 000000   0. 000000   69.01   06901   CARDIOLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0. 120992   0. 000000   69. 01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 285, 174   8, 192, 686   11, 477, 860   0. 328026   0. 000000   71. 00   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   73. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   90. 01   79.00   09000   CLINIC   0   0   0   0. 000000   0. 000000   90. 01   79.01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0. 000000   0. 000000   90. 01   79.02   09003   DRUGS CHARGED TO PATIENT   0   0   0   0. 000000   0. 000000   90. 01   79.03   09003   DRUGS CHARGED TO PATIENT   0   0   0   0. 000000   0. 000000   90. 01   79.04   09001   OTHER OUTPATIENT SERVICE COST CENTER   0   0   0   0. 000000   0. 000000   90. 01   79.05   09005   SURGERY CLINIC   0   0   0   0. 000000   0. 000000   90. 03   79.06   09005   SURGERY CLINIC   0   0   0   0. 000000   0. 000000   90. 07   79.09   09009   GASTROENTEROLOGY CLINIC   0   0   0   0. 000000   0. 000000   90. 07   79.01   09011   THERNOLOGY CLINIC   0   0   0   0. 000000   0. 000000   90. 07   79.02   09101   DEBENCATION BEDS (NON-DISTINCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351663   0. 000000   90. 01   79.01   09101   EMERGENCY   09101   EMERGENCY   09101								
67. 01 06700   06700   0CCUPATI (NALL THERAPY   2, 132, 398   905, 260   3, 037, 658   0. 266212   0. 000000   67. 01   68. 00   06800   SPEECH PATHOLOGY   176, 554   623, 639   800, 193   0. 334974   0. 000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0. 0000000   0. 000000   69. 01   69. 01   06901   CARDI OLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0. 120992   0. 000000   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   3, 285, 174   8, 192, 686   11, 477, 860   0. 328026   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   1, 978, 896   9, 318, 540   11, 297, 436   0. 149530   0. 000000   72. 00   73. 00   7300   DRUGS CHARGED TO PATIENTS   10, 349, 061   17, 826, 452    090. 01   09000   CLI NI C   0   0   0   0. 000000   0. 000000   90. 01   79. 02   09002   CLI NI C   0   0   0   0. 000000   0. 000000   90. 01   79. 03   09003   DERMATOLOGY CLI NI C   0   0   0   0. 000000   0. 000000   90. 02   79. 04   09004   ENT CLI NI C   0   0   0   0. 000000   0. 000000   90. 03   79. 07   09007   INDICATE CHARGED TO PATIENTS   0. 000000   0. 000000   0. 000000   90. 03   79. 08   09003   DERMATOLOGY CLI NI C   0   0   0   0. 000000   0. 000000   90. 03   79. 01   09001   CLI NI C   0   0   0   0. 000000   0. 000000   90. 03   79. 02   09003   DERMATOLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 09   09009   GASTROENTEROLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 09   09009   GASTROENTEROLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 10   09011   NEUROLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 11   09011   NEUROLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 12   09012   OPTHAMOLOGY CLI NI C   0   0   0. 000000   0. 000000   90. 05   79. 14   09014   MOUND CAPE   15, 322   5, 652, 819   5, 668, 141   0. 215567   0. 000000   90. 05   79. 10   09014   MOUND CAPE   15, 322   5, 652, 819   3, 681, 141   0. 215567   0. 000000   90. 05   79. 10   09000   DERRORNICI OSST CENTERS   7		l e	1					1
67. 01   06.701   AUDI OLOGY   0   766, 296   766, 296   0.610867   0.000000   67. 01   68. 00   068000   SPECCH PATHOLOGY   176, 554   623, 639   800, 193   0.334974   0.000000   68. 00   69. 01   06901   CARDI OLOGY   0   0   0.000000   0.000000   69. 00   69. 01   06901   CARDI OLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0.120992   0.000000   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3, 285, 174   8, 192, 686   11, 477, 860   0.328026   0.000000   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENT   1, 978, 896   9, 318, 540   11, 297, 436   0.149530   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   10, 349, 061   17, 826, 452   28, 175, 513   0.387475   0.000000   73. 00   90. 01   09000   CLI NI C   0   0   0   0.000000   0.000000   90. 01   90. 01   09000   OTHER OUTPATI ENT SERVI CE COST CENTER   0   0   0   0.000000   0.000000   90. 02   90. 03   09003   DERMATOLOGY CLI NI C   0   0   0   0.000000   0.000000   90. 03   90. 04   09004   ENT CLI NI C   0   0   0   0.000000   0.000000   90. 03   90. 05   09005   SURGEREY CLI NI C   0   0   0   0.000000   0.000000   90. 05   90. 07   09007   UROLOGY CLI NI C   0   0   0   0.000000   0.000000   90. 05   90. 07   09007   UROLOGY CLI NI C   0   0   0   0.000000   0.000000   90. 07   90. 10   09011   DEPMI CLINI C   0   0   0   0.000000   0.000000   90. 07   90. 10   09011   OTHER OUTPATI ENT SERVI CE COST CENTER   0   0   0   0.000000   0.000000   90. 05   90. 07   09007   UROLOGY CLI NI C   0   0   0   0.000000   0.000000   90. 05   90. 07   09007   UROLOGY CLI NI C   0   0   0   0.000000   0.000000   90. 05   90. 11   09011   OTHER REI MURSABLE COST CENTER   15, 322   5, 652, 819   5, 668, 141   0.215567   0.000000   90. 12   90. 10   09000   DERROGENCY   4, 523, 300   29, 184, 897   33, 708, 197   0.232128   0.000000   90. 00   90. 00   09000   DERROGENCY   4, 523, 300   29, 184, 897   33, 708, 197   0.232128   0.000000   90. 00   90. 00   09000   DERROGENCY   4, 523, 300   29, 184, 897   33, 708, 197								1
68. 00   06800   SPECH PATHOLOGY   176, 554   623, 639   800, 193   0.334974   0.000000   68. 00   69. 00   06900   ELECTROCARDIOLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0.120992   0.000000   69. 01   07100   06910   CARDIOLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0.120992   0.000000   69. 01   07100   071			2, 132, 390					1
69.00   06900   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0			176 554					
69. 01   06901   CARDI OLOGY   7, 040, 747   16, 816, 573   23, 857, 320   0. 120992   0. 000000   69. 01   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   72. 00   73.			170, 554					
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   3, 285, 174   8, 192, 686   11, 477, 860   0. 328026   0. 000000   72. 00   72. 00   72.00   IMPL. DEV. CHARGED TO PATI ENTS   1, 978, 896   9, 318, 540   11, 297, 436   0. 149530   0. 000000   72. 00   73. 00   07200   DRUGS CHARGED TO PATI ENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   73. 00   000000   0. 00000		l e e e e e e e e e e e e e e e e e e e	7 040 747	-				1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   1,978,896   9,318,540   11,297,436   0.149530   0.000000   72. 00   73. 00   DRUGS CHARGED TO PATIENTS   10,349,061   17,826,452   28,175,513   0.387475   0.000000   73. 00   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   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000								
73. 00   07300   DRUGS CHARGED TO PATIENTS   10, 349, 061   17, 826, 452   28, 175, 513   0. 387475   0. 000000   73. 00								
90. 00   09000   CLI NI C   0   0   0   0   0.000000   90. 00			1					1
90. 00			10, 347, 001	17,020, 432	20, 173, 31	0.307473	0.000000	73.00
90. 01			0	0		0.00000	0.000000	90.00
90. 02   09002   CLINIC   0   0   0   0   0   0   0   0   0			0	0				
90. 03			o	0				1
90. 05	90. 03	09003 DERMATOLOGY CLINIC	0	0		0.000000		
90. 07   09007   09007   09007   09007   09009   00009	90. 04	09004 ENT CLINIC	0	0		0.000000	0. 000000	90. 04
90. 09   09009   00009	90. 05	09005 SURGERY CLINIC	0	0				
90. 09   09009   00009	90. 07	09007 UROLOGY CLINIC	0	132, 087	132, 08	0. 375836	0. 000000	90. 07
90. 12   09012   0PTHAMOLOGY CLINIC   0   0   0   0   0   0   0   0   0	90. 09	09009 GASTROENTEROLOGY CLINIC	0	0			0. 000000	90. 09
90. 13   09013   ALLERGY CLINIC   0   296, 430   296, 430   0. 612833   0. 000000   90. 13   90. 14   09014   WOUND CARE   15, 322   5, 652, 819   5, 668, 141   0. 215567   0. 000000   90. 14   91. 00   09100   EMERGENCY   4, 523, 300   29, 184, 897   33, 708, 197   0. 232128   0. 000000   91. 00   09200   0958VATION BEDS (NON-DISTINCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   AMBULANCE SERVICES   0   4, 144, 138   4, 144, 138   1. 000395   0. 000000   95. 00   09500   AMBULANCE SERVICES   0   4, 144, 138   4,	90. 11	09011 NEUROLOGY CLINIC	0	0		0. 000000	0. 000000	90. 11
90. 14   09014   WOUND CARE   15, 322   5, 652, 819   5, 668, 141   0. 215567   0. 000000   90. 14   91. 00   09100   EMERGENCY   4, 523, 300   29, 184, 897   33, 708, 197   0. 232128   0. 000000   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   09500   OBSERVATI ON BEDS (NON-DI STI NCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 000000   92. 00   0000000   0000000000000000000000	90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0. 000000	0. 000000	90. 12
91. 00   09100   EMERGENCY   4, 523, 300   29, 184, 897   33, 708, 197   0. 232128   0. 000000   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   294, 759   7, 852, 730   8, 147, 489   0. 351063   0. 0000000   92. 00   92. 00   92. 00   00000000000000000000000000000000	90. 13	09013 ALLERGY CLINIC	0	296, 430	296, 43	0. 612833	0.000000	90. 13
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   294,759   7,852,730   8,147,489   0.351063   0.000000   92.00	90. 14	09014 WOUND CARE	15, 322	5, 652, 819	5, 668, 14	0. 215567	0.000000	90. 14
OTHER REI MBURSABLE COST CENTERS  95. 00	91.00	09100 EMERGENCY	4, 523, 300	29, 184, 897	33, 708, 19	7 0. 232128	0. 000000	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	294, 759	7, 852, 730	8, 147, 48	0. 351063	0. 000000	92.00
200.00 Subtotal (see instructions) 101,536,978 325,631,381 427,168,359 200.00 201.00 Less Observation Beds 200.00		OTHER REIMBURSABLE COST CENTERS						
201.00 Less Observation Beds 201.00							0.000000	1
		,	101, 536, 978	325, 631, 381	427, 168, 35	9		
202.00   Total (see instructions)   101,536,978  325,631,381  427,168,359    202.00								1
	202. 00	Total (see instructions)	101, 536, 978	325, 631, 381	427, 168, 35	9		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104
Period:
From 01/01/2022
To 12/31/2022
Under the prepared:
5/30/2023 4:58 pm

					5/30/2023 4:5	8 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
11	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00 0	03000 ADULTS & PEDIATRICS					30.00
31.00 0	03100 INTENSIVE CARE UNIT					31.00
40.00 0	04000 SUBPROVIDER - IPF					40.00
	04100 SUBPROVI DER - I RF					41.00
	04200 SUBPROVI DER					42.00
	04300 NURSERY					43. 00
	04400 SKILLED NURSING FACILITY					44. 00
_	NCILLARY SERVICE COST CENTERS					1 00
	05000 OPERATING ROOM	0. 000000				50.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
	05501 ULTRA SOUND	0. 000000				55. 01
	l l					
	05700 CT SCAN	0.000000				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
1	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
4	06000 LABORATORY	0. 000000				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
4	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
4	06600 PHYSI CAL THERAPY	0. 000000				66. 00
4	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
1	06701 AUDI OLOGY	0. 000000				67. 01
	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 0	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
69. 01 0	06901 CARDI OLOGY	0. 000000				69. 01
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73.00 0	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
0	OUTPATIENT SERVICE COST CENTERS					
90.00 0	99000 CLI NI C	0. 000000				90.00
90. 01 0	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				90. 01
90. 02 0	09002 CLI NI C	0. 000000				90. 02
90. 03 0	09003 DERMATOLOGY CLINIC	0. 000000				90. 03
	09004 ENT CLINIC	0. 000000				90. 04
90.05 0	09005 SURGERY CLINIC	0. 000000				90. 05
1	09007 UROLOGY CLINIC	0. 000000				90. 07
	09009 GASTROENTEROLOGY CLINIC	0. 000000				90. 09
	09011 NEUROLOGY CLINIC	0. 000000				90. 11
	09012 OPTHAMOLOGY CLINIC	0. 000000				90. 11
	09013 ALLERGY CLINIC	0. 000000				90. 12
	09014 WOUND CARE	0. 000000				90. 13
	09100 EMERGENCY	0. 000000				91.00
4	· ·	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				J 9∠. UU
	OTHER REIMBURSABLE COST CENTERS	0.000000				05.00
	09500 AMBULANCE SERVICES	0. 000000				95. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems	WITHAM MEMORI	AL HOSDITAL		ln lie	u of Form CMS-2	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I	pared:
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		Per Diem (col. 3 / col. 4)	
	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 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)  Cost Center Description	876, 565 256, 880 272, 147 1 0 231, 984 1, 637, 577 Inpati ent Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	876, 56 256, 88 272, 14 231, 98 1, 637, 57	0 2, 473 7 2, 065 1 0 0 0 0 0 4 4, 085	90. 55 103. 87 131. 79 0. 00 0. 00 0. 00 56. 79	31. 00 40. 00 41. 00 42. 00 43. 00
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS  30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)	2, 285 710 1, 172 0 0 0 2, 172 6, 339	73, 748 154, 458 0 0 0 0 123, 348				30. 00 31. 00 40. 00 41. 00 42. 00 43. 00 44. 00 200. 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 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/30/2023 4:5	
		Ti tl e	e XVIII	Hospi tal	PPS	ο μιι
Cost Center Description	Capi tal	Total Charges			Capital Costs	
out contoi bood prom	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)		,	
	26)	·				
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATING ROOM	771, 777		•		41, 119	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	730, 921	34, 537, 877			20, 040	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	
55. 01   05501   ULTRA SOUND	9, 480				82	
57. 00   05700   CT   SCAN	11, 230				602	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	64, 133				2, 331	
59. 00 05900 CARDI AC CATHETERI ZATI ON	54, 454				702	
60. 00   06000   LABORATORY	389, 233		1			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 502			·	180	
64. 00 06400 I NTRAVENOUS THERAPY	29			·	3	
66. 00   06600   PHYSI CAL THERAPY	318, 115			·	19, 418	
67. 00 06700 OCCUPATI ONAL THERAPY	7, 071			·	691	
67. 01   06701   AUDI OLOGY	32, 413				0	
68. 00 06800 SPEECH PATHOLOGY	1, 712				131	
69. 00 06900 ELECTROCARDI OLOGY	0	_			0	
69. 01 06901 CARDI OLOGY	53, 133				7, 255	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 651	11, 477, 860	•	·	1, 445	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 895		•	·	584	
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	80, 127	28, 175, 513	0. 00284	4 1, 864, 220	5, 302	73. 00
90. 00   09000   CLINIC	1 0	0	0.00000	0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	145, 519	_	1		0	
90. 02   09002   CLINI C	143, 319				0	
90. 03   09003   DERMATOLOGY   CLI NI C		_	1		0	
90. 04   09004 ENT CLINIC	0	_	0.00000		0	
90. 05 09005 SURGERY CLINIC	0	_	0.00000		0	
90. 07   09007   UROLOGY CLINIC	273	ļ	•		0	
90. 09 09009 GASTROENTEROLOGY CLINIC	48		1		0	
90. 11   09011   NEUROLOGY   CLI NI C	1, 700	l .	0. 00000		0	
90. 12 09012 OPTHAMOLOGY CLINIC	1,750		0. 00000		0	
90. 13   09013   ALLERGY   CLINIC	30, 451	296, 430	•		0	
90. 14   09014   WOUND CARE	255, 482				0	
91. 00 09100 EMERGENCY	851, 982		1		40, 001	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	230, 550				4, 098	
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	4, 066, 881	393, 624, 960	p	22, 450, 248	170, 874	200. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/30/2023 4:5	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program		Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF	0	0		0 0	0 0	30. 00 31. 00 40. 00
40. 00   04000  SUBPROVI DER - I PF 41. 00   04100  SUBPROVI DER - I RF 42. 00   04200  SUBPROVI DER	0	0		0 0	0	40.00 41.00 42.00
43. 00   04300   NURSERY 44. 00   04400   SKI LLED   NURSI NG   FACI LI TY	0	0		0 0	0	43. 00 44. 00
200.00   Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVI DER - I PF	0	0	9, 68 2, 47 2, 06	0.00	710	30. 00 31. 00 40. 00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER	0	0	2, 33	0.00 0.00	0	41. 00 42. 00
43.00   04300   NURSERY 44.00   04400   SKILLED NURSING FACILITY 200.00   Total (lines 30 through 199)		0 0 0	4, 08 18, 30		2, 172	43. 00 44. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 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 | 04200| SUBPROVI DER 43. 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 01/01/2022 Part IV
To 12/31/2022 Date/Time Prepared: THROUGH COSTS 5/30/2023 4:58 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 0 05400 RADI OLOGY-DI AGNOSTI C 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 59.00 60.00 06000 LABORATORY 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 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 90. 01 0000000000000 0 0 0 0 0 0 0 0 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 90 07 0 0 09009 GASTROENTEROLOGY CLINIC 90.09 0 0 90.09 90.11 09011 NEUROLOGY CLINIC 0 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0 0 90.12 0 09013 ALLERGY CLINIC 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

0

0

0

0

95.00

0 200.00

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

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
THROUGH COSTS			From 01/01/2022	Part IV

THROUGH COSTS To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 197, 809 0.000000 50.00 000000000000000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 34, 537, 877 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 05501 ULTRA SOUND 0 0 55 01 8 718 757 0.000000 55 01 0 57.00 05700 CT SCAN 0 55, 058, 097 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 13, 928, 648 0.000000 58.00 05900 CARDIAC CATHETERIZATION 0 0 16, 940, 415 0.000000 59 00 59 00 0 0 60.00 06000 LABORATORY 70, 600, 501 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 161, 523 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 3, 583, 608 0.000000 64.00 06600 PHYSI CAL THERAPY 0 6, 533, 105 0 000000 66.00 66 00 67.00 06700 OCCUPATIONAL THERAPY 3, 037, 658 0.000000 67.00 06701 AUDI OLOGY 766, 296 0.000000 67.01 67.01 06800 SPEECH PATHOLOGY 800, 193 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 Ω 0.000000 69 00 69.01 06901 CARDI OLOGY 0 0 23, 857, 320 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 11, 477, 860 0.000000 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 11, 297, 436 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 28, 175, 513 73.00 0 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 0.000000 09000 CLI NI C 90.00 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0000000000 90.01 0 0 0.000000 90.01 0 0 90.02 09002 CLI NI C 0.000000 90 02 90.03 09003 DERMATOLOGY CLINIC 0 0 0.000000 90.03 09004 ENT CLINIC 90. 04 0.000000 90.04 09005 SURGERY CLINIC 0 0 90.05 0.000000 90.05 09007 UROLOGY CLINIC 0 132, 087 90.07 0 0.000000 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 90.09 90. 11 09011 NEUROLOGY CLINIC 0 0 0 0.000000 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0 0.000000 90 12 90. 13 | 09013 | ALLERGY CLINIC C 296, 430 0.000000 90.13 0 09014 WOUND CARE 90. 14 0 0 5, 668, 141 0.000000 90.14 09100 EMERGENCY 0 91.00 33, 708, 197 0.000000 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 8, 147, 489 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

393, 624, 960

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	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0104	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	

THROUGH COSTS				rom 01/01/2022 o 12/31/2022	Part IV Date/Time Pre 5/30/2023 4:5	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	2, 940, 821	0	10, 732, 415	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	946, 951	0	8, 772, 670	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
55. 01   05501   ULTRA SOUND	0. 000000	75, 543	0	847, 730	0	55. 01
57.00   05700   CT SCAN	0. 000000	2, 952, 067	0	9, 253, 428	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	506, 331	0	5, 024, 905	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	218, 448	0	347, 725	0	59. 00
60. 00 06000 LABORATORY	0. 000000	4, 877, 546	0	5, 439, 276	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	139, 275		176, 595	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	412, 570			0	64.00
66. 00   06600 PHYSI CAL THERAPY	0. 000000	398, 791	1 0	50, 075	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	296, 734	0	11, 988	0	67. 00
67. 01   06701   AUDI OLOGY	0. 000000	0	0	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 000000	61, 067	0	68, 777	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	01,007	· -	l	0	69.00
69. 01   06901 CARDI OLOGY	0. 000000	3, 257, 830	Ĭ	5, 356, 638	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	939, 293		1, 427, 031	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	835, 316		2, 352, 139	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 864, 220			0	73. 00
OUTPATIENT SERVICE COST CENTERS	0.00000	1,001,220		11, 100, 077		70.00
90. 00 09000 CLINI C	0. 000000	0	0	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0			0	90. 01
90. 02   09002   CLINI C	0. 000000	0		_	0	90. 02
90. 03 09003 DERMATOLOGY CLINIC	0. 000000	0	1	0	0	90. 03
90. 04   09004 ENT CLINIC	0. 000000	0	1	0	0	90. 04
90. 05 09005 SURGERY CLINIC	0. 000000	0		_	0	90. 05
90. 07   09007   UROLOGY   CLI NI C	0. 000000	0	ľ	0	0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0	0	90. 09
90. 11   09011   NEUROLOGY   CLI NI C	0. 000000	0		0	0	90. 11
90. 12   09012   0PTHAMOLOGY   CLI NI C	0. 000000	0	1	0	0	90. 12
90. 13   09013   ALLERGY CLINIC	0. 000000	0		0	0	90. 13
90. 14   09014   WOUND CARE	0. 000000	0	1	1, 150, 714	0	90. 14
91. 00 09100 EMERGENCY	0. 000000	1, 582, 630	ľ		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	144, 815			0	
OTHER REIMBURSABLE COST CENTERS	0.000000	144,013		1, 703, 030	0	12.00
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)		22, 450, 248	0	68, 603, 219	Ω	200.00
200.00   10tal (11103 00 till ough 177)	1 1	22, 750, 240	1	00, 000, 217	U	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0104 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/30/2023 4:58 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 153436 10, 732, 415 1, 646, 739 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 235026 8, 772, 670 0 0 54.00 2,061,806 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 o 55 00 55 00 0 55.01 05501 ULTRA SOUND 0.147839 847, 730 0 0 125, 328 55.01 57.00 05700 CT SCAN 0.024977 9, 253, 428 3.426 231, 123 57.00 5, 024, 905 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.072073 0 0 362, 160 58 00 05900 CARDIAC CATHETERIZATION 59.00 0.082649 347, 725 0 0 28, 739 59.00 60.00 06000 LABORATORY 0.145882 5, 439, 276 540 0 793, 492 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.276764 176, 595 0 48, 875 63.00 06400 I NTRAVENOUS THERAPY 0 64 00 0.001725 503, 641 869 64 00 66.00 06600 PHYSI CAL THERAPY 0.443621 50,075 0 0 22, 214 66.00 06700 OCCUPATIONAL THERAPY 0. 266212 11, 988 0 3, 191 67.00 67.00 0 06701 AUDI OLOGY 0.610867 67.01 0 67.01 0 68.00 06800 SPEECH PATHOLOGY 0.334974 68, 777 23, 039 68 00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 06901 CARDI OLOGY 0. 120992 5, 356, 638 0 0 648, 110 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 328026 1, 427, 031 0 0 468, 103 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72 00 0.149530 2, 352, 139 0 351, 715 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 387475 11, 480, 379 31, 928 4, 448, 360 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.000000 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 90.01 0.000000 0 90.01 09002 CLI NI C 0.000000 0 0 0 90.02 90.02 0 09003 DERMATOLOGY CLINIC 0 90.03 0.000000 0 90.03 09004 ENT CLINIC 0.000000 0 90.04 90.04 0 0 0 90.05 09005 SURGERY CLINIC 0.000000 0 Ω 90.05 90.07 09007 UROLOGY CLINIC 0.375836 0 90.07 0 0 90.09 09009 GASTROENTEROLOGY CLINIC 0.000000 0 0 90.09 09011 NEUROLOGY CLINIC 0 90 11 90 11 0.000000 C Ω 0 0 90. 12 09012 OPTHAMOLOGY CLINIC 0.000000 0 90.12 09013 ALLERGY CLINIC 0 90. 13 0.612833 0 90.13 09014 WOUND CARE 0 90.14 0.215567 1, 150, 714 248, 056 90.14 3, 238 0 91.00 09100 EMERGENCY 0. 232128 3, 903, 443 906, 098 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.351063 1, 703, 650 0 598, 088 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 95 00 1.000395 200.00 Subtotal (see instructions) 68, 603, 219 540 38, 592 13, 016, 105 200.00

201.00

13, 016, 105 202. 00

540

68, 603, 219

38, 592

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part V
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:58 pm	Provider CCN: 15-0104

					12,01,2022	5/30/2023 4:5	8 pm
			Title	XVIII	Hospi tal	PPS	
		Cost	:S				
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins. [	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 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	0				55. 00
55. 01	05501 ULTRA SOUND	0	0				55. 01
57. 00	05700 CT SCAN	0	86				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0				58. 00
	05900 CARDI AC CATHETERI ZATI ON	o	0				59.00
60.00	06000 LABORATORY	79	o				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	o				63. 00
	06400 I NTRAVENOUS THERAPY	0	0				64.00
	06600 PHYSI CAL THERAPY	l ol	0				66. 00
	06700 OCCUPATI ONAL THERAPY		0				67. 00
	06701 AUDI OLOGY		0				67. 01
	06800 SPEECH PATHOLOGY		0				68. 00
	06900 ELECTROCARDI OLOGY		0				69. 00
	06901 CARDI OLOGY		0				69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT		o				72.00
	07300 DRUGS CHARGED TO PATIENTS		12, 371				73. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	12, 571				73.00
	09000 CLINIC		0				90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER		0				90. 01
	09002 CLINIC		0				90. 02
	09003 DERMATOLOGY CLINIC		0				90. 03
	09004 ENT CLINIC		0				90. 04
	09005 SURGERY CLINIC	0	0				90. 05
	09007 UROLOGY CLINIC	0	0				90. 03
	09009 GASTROENTEROLOGY CLINIC		0				90.07
	09011 NEUROLOGY CLINIC	0	0				90. 09
			0				90. 11
	09012 OPTHAMOLOGY CLINIC	0					1
	09013 ALLERGY CLINIC	0	0				90. 13
	09014 WOUND CARE	0	698				90. 14
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	] 0	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						05.00
	09500 AMBULANCE SERVICES	0	40 4				95. 00
200.00	Subtotal (see instructions)	79	13, 155				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
000 00	Only Charges		40.455				000 00
202.00	Net Charges (line 200 - line 201)	79	13, 155				202. 00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In lie	eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D	pared:
			Title	e XVIII	Subprovi der -	PPS	о ріп
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATI NG ROOM	771, 777					
54.00	05400 RADI OLOGY-DI AGNOSTI C	730, 921				471	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				_	
55. 01	05501 ULTRA SOUND	9, 480					
57. 00	05700 CT SCAN	11, 230		1			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	64, 133		1		15	
59. 00	05900 CARDI AC CATHETERI ZATI ON	54, 454					
60.00	06000 LABORATORY	389, 233				2, 207	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 502				0	
64.00	06400 I NTRAVENOUS THERAPY	29					
66. 00	06600 PHYSI CAL THERAPY	318, 115		1			1
67.00	06700 OCCUPATI ONAL THERAPY	7, 071					1
67. 01	06701 AUDI OLOGY	32, 413		1		0	
68. 00 69. 00	06800 SPEECH PATHOLOGY	1, 712				5	68. 00 69. 00
	06900 ELECTROCARDI OLOGY	0	_	0.0000		0	
69. 01	06901 CARDI OLOGY	53, 133					69. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	17, 651					
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 895		1		391	
73.00	OUTPATIENT SERVICE COST CENTERS	80, 127	28, 175, 513	0.0028	137, 317	391	73.00
90. 00	09000 CLINIC	0	0	0.0000	00 00	0	90.00
90. 00	09001 OTHER OUTPATIENT SERVICE COST CENTER	145, 519		1			1
90. 01	09002 CLINIC	143, 317		1		-	
90. 02	09003 DERMATOLOGY CLINIC			1			
90. 04	09004 ENT CLINIC	0	_	1		-	1
90. 05	09005 SURGERY CLINIC	0	ļ	1			
90. 07	09007 UROLOGY CLINIC	273		1		0	1
90. 09	09009 GASTROENTEROLOGY CLINIC	48		1			
90. 11	09011 NEUROLOGY CLINIC	1, 700				0	1
90. 12	09012 OPTHAMOLOGY CLINIC	0				0	
90. 13	09013 ALLERGY CLINIC	30, 451	296, 430			Ö	
90. 14	09014 WOUND CARE	255, 482				-	
91. 00	09100 EMERGENCY	851, 982		1		434	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					1
	OTHER REIMBURSABLE COST CENTERS						1
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	3, 836, 331	393, 624, 960		779, 433	5, 212	200. 00

	Financial Systems	WI THAM MEMORI		ON 45 0404		u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE UTHER PASS	Provider C	JN: 15-0104	Peri od: From 01/01/2022	Worksheet D Part IV	
THRUUG	H COSTS		Component	CCN: 15-S104	To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
			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	2.00	2.4	2.00	
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3. 00	
50. 00	05000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
55. 01	05501 ULTRA SOUND	o o	0		0 0	0	
57. 00	05700 CT SCAN	0	0		0 0	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
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
6.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
57. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
67. 01	06701 AUDI OLOGY	0	0		0 0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	06901 CARDI OLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	•
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
00 00	OUTPATIENT SERVICE COST CENTERS			I		0	1 00 00
90. 00 90. 01	09000   CLINIC   09001   OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	0	
	09002 CLINIC	0	0		0 0	0	
0. 02	09003 DERMATOLOGY CLINIC	0	0		0 0	0	
0. 04	09004 ENT CLINIC	0	0		0 0	0	•
	09005 SURGERY CLINIC	Ŏ	0			0	1
0. 07	09007 UROLOGY CLINIC	0	0		0 0	0	
0.09	09009 GASTROENTEROLOGY CLINIC	0	0		0 0	0	
0. 11	09011 NEUROLOGY CLINIC	0	0		0 0	0	90. 1
0. 12	09012 OPTHAMOLOGY CLINIC	0	0		0 0	0	90. 12
0. 13	09013 ALLERGY CLINIC	0	0		0 0	0	90. 13
0. 14	09014 WOUND CARE	0	0		0 0	0	90. 14
	09100 EMERGENCY	0	0		0 0	0	
2. 00	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	I	0 0	0	200.00

llool +b	Financial Systems	WLTHAM MEMORI	AL HOCDITAL		lm lia	u of Form CMC	2552 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	WI THAM MEMORI		CN: 15_0104	Peri od:	u of Form CMS-: Worksheet D	2332-10
	SH COSTS	WICE OTHER TAS	J TTOVICE C	CN. 15-0104	From 01/01/2022	Part IV	
11111000	11 00313		Component	CCN: 15-S104	To 12/31/2022	Date/Time Pre	pared:
						5/30/2023 4:5	8 pm
			Ti tl e	× XVIII	Subprovi der -	PPS	
		1	T		I PF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	cols. 2, 3, and 4)	8)	7) (see	
				and 4)		instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	0	ı	0 55, 197, 809	0. 000000	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			1	0 34, 537, 877	0.00000	
55. 00	05500 RADI OLOGY - THERAPEUTI C			1	0 34, 337, 877	0.00000	
	05500 RADI OLOGY-THERAPEUTI C	0			-1		
55. 01	1 1	0	0		-,	0.000000	
57. 00	05700 CT SCAN	0	1		0 55, 058, 097	0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	1	0 13, 928, 648	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .	0 16, 940, 415	0.000000	
60.00	06000 LABORATORY	0	0	1	0 70, 600, 501	0.000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0 1, 161, 523	0.000000	
64. 00	06400 I NTRAVENOUS THERAPY	0		l .	0 3, 583, 608	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0	l .	0 6, 533, 105	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 3, 037, 658	0. 000000	
67. 01	06701 AUDI OLOGY	0	0	l .	0 766, 296	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	1	0 800, 193	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	
69. 01	06901 CARDI OLOGY	0	0		0 23, 857, 320	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 11, 477, 860	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0		1	0 11, 297, 436	0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 28, 175, 513	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0		1	0	0. 000000	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0			0	0. 000000	1
90. 02	09002 CLI NI C	0	0		0	0. 000000	
90. 03	09003 DERMATOLOGY CLINIC	0	0		0	0. 000000	1
90. 04	09004 ENT CLINIC	0	1	1	0	0. 000000	
90. 05	09005 SURGERY CLINIC	0	0	1	0	0. 000000	
90. 07	09007 UROLOGY CLINIC	0	0	1	0 132, 087	0. 000000	
90. 09	09009 GASTROENTEROLOGY CLINIC	0	0	1	0	0. 000000	
90. 11	09011 NEUROLOGY CLI NI C	0	0		0	0. 000000	
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	)	0	0. 000000	
90. 13	09013 ALLERGY CLINIC	0	0		0 296, 430	0. 000000	
90. 14	09014 WOUND CARE	0	0	l .	0 5, 668, 141	0. 000000	
91. 00	09100 EMERGENCY	0	1	l .	0 33, 708, 197	0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 8, 147, 489	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	1	0 393, 624, 960		200. 00

THROUGH COSTS    Component CCN: 15-S104   To   12/31/2022   Date/Time Prepared: 5/39/2023 4:58 pm   12/31/2022   Date/Time Prepared: 5/39/2023   Date/Time Prepared: 5/3		Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	WITHAM MEMORIAL	HOSPITAL Provider CO	CN: 15-0104	In Lie	u of Form CMS-2 Worksheet D	2552-10
Cost Center Description			WIGE OTHER TAGS			From 01/01/2022	Part IV Date/Time Pre	pared: 8 pm
Ratio of Cost to Charges (col. 6 + col. 7)   Program (Pages Program Pass-Through Cost (col. 9   Pass-Through Cos				Title	XVIII		PPS	<u> </u>
to Charges (col. 6 e col. 7)    Col. 16 e col. 7)   P. 00   10.00   11.00   12.00   13.00     Col. 6 e col. 7)   P. 00   10.00   11.00   12.00   13.00     Col. 16 e col. 7)   P. 00   10.00   11.00   12.00   13.00     Col. 16		Cost Center Description						
Cost				~				
ANGILLARY SERVICE COST CENTERS				Charges				
ANCILLARY SERVICE COST CENTERS						8		
ANCI LLARY SERVICE COST CENTERS				10.00		12.00		
50.00     05000     05000   05000   05000   0		ANCLLLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.000000   22, 277   0   0   0   54. 00	50 00		0.000000	7 090		0 0	0	50 00
55. 00   05500   RADI OLOGY-THERAPEUTI C		· · · · · · · · · · · · · · · · · · ·	1	•				
55.01   OS501   UITAR SOUND   0.000000   1.516   0 0 0 55.01   0.570   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5700   0.5800   0.5900   0.			1					
57, 00   05700   CT SCAN   0.000000   0.55, 750   0.000000   0.57, 00   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000				-				1
S8 00   05900   05900   CARDI AC CATHETERI ZATI ON   0.000000   3.231   0   0   0   58.00		1 1				0 0	-	
59, 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   5, 655   0   0   0   59, 00			1			0 0		
60.00   06000   LABORATORY   0.000000   400, 381   0   0   0   0   63.00			1			0 0		
64. 00   06400   INTRAVENOUS THERAPY   0. 000000   3, 749   0   0   0   64. 00   66. 00   06600   PHYSI CAL THERAPY   0. 000000   28, 468   0   0   0   0   067. 00   67. 01   06701   00701   00701   00701   00701   00701   00701   68. 00   06800   SPEECH PATHOLOGY   0. 000000   0   0   0   0   0   0   69. 01   06900   ELECTROCARDI OLOGY   0. 000000   0   0   0   0   0   0   69. 01   06901   CARDI OLOGY   0. 000000   0   0   0   0   0   0   69. 01   06901   CARDI OLOGY   0. 000000   0   0   0   0   0   69. 01   06901   CARDI OLOGY   0. 000000   0   0   0   0   0   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 000000   28, 182   0   0   0   0   0   71. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   0   0   0   0   70. 01   09000   CLI NI C   0. 000000   0   0   0   0   70. 01   09000   CLI NI C   0. 000000   0   0   0   0   70. 01   09000   CLI NI C   0. 000000   0   0   0   0   70. 02   09002   CLI NI C   0. 000000   0   0   0   0   70. 03   09003   DERMATOLOGY CLI NI C   0. 000000   0   0   0   0   70. 04   09004   ENTE CLI NI C   0. 000000   0   0   0   0   70. 05   09005   SURGERY CLI NI C   0. 000000   0   0   0   0   70. 07   09007   URLOGY CLI NI C   0. 000000   0   0   0   0   70. 07   09007   URLOGY CLI NI C   0. 000000   0   0   0   0   70. 07   09007   URLOGY CLI NI C   0. 000000   0   0   0   0   70. 07   09007   URLOGY CLI NI C   0. 000000   0   0   0   0   70. 07   09001   O7000   O7000   O7000   O7000   O7000   O7000   70. 07   09001   O7000   O7000   O7000   O7000   O7000   O7000   70. 07   09001   O7000   O7000   O7000   O7000   O7000   O7000   70. 07   09001   O7000   O7000   O70000   O70000   O70000   O70000   O70000   70. 07   09001   O700000   O700000   O700000   O700000   O700000   O700000   O7000000   O7000000   O7000000   O7000000   O7000000   O7000000   O70000000   O70000000   O70000000   O70000000   O70000000   O7000	60.00	1 1	1			0 0	0	60.00
66.00   06600   PHYSI CAL THERAPY   0.000000   28, 468   0   0   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0.000000   26, 303   0   0   0   67.00   68.00   06701   AUDI OLOGY   0.000000   0   0   0   0   67.00   68.00   06800   SPECH PATHOLOGY   0.000000   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   69.00   69.01   06901   CARDI OLOGY   0.000000   30, 292   0   0   0   0   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   28, 182   0   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   28, 182   0   0   0   0   72.00   72.00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   137, 317   0   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   137, 317   0   0   0   0   70.00   07000   CLI NI C   0.000000   0   0   0   0   0   70.01   09001   OTHER OUTPATI ENT SERVICE COST CENTER   0.000000   0   0   0   0   70.02   09002   CLI NI C   0.000000   0   0   0   0   0   70.03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   0   0   70.04   09004   ENT CLI NI C   0.000000   0   0   0   0   70.05   09005   SURGERY CLI NI C   0.000000   0   0   0   0   70.07   09007   WORDOGY CLI NI C   0.000000   0   0   0   0   70.08   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0   70.09   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0   70.01   09011   NEUROLOGY CLI NI C   0.000000   0   0   0   70.02   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0   70.03   09012   OPTHAMOLOGY CLI NI C   0.000000   0   0   0   70.04   09014   WOUND CARE   0.000000   0   0   0   0   70.07   09009   OSSERVATI ON BEDS (NON-DISTINCT PART)   0.000000   0   0   0   70.00   09100   EMERGENCY   0.000000   0   0   0   70.00   09500   MBULANCE SERVI CES	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
67. 00   06700   06700   0CCUPATIONAL THERAPY   0.000000   26,303   0   0   0   0   67.00   67. 01   06701   AUDIOLOGY   0.000000   0   0   0   0   0   68. 00   06800   SPEECTROCARDIOLOGY   0.000000   2,247   0   0   0   0   69. 01   06900   ELECTROCARDIOLOGY   0.000000   0   0   0   0   69. 01   06901   CARDIOLOGY   0.000000   0   0   0   0   69. 01   06901   CARDIOLOGY   0.000000   30,292   0   0   0   0   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.000000   28,182   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   137,317   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0   0   75. 00   07000   CLINIC   0.000000   0   0   0   0   76. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   0   0   76. 02   09002   CLINIC   0.000000   0   0   0   0   0   77. 00   09001   DREMATOLOGY CLINIC   0.000000   0   0   0   0   0   78. 00   09003   DREMATOLOGY CLINIC   0.000000   0   0   0   0   0   79. 0.01   09005   SURGERY CLINIC   0.000000   0   0   0   0   0   79. 0.02   09005   SURGERY CLINIC   0.000000   0   0   0   0   0   79. 0.03   09003   DREMATOLOGY CLINIC   0.000000   0   0   0   0   79. 0.09   09009   GASTROENTERCOLOGY CLINIC   0.000000   0   0   0   0   79. 0.11   09011   NEUROLOGY CLINIC   0.000000   0   0   0   0   79. 0.12   09012   OPTHAMOLOGY CLINIC   0.000000   0   0   0   0   79. 0.14   09014   WOUND CARE   0.000000   0   0   0   0   79. 0.15   09014   WOUND CARE   0.000000   0   0   0   0   79. 0.16   09006   DREMERGENCY   0.000000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.00000   0   0   0   0   79. 0.00   0.000000   0   0   0   79. 0.00   0.000000   0   0   0   0   79. 0.00   0.000000   0   0	64.00	06400 I NTRAVENOUS THERAPY	0. 000000	3, 749		0 0	0	64. 00
67. 01   06.701   06.701   06.701   0.00000   0   0   0   0   0   0   67. 011   68. 00   06.800   06.800   06.800   0.00000   0   0   0   0   0   0   0	66.00	06600 PHYSI CAL THERAPY	0. 000000	28, 468		0 0	0	66. 00
68. 00   06800   SPEECH PATHOLOGY   0.000000   2,247   0   0   0   0   68. 00   69. 00   06900   CLECTROCARDI OLOGY   0.000000   0   0   0   0   0   69. 01   06901   CARDI OLOGY   0.000000   30,292   0   0   0   0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.000000   28,182   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   137, 317   0   0   0   00   09700   CLI NI C   0.000000   0   0   0   0   90. 01   09900   CLI NI C   0.000000   0   0   0   0   90. 02   09900   CLI NI C   0.000000   0   0   0   0   90. 03   09903   DERMATOLOGY CLI NI C   0.000000   0   0   0   90. 04   09004   ENT CLI NI C   0.000000   0   0   0   90. 05   099005   SURGERY CLI NI C   0.000000   0   0   0   90. 05   099005   SURGERY CLI NI C   0.000000   0   0   0   90. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0   90. 08   09007   DASTROLOGY CLI NI C   0.000000   0   0   0   90. 09   09009   SASTROLOGY CLI NI C   0.000000   0   0   0   90. 01   09001   NEUROLOGY CLI NI C   0.000000   0   0   0   90. 02   09002   CLI NI C   0.000000   0   0   0   90. 05   09005   SURGERY CLI NI C   0.000000   0   0   0   90. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0   90. 09   09009   SASTROLOGY CLI NI C   0.000000   0   0   0   90. 01   09001   NEUROLOGY CLI NI C   0.000000   0   0   0   90. 11   09011   NEUROLOGY CLI NI C   0.000000   0   0   0   90. 12   09012   OPTHAMOLOGY CLI NI C   0.000000   0   0   0   90. 14   09014   MOUND CARE   0.000000   0   0   0   0   90. 16   09001   DEBERGENCY   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 10   09104   MOUND CARE   0.000000   0   0   0   0   90. 1	67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	26, 303		0 0	0	67. 00
69. 00   06900   CARDI OLOGY   0.000000   0   0   0   0   69. 00   69. 01   06901   CARDI OLOGY   0.000000   30, 292   0   0   0   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   28, 182   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   137, 317   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   137, 317   0   0   0   0   73. 00   09000   CLI NI C   0.000000   0   0   0   0   0   74. 00   09000   CLI NI C   0.000000   0   0   0   0   75. 00   09000   CLI NI C   0.000000   0   0   0   0   76. 00   09000   CLI NI C   0.000000   0   0   0   0   77. 00   09000   CLI NI C   0.000000   0   0   0   0   79. 01   09001   DRIMATOLOGY CLI NI C   0.000000   0   0   0   0   79. 02   09002   CLI NI C   0.000000   0   0   0   0   79. 03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   0   79. 04   09004   ENT CLI NI C   0.000000   0   0   0   0   79. 05   09005   SURGERY CLI NI C   0.000000   0   0   0   79. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0   79. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0   79. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0   79. 11   09011   NEUROLOGY CLI NI C   0.000000   0   0   0   79. 12   09012   OPTHAMOLOGY CLI NI C   0.000000   0   0   0   79. 14   09014   WOUND CARE   0.000000   0   0   0   79. 09009   OBSERVATI ON BEDS (NON-DISTINCT PART)   0.000000   0   0   0   79. 09500   AMBULANCE SERVICES   95. 00	67. 01	06701 AUDI OLOGY	0. 000000	0		0 0	0	67. 01
69. 01   06901   CARDI OLOGY   0.000000   30, 292   0   0   0   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   28, 182   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0.000000   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENT   0.000000   137, 317   0   0   0   73. 00   001700   CLINIC   0.000000   0   0   0   0   90. 01   09001   CHINIC   0.000000   0   0   0   0   90. 01   09001   OTHER OUTPATI ENT SERVICE COST CENTER   0.000000   0   0   0   0   90. 02   09002   CLINIC   0.000000   0   0   0   0   90. 03   09003   DERMATOLOGY CLINIC   0.000000   0   0   0   0   90. 04   09004   ENT CLINIC   0.000000   0   0   0   90. 05   09005   SURGERY CLINIC   0.000000   0   0   0   90. 07   09007   UROLOGY CLINIC   0.000000   0   0   0   90. 09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   0   90. 01   09011   NEUROLOGY CLINIC   0.000000   0   0   0   90. 02   09012   OTHEROLOGY CLINIC   0.000000   0   0   0   90. 01   09011   NEUROLOGY CLINIC   0.000000   0   0   0   90. 02   09013   ALLERGY CLINIC   0.000000   0   0   0   90. 11   09011   NEUROLOGY CLINIC   0.000000   0   0   0   90. 12   09012   OTHAMOLOGY CLINIC   0.000000   0   0   0   90. 14   09014   WOUND CARE   0.000000   0   0   0   90. 14   09014   WOUND CARE   0.000000   0   0   0   90. 17, 161   0910   EMERGENCY   0.000000   0   0   90. 09000   OSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0   90. 09000   OSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0   90. 09000   OSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0   90. 09000   OSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0   90. 09000   OSERVATION BEDS (SERVICES   0.000000   0   0   0   90. 00000000000000000000000000000000000	68.00	06800 SPEECH PATHOLOGY	0. 000000	2, 247		0 0	0	68. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   28, 182   0   0   0   0   71. 00   72.00   73.00   07200   IMPL. DEV. CHARGED TO PATIENT   0.000000   0   0   0   0   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.000000   137, 317   0   0   0   0   0   73.00   000000   000000   000000   0000000   000000	69. 00		0. 000000	0		0 0	0	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0.000000   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   137, 317   0   0   0   0   0   0   0   0   0   0	69. 01			30, 292		0 0	0	69. 01
73. 00			1	•	•	-		
90. 00   09000   CLI NI C   0. 000000   0   0   0   0   0   0   0				-		-	-	
90. 00	73. 00		0. 000000	137, 317		0 0	0	73. 00
90. 01					<b>-</b>			
90. 02						-		
90. 03		1	1					
90. 04   09004   ENT CLINIC   0.000000   0   0   0   0   90. 04   90. 05   09005   SURGERY CLINIC   0.000000   0   0   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0.000000   0   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   0   0   90. 09   90. 11   09011   NEUROLOGY CLINIC   0.000000   0   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0.000000   0   0   0   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0.000000   0   0   0   0   0   90. 13   90. 13   ALLERGY CLINIC   0.000000   0   0   0   0   90. 14   90. 14   09014   WOUND CARE   0.000000   0   0   0   0   90. 14   91. 00   09100   EMERGENCY   0.000000   17, 161   0   742   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0.000000   0   0   0   0   92. 00   00000   000000   0   0   0   0				0		-		
90. 05			1	0		-		
90. 07   09007   UROLOGY CLINI C   0. 000000   0   0   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINI C   0. 000000   0   0   0   0   90. 09   90. 11   09011   NEUROLOGY CLINI C   0. 000000   0   0   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINI C   0. 000000   0   0   0   0   0   90. 12   90. 13   09013   ALLERGY CLINI C   0. 000000   0   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   17, 161   0   742   0   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0. 000000   0   0   0   92. 00   00000   OTHER REIMBURSABLE COST CENTERS   95. 00			1	ŭ		-		
90. 09			1	ū		0	-	1
90. 11			1	ŭ		0		1
90. 12				ŭ		٥		
90. 13   09013   ALLERGY CLINI C   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   17, 161   0   742   0   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0. 000000   0   0   0   0   0THER REI MBURSABLE COST CENTERS   95. 00		1 1	1	ŭ		-	-	
90. 14   09014   WOUND CARE   0. 000000   0   0   0   0   90. 14   91. 00   09100   EMERGENCY   0. 000000   17, 161   0   742   0   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   0   0   0   0   0   0   92. 00   0THER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   95. 00   99. 14   0   90. 14   0   0   0   0   0   0   0   0   0				ŭ		0		
91. 00   09100   EMERGENCY   0. 000000   17, 161   0   742   0   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   0   0   0   0   0   0   0			1	-		-		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0. 000000   0   0   0   0   0   0   0				-		-		
OTHER REIMBURSABLE COST CENTERS  95. 00   09500   AMBULANCE SERVICES   95. 00		1 1		•			-	
95. 00 09500 AMBULANCE SERVICES 95. 00	00		1. 000000					1
200.00   Total (lines 50 through 199)   779,433   0 742   0 200.00	95.00							95. 00
	200.00	Total (lines 50 through 199)		779, 433		0 742	0	200. 00

5/30/2023 4:58 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. 153436 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0. 235026 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 0.147839 0 0 55.01 05700 CT SCAN 0.024977 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.072073 0 0 58.00 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 0.082649 0 0 59 00 60.00 06000 LABORATORY 0.145882 0 0 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 276764 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0.001725 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 0.443621 0 0 66.00 06700 OCCUPATIONAL THERAPY 0. 266212 67.00 67.00 0 06701 AUDI OLOGY 0 0 67.01 0.610867 0 67.01 0 68.00 06800 SPEECH PATHOLOGY 0.334974 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.01 06901 CARDI OLOGY 0.120992 0 0 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0. 328026 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0.149530 0 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.387475 0 0 3,835 0 73.00 73.00 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 0.375836 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 0.612833 0 0 0 90.13 09014 WOUND CARE 0 90 14 Ω 90 14 0.215567 0 09100 EMERGENCY 0 91.00 0. 232128 742 0 172 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 351063 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 0 95 00 09500 AMBULANCE SERVICES 1.000395 200.00 Subtotal (see instructions) 742 3, 835 172 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201. 00 Only Charges

0

3,835

742

172 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES	S AND VACCINE COST	Provi der CO	CN: 15-0104	Peri od: From 01/01/2022	Worksheet D Part V	
		Component (	CCN: 15-S104	To 12/31/2022		
		Title	XVIII	Subprovi der -	PPS	•
	Costs			I PF		

			Title X	KVIII	Subprovi der  - I PF	PPS	
		Costs	5				
	Cost Center Description	Cost	Cost				
	<b>'</b>	Rei mbursed	Rei mbursed				
		Services S	Services Not				
		Subject To	Subject To				
		Ded. & Coins. De	ed. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				50. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	05501 ULTRA SOUND	0	0				55. 01
	05700 CT SCAN	0	0				57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
	06000 LABORATORY	0	0				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
	06400 I NTRAVENOUS THERAPY	0	0				64. 00
	06600 PHYSI CAL THERAPY	0	0				66. 00
	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
	06701 AUDI OLOGY	0	0				67. 01
	06800 SPEECH PATHOLOGY	0	0				68. 00
	06900 ELECTROCARDI OLOGY	0	0				69. 00
	06901 CARDI OLOGY	0	0				69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 486				73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0				90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90. 01
	09002 CLI NI C	0	0				90. 02
	09003 DERMATOLOGY CLINIC	0	0				90. 03
	09004 ENT CLINIC	0	0				90. 04
	09005 SURGERY CLINIC	0	0				90. 05
	09007 UROLOGY CLINIC	0	0				90. 07
	09009 GASTROENTEROLOGY CLINIC	0	0				90.09
	09011 NEUROLOGY CLINIC	0	0				90. 11
	09012 OPTHAMOLOGY CLINIC	0	0				90. 12
	09013 ALLERGY CLINIC	0	0				90. 13
	09014 WOUND CARE	0	0				90. 14
	09100 EMERGENCY	0	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	<u> </u>	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						05.00
	09500 AMBULANCE SERVICES	0	1 40/				95. 00
200.00	Subtotal (see instructions)		1, 486				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	١					201. 00
202. 00	Only Charges Net Charges (line 200 - line 201)	0	1, 486				202. 00
202.00	INEL GIALGES (TITLE 200 - TITLE 201)	ı Y	1, 400				1202.00

			Ti +Lo	XVIII	Skilled Nursing	PPS	о рііі
			11116	· AVIII	Facility	PPS	
				Charges	гасттту	Costs	
	Cost Contor Doscription	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Cost Center Description	Ratio From	Services (see	Rei mbursed	Rei mbursed		
						(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1	1	Г			1
50.00	05000 OPERATI NG ROOM	0. 153436			0	0	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 235026	l .		0	-	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	l .		0	0	55. 00
55. 01	05501 ULTRA SOUND	0. 147839	0		0	0	55. 01
57.00	05700 CT SCAN	0. 024977	0		0 4, 339	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 072073	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 082649	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 145882	0		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 276764			0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 001725	l .		0 0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	0. 443621	l o		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 266212			0 0	0	67.00
67. 01	06701 AUDI OLOGY	0. 610867	l .		0 0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 334974	l .		0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
					0		
69. 01	06901 CARDI OLOGY	0. 120992	l .		0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 328026	l .		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 149530			0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 387475	0		0 11, 019	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		1				
90.00	09000 CLI NI C	0. 000000	l .		0		90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	l .		0	0	90. 01
90. 02	09002 CLI NI C	0. 000000	l .		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	0	90. 05
90.07	09007 UROLOGY CLINIC	0. 375836	0		0 0	0	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90. 09
90. 11	09011 NEUROLOGY CLINIC	0. 000000	0		0 0	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	0	90. 12
90. 13	09013 ALLERGY CLINIC	0. 612833	l .		0 0	0	90. 13
90. 14	09014 WOUND CARE	0. 215567	l .		0 0	0	90. 14
91. 00	09100 EMERGENCY	0. 232128			0 0	· -	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 351063			0 0		1
72.00	OTHER REIMBURSABLE COST CENTERS	0. 331003			0		72.00
95. 00		1. 000395			0		95. 00
200.00		1. 000395	0				200.00
	,				0 15, 358	1	
201.00	9				0		201. 00
202.00	Only Charges (Line 200 Line 201)				15 250	1	202 00
202.00	Net Charges (line 200 - line 201)	1	0	I	0 15, 358	i	202. 00

Health Financial Systems		WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15-0104	Peri od: From 01/01/2022	Worksheet D
			Component CCN: 15-5832		
			Title XVIII	Skilled Nursing	PPS
				Facility	

			Title	XVIII	Skilled Nursing	PPS	
		Cost	·e l		Facility		
	Cost Center Description	Cost	Cost				
	oust defiter beschiptron	Rei mbursed	Rei mbursed				
			Servi ces Not				
		Subject To	Subject To				
			ed. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG 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	0				55. 00
55. 01	05501 ULTRA SOUND	0	0				55. 01
57. 00	05700 CT SCAN	0	108				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64. 00
66. 00	06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
67. 01	06701 AUDI OLOGY	0	0				67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01	06901 CARDI OLOGY	0	0				69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72. 00
/3.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 270				73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0				00.00
90.00	09000 CLINIC	0	0				90.00
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0	0				90. 01
90. 02		0	0				90. 02 90. 03
90. 03	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC		0				90.03
90.04	09005 SURGERY CLINIC		0				90.04
90.03	09007 UROLOGY CLINIC		0				90.03
90.07	09009 GASTROENTEROLOGY CLINIC		0				90.07
90. 11	09011 NEUROLOGY CLINIC		0				90. 11
90. 11	09012 OPTHAMOLOGY CLINIC		0				90. 12
90. 12	09013 ALLERGY CLINIC		0				90. 12
90. 13	09014 WOUND CARE		0				90. 13
91. 00	09100 EMERGENCY		0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
, 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	O O				1 00
95. 00	09500 AMBULANCE SERVICES	O					95. 00
200.00	l l		4, 378				200.00
201.00	, ,		., ., .				201. 00
	Only Charges						
202.00		o	4, 378				202. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/30/2023 4:5		
	Title XVIII	Hospi tal	PPS		
Coot Conton Decemintion			•		

-		Title XVIII	Hospi tal	5/30/2023 4: 5 PPS	3 pm	
	Cost Center Description	II the Aviii	1103pi tai	113		
	·			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		9, 680	1. 00	
2.00	Inpatient days (including private room days, excluding swing-			9, 680	2.00	
3.00						
4.00	do not complete this line.  Semi-private room days (excluding swing-bed and observation be	ed days)		7, 134	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00	
	reporting period	3 7				
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December :	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00	
7.00	reporting period	m days) tim dagii becember	or or the cost	o o	7.00	
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Dreamer (eveluding	out no bod and	2, 285	9. 00	
9.00	newborn days) (see instructions)	o the Program (excluding	Swifig-bed and	2, 200	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00	
	through December 31 of the cost reporting period (see instructions)			_		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room davs)	0	12. 00	
	through December 31 of the cost reporting period					
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00	
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	diii (exci dariig swi iig-bed i	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 reporting period	es through December 31 o	f the cost	0.00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00			
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00			
20.00	reporting period	s ar ter becomber or or tr	10 0031	0.00	20.00	
21. 00	Total general inpatient routine service cost (see instructions			10, 874, 947		
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ 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 reporting	a period (line 6	0	23. 00	
	x line 18)		9			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00	
25. 00	$7 \times 1$ ine 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00	
23.00	x line 20)	or the cost reporting	perrod (Trie o		23.00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 874, 947	27. 00	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed ch	arnes)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed em	ii gcs)	Ö		
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	ine 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.00				
33. 00 34. 00	Average per diem private room charge differential (line 32 mi)	nus lina 33)(saa instruc	tions)	0. 00 0. 00		
35. 00	Average per diem private room cost differential (line 34 x line		ti ons)	0.00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	ie 31)		0.00	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	10, 874, 947	37. 00	
07.00	27 minus line 36)	and private room cost ar	Tronomeran (Trino	10,071,717	07.00	
	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, 123. 44		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line	•		2, 567, 060 0	39. 00 40. 00	
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)			2, 567, 060		
00	1.1.1 13. a 35 apat. 5 1 odtino 551 vi 66 5551 (1116 57			2,007,000	00	

	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1	pared:
			Title XVIII	Hospi tal	PPS	O PIII
	Cost Center Description	Total Inpatient Cost In	Total Average Per patient Days Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00 3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0 0.	00 0	0	42. 00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		2 472 1 050	71 710	1 214 004	1 42 00
43. 00 44. 00	CORONARY CARE UNIT	4, 576, 816	2, 473 1, 850.	/ 10	1, 314, 004	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT					45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT					46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)					47. 00
	Cost Center Description				1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)		3, 808, 142	48. 00
48. 01	Program inpatient cellular therapy acquisiti			, column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.01)	(see instructions)		7, 689, 206	49. 00
FO 00	PASS THROUGH COST ADJUSTMENTS			Dt- 11	200 /55	
50. 00	Pass through costs applicable to Program inp	eatient routine se	ervices (from WKSt. D, su	m or Parts I and	280, 655	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from Wkst. D,	sum of Parts II	170, 874	51.00
	and IV)	,	•			
52.00	Total Program excludable cost (sum of lines		stad non street st	hotiot!	451, 529	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rteu, non-physician anest	netist, and	7, 237, 677	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)				
54.00	Program di scharges					54. 00
55. 00	Target amount per discharge					55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55				0.00	56.00
57.00	Difference between adjusted inpatient operat		get amount (line 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)				0	58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost reporting period	ending 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,		prior year cost report,	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les				0	61. 00
(2.00	53) are less than expected costs (lines 54 x enter zero. (see instructions)	: 60), or 1 % of t	he target amount (line 5	6), otherwise	0	42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	(**************************************				
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the cost report	ing 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 cost reportin	a period (See	0	65. 00
	instructions)(title XVIII only)		•			
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(title XVI	ll only); for	0	66. 00
67. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routin	e costs through D	December 31 of the cost r	eporting period	0	67. 00
	(line 12 x line 19)	· ·				
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 of the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient				0	69. 00
70 5-	PART III - SKILLED NURSING FACILITY, OTHER N	•				70
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•	•	)		70. 00 71. 00
71.00	Program routine service cost (line 9 x line					72.00
73. 00	Medically necessary private room cost applic	able to Program (				73. 00
74.00	Total Program general inpatient routine serv	•		D+ 11 '		74.00
75. 00	Capital-related cost allocated to inpatient   26, line 45)	routine service o	costs (trom Worksheet B,	rart II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				76. 00
77. 00	Program capital-related costs (line 9 x line	76)				77. 00
78.00	Inpatient routine service cost (line 74 minu	,	ud don mon			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp		*.	nus line 70)		79. 00 80. 00
81.00	Inpatient routine service costs for comp			11110 /7)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)				82. 00
83.00	Reasonable inpatient routine service costs (					83.00
84.00	Program inpatient ancillary services (see in	,	•)			84. 00 85. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS		<u> </u>			1
87.00	Total observation bed days (see instructions	•			2, 546	1
88. 00	Adjusted general inpatient routine cost per	diam (line 27 1			1, 123. 44	88.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 4:58	
		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	876, 565	10, 874, 947	0.08060	4 2, 860, 278	230, 550	90.00
91.00 Nursing Program cost	0	10, 874, 947	0.00000	0 2, 860, 278	0	91.00
92.00 Allied health cost	0	10, 874, 947	0.00000	0 2, 860, 278	0	92.00
93.00 All other Medical Education	0	10, 874, 947	0.00000	2, 860, 278	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-S104	From 01/01/2022 To 12/31/2022	Date/Time Prepared:
			5/30/2023 4:58 pm
	Title XVIII	Subprovi der -	PPS
		IDE	

		litie XVIII	Subprovider -	PPS	
	Cost Center Description				
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		2, 065	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			2, 065	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 -1	2, 065	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	er 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
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 Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	ii oi tile cost	U	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 172	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on	ulv (including private r	nom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, en		dayo, a. to.	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/!·· (!! ·! · ·! · ·		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	3 - 3 - 3		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6 11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
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	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	s arter becember 51 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			2, 613, 119	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 613, 119	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	==,		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		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 613, 119	
200	27 minus line 36)				27.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 0/5 40	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 265. 43 1, 483, 084	
40.00	Medically necessary private room cost applicable to the Program			1, 463, 064	
	Total Program general inpatient routine service cost (line 39	,		1, 483, 084	
			•		

COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2022 To 12/31/2022		pared:
			Title	e XVIII	Subprovi der - I PF	PPS	о ріп
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 00 0	5.00	42.00
	Intensive Care Type Inpatient Hospital Units	<u> </u>		, O. 1	00  0		42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(	0.	00 0	0	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
						1. 00	
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisition			III line 10	column 1)	157, 782 0	1
	Total Program inpatient costs (sum of lines				, corumn r)	1, 640, 866	
	PASS THROUGH COST ADJUSTMENTS		, ,	,			
50. 00	Pass through costs applicable to Program inp.	atient routine s	services (from	n Wkst. D, sui	m of Parts I and	154, 458	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fi	om Wkst. D,	sum of Parts II	5, 212	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				159, 670	52. 00
	Total Program inpatient operating cost exclumed reducation costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rel	ated, non-phy	/sician anest	hetist, and	1, 481, 196	1
54. 00	Program discharges					0	54.00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
56. 00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)				0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	
60. 00	updated and compounded by the market basket)  Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if lin- 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of th	ne amount by w	which operatio	ng costs (line	0	61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	nber 31 of the	e cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi CAH, see instructions</pre>	ne costs (line 6	64 plus line o	55)(title XVI	II only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost r	eporting period	О	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY		0	
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				)		70.00
	Program routine service cost (line 9 x line		110 70 . 11110	2)			72. 00
	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•	,			73. 00 74. 00
75. 00	Capital Program general Theatrent Fourthe Serv Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column		75. 00
	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital -related costs (line 9 x line						77. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		ovi der record	ds)			78. 00 79. 00
80. 00	Total Program routine service costs for comp	arison to the co			nus line 79)		80.00
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		ı				81. 00 82. 00
	Reasonable inpatient routine service costs (						83. 00
	Program inpatient ancillary services (see in		,a)				84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
		00 2111	/			•	1
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (	CCN: 15-S104	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	272, 147	2, 613, 119	0. 10414	6 0	0	90. 00
91.00 Nursing Program cost	0	2, 613, 119	0. 00000	0	0	91. 00
92.00 Allied health cost	0	2, 613, 119	0. 00000	0	0	92. 00
93.00 All other Medical Education	0	2, 613, 119	0. 00000	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	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-5832		
	Title XVIII	Skilled Nursing	PPS
		Facility	

		litle XVIII	Facility	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 085	1. 00
2.00	Inpatient days (including private room days, excluding swing-		ivata maam daya	4, 085 0	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). It you have only pr	ivate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		4, 085	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)	om days) arter becomber	or 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 Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter becember 3	i or the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	2, 172	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including privato r	oom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		oon days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therdaing privat	e room days)	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	alli (exci during Swirig-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	+b	e +1 I	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	3 through becember 31 of	the cost	0.00	19.00
20. 00	Medical drate 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	s)		2, 719, 146	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (Line 4	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Trile 6	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or or the cost reporting	perrou (rriie o	O	25.00
	Total swing-bed cost (see instructions)	(   21 -     2/)		0 710 147	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE ZI IIITIUS TITIE ZO)		2, 719, 146	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00				0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. Triic 20)		0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 mil		tions)	0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	iic 31 <i>)</i>		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 719, 146	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	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 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,			40. 00 41. 00
	,		'		

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0104 CCN: 15-5832	Peri od: From 01/01/2022 To 12/31/2022		pared:
			Title	e XVIII	Skilled Nursing	5/30/2023 4: 5 PPS	8 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost In		col . 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	; 					43.00
44.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk						48. 00
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)		48. 01 49. 00
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	batient routine se	rvices (Tron	ıwkst. D, su	m or Parts I and		50.00
51.00	Pass through costs applicable to Program inp	patient ancillary	servi ces (fr	om Wkst. D,	sum of Parts II		51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ted, non-phy	/sician anest	hetist, and		53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00 55. 00	Program discharges Target amount per discharge						54. 00 55. 00
	Permanent adjustment amount per discharge						55. 01
	Adjustment amount per discharge (contractor						55. 02
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		et amount (I	ine 56 minus	line 53)		56.00
	Bonus payment (see instructions)	line FF & b					58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		ne cost repo	orting period	ending 1996,		59.00
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	orior year o	cost report,	updated by the		60.00
61. 00	<pre>market basket) Continuous improvement bonus payment (if lir</pre>	ne 53 ÷ line 54 is	less than t	the lowest of	lines 55 plus		61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	( 00), 01 1 % 01 1	io tai got aii	iodire (11116 0	o), otherwise		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ment (see instruct	ons)				62.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decemb	er 31 of the	cost report	ing period (See		64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the c	ost reportin	g period (See		65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	plus line 6	55)(title XVI	II only); for		66. 00
<i>(</i> 7 00	CAH, see instructions	. aaata theawah D		 	ananting paried		47.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ie costs through b	ecember 31 c	n the cost i	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Dec	ember 31 of	the cost rep	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	e 68)			69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)	2, 719, 146	70.00
71. 00	Adjusted general inpatient routine service of	-		•	)	665. 64	1
	Program routine service cost (line 9 x line Medically necessary private room cost applic		lino 14 v li	no 25)		1, 445, 770 0	1
	Total Program general inpatient routine serv					1, 445, 770	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from V	Vorksheet B,	Part II, column	0	75. 00
	Per diem capital-related costs (line 75 ÷ li	. *					76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu					0	
79. 00	Aggregate charges to beneficiaries for exces	ss costs (from pro		*.		0	79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		t limitatior	ı (line 78 mi	nus line 79)	0 0. 00	
82. 00	Inpatient routine service cost limitation (I					0.00	82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (	•				1, 445, 770	1
	Program inpatient ancillary services (see in Utilization review - physician compensation		)			904, 221 0	
	Total Program inpatient operating costs (sum	n of lines 83 thro				2, 349, 991	86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					0	87. 00
87. 00			ne 2)			0.00	1

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-5832	From 01/01/2022 To 12/31/2022		
		Title	: XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	0	0	0. 00000	0 0	0	90. 00
91.00 Nursing Program cost	0	0	0.00000	00	0	91.00
92.00 Allied health cost	0	0	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0. 00000	00	0	93. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/30/2023 4:5	
	Title XIX	Hospi tal	Cost	
C+ C+			•	

		Title XIX	Hospi tal	5/30/2023 4:58 Cost	8 pm
	Cost Center Description	II LIE AIA	поѕрі таі	COST	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS			0.400	4.00
1.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			9, 680	1.00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed day		vato room days	9, 680 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate 100iii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 134	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private room	om days) after December :	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through Docombor	21 of the cost	0	7. 00
7.00	reporting period	ii days) tili ougii beceiibei	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	248	9. 00
40.00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		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, en		Join days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	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 (excidaring swing-bed t	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	es through December 31 o	f the cost	0. 00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 through becomber 31 or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			10, 874, 947	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)		9	_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24. 00
	7 x line 19)				
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	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 874, 947	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27 -	Line 20)		0. 000000	30. 00 31. 00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 26)		0.00000	
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	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 di	fferential (line	10, 874, 947	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 123. 44	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			278, 613	
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41.00	Total Program general inpatient routine service cost (line 39			278, 613	41.00

Hool +b	Financial Cyatama	WLTHAM MEMORIA	LUCCLIAL		ا ما	u of Form CMC	DEED 10
	Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORIA	Provider C	CN: 15-0104	Period: From 01/01/2022	w of Form CMS-2 Worksheet D-1	
					To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
			_	e XIX	Hospi tal	Cost	<u>о рііі</u>
	Cost Center Description	Total Inpatient Cost	Total npatient Days			Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 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	4, 576, 816	2, 473	1, 850.	71 0	0	43. 00
44.00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					174, 516	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 453, 129	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>	,	•			
50. 00	Pass through costs applicable to Program inp	oatient routine s	services (from	Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpand IV)	oatient ancillary	/ services (fr	om Wkst. D,	sum of Parts II	0	51. 00
52. 00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sician anest	hetist, and	0	53.00
54.00	Program di scharges					0	54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge						55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor	use only)					55. 02
56.00	Target amount (line 54 x sum of lines 55, 55	5. 01, and 55. 02)				0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0 0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,		59.00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		n prior year c	ost report,	updated by the	0. 00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	sser of 50% of th	ne amount by w	hich operati	ng costs (line	0	61. 00
62.00	enter zero. (see instructions) Relief payment (see instructions)						62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	•	ĺ			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Decem	mber 31 of the	cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 6	64 plus line 6	5)(title XVI	II only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin ((line 12 x line 19)	ne costs through	December 31 c	f the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		70.00
71. 00	Adjusted general inpatient routine service o	cost per diem (li					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	s)			78. 00 79. 00
80.00	Total Program routine service costs for comp	parison to the co			nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (						83. 00
84.00	Program inpatient ancillary services (see in	nstructions)					84. 00
85. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
86 00			cagii 00)				, 55. 66
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	0 1111100011 0001					
86. 00 87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	5)	line 2)			2, 546 1, 123. 44	87.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 4:58	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	876, 565	10, 874, 947	0.08060	4 2, 860, 278	230, 550	90.00
91.00 Nursing Program cost	0	10, 874, 947	0.00000	0 2, 860, 278	0	91.00
92.00 Allied health cost	0	10, 874, 947	0.00000	0 2, 860, 278	0	92.00
93.00 All other Medical Education	0	10, 874, 947	0.00000	2, 860, 278	0	93. 00

	W. T				6.5. 0110.6	
Health Financial Systems	WITHAM MEMORIAL	HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der		Peri od: From 01/01/2022	Worksheet D-3	
				To 12/31/2022	Date/Time Prep 5/30/2023 4:58	pared: 8 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				_	2)	
			1, 00	2. 00	3, 00	

	Title XV	III	Hospi tal	PPS	
Cost Center Description	Ra <sup>-</sup>	tio of Cost	I npati ent	I npati ent	
	T	o Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LUBATI ENT. DOUTLING OFFINIAGE COOT OFFITTED		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0 544 045		00.00
30. 00   03000   ADULTS & PEDI ATRI CS			2, 544, 345		30.00
31. 00   03100   INTENSIVE CARE UNIT			1, 931, 481		31. 00
40. 00   04000   SUBPROVI DER -   PF			0		40.00
41. 00   04100   SUBPROVI DER -   I RF			0		41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			0		42.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0 152426	2, 940, 821	451, 228	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 153436 0. 235026	946, 951	222, 558	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 233028	940, 951		55. 00
55. 01   05501   ULTRA   SOUND		0. 147839	75, 543	0 11, 168	55. 00 55. 01
57. 00   05700   CT   SCAN		0. 147639	2, 952, 067	73, 734	57. 00
		0.024977	506, 331	36, 493	58. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   05900   CARDIAC CATHETERIZATION		0.072073	218, 448	18, 055	59. 00
60. 00   06000 LABORATORY		0. 145882	4, 877, 546	711, 546	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 143862	139, 275	38, 546	63.00
64. 00   06400   NTRAVENOUS THERAPY		0. 270704	412, 570	712	64. 00
66. 00   06600 PHYSI CAL THERAPY		0. 443621	398, 791	176, 912	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY		0. 443621	296, 734	78, 994	67. 00
67. 01   06701   AUDI OLOGY		0. 266212	290, 734	76, 994	67. 00 67. 01
68. 00   06800   SPEECH PATHOLOGY		0. 334974	_	20, 456	68. 00
69. 00   06900  SPEECH PATHOLOGY		0. 334974	61, 067	20, 430	69. 00
69. 01   06901   CARDI OLOGY		0. 120992	3, 257, 830	394, 171	69. 01
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 120992	939, 293	308, 113	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENT		0. 149530	835, 316	124, 905	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 387475	1, 864, 220	722, 339	73. 00
OUTPATIENT SERVICE COST CENTERS		0. 367473	1, 004, 220	122, 337	73.00
90. 00 09000 CLINIC		0. 000000	0	0	90.00
90. 01   09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 000000	0	0	90. 01
90. 02   09002   CLINIC		0. 000000	0	0	90. 02
90. 03   09003   DERMATOLOGY CLI NI C		0. 000000	0	0	90. 03
90. 04   09004   ENT CLI NI C		0. 000000	0	0	90. 04
90. 05   09005   SURGERY CLINIC		0. 000000	0	0	90. 05
90. 07   09007   UROLOGY   CLI NI C		0. 375836	0	0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC		0. 000000	0	0	90. 09
90. 11   09011   NEUROLOGY CLI NI C		0. 000000	0	0	90. 11
90. 12   09012   0PTHAMOLOGY CLI NI C		0. 000000	0	0	90. 12
90. 13   09013   ALLERGY CLINIC		0. 612833	0	0	90. 13
90. 14   09014   WOUND CARE		0. 215567	0	0	90. 14
91. 00   09100   EMERGENCY		0. 232128	1, 582, 630	367, 373	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 351063	144, 815	50, 839	92. 00
OTHER REI MBURSABLE COST CENTERS		3. 55 1505	111,015	33, 037	, 2. 00
95. 00 O9500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			22, 450, 248	3, 808, 142	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0.00	0,000,112	201. 00
202.00 Net charges (line 200 minus line 201)	/		22, 450, 248		202. 00
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	1	,,,	'	

NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0104	Peri od: From 01/01/2022	Worksheet D-3	
		Component	CCN: 15-S104	To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
		Ti tl e	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	IPATIENT ROUTINE SERVICE COST CENTERS					20.0
	8000 ADULTS & PEDIATRICS 8100 INTENSIVE CARE UNIT					30.0
	1000 SUBPROVI DER - I PF			1, 604, 256		40.
	1100 SUBPROVI DER - I RF			1,001,200		41. (
	1200 SUBPROVI DER					42. (
-	300 NURSERY					43. (
	ICI LLARY SERVI CE COST CENTERS					
	OOO OPERATING ROOM		0. 15343		1, 088	
- 1	6400 RADI OLOGY-DI AGNOSTI C		0. 23502		5, 234	
	500 RADI OLOGY-THERAPEUTI C		0.00000		0	
	5501 ULTRA SOUND		0. 14783		224	1
	7700 CT SCAN		0. 02497		1, 638	1
1	MAGNETIC RESONANCE IMAGING (MRI)		0. 07207		233	
1	5900 CARDI AC CATHETERI ZATI ON		0. 08264		467	1
	000 LABORATORY		0. 14588	I I	58, 408	1
1	300 BLOOD STORING, PROCESSING & TRANS. 3400 INTRAVENOUS THERAPY		0. 27676		0	
	600 PHYSI CAL THERAPY		0. 00172		6 12, 629	1
	5700 OCCUPATIONAL THERAPY		0. 26621		7, 002	1
	7700 OCCONTITIONAL THERAILY		0. 61086		0	1
	8800 SPEECH PATHOLOGY		0. 33497		753	1
	900 ELECTROCARDI OLOGY		0.00000		0	1
	9901 CARDI OLOGY		0. 12099	I I	3, 665	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 32802		9, 244	1
	200 IMPL. DEV. CHARGED TO PATIENT		0. 14953		0	72.
3. 00 07	300 DRUGS CHARGED TO PATIENTS		0. 38747	75 137, 317	53, 207	73.
OU	TPATIENT SERVICE COST CENTERS					
	POOD CLINIC		0.00000	00	0	90.
	0001 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		0	
- 1	POO2 CLI NI C		0.00000		0	1
	2003 DERMATOLOGY CLINIC		0.00000		0	1
	2004 ENT CLINIC		0.00000	I I	0	
	2005 SURGERY CLINIC		0.00000		0	
	2007 UROLOGY CLINIC		0. 37583		0	
1	2009 GASTROENTEROLOGY CLINIC		0.00000		0	
	2011 NEUROLOGY CLINIC		0.00000		0	1
	0012 OPTHAMOLOGY CLINIC		0.00000		0	1
	0013 ALLERGY CLINIC 0014 WOUND CARE		0. 61283 0. 2155 <i>6</i>		0	1
1	2100 EMERGENCY		0. 21556		3, 984	
	2000 OBSERVATION BEDS (NON-DISTINCT PART)		0. 23212		3, 984	1
	HER REIMBURSABLE COST CENTERS		0.33100	, o <sub>l</sub>	0	1 12.
	2500 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			779, 433	157, 782	
01. 00	Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0	,	201.
02.00	Net charges (line 200 minus line 201)	5 - ( 1)	1	1 9		202.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0104	Peri od:	worksheet D-3	
	Component	CCN: 15-5832	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
	Ti tl e	e XVIII	Skilled Nursing Facility		
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
80. 00   03000   ADULTS & PEDIATRICS 81. 00   03100   I NTENSI VE CARE UNIT 80. 00   04000   SUBPROVI DER - I PF 81. 00   04100   SUBPROVI DER - I RF 82. 00   04200   SUBPROVI DER 83. 00   04300   NURSERY					30. ( 31. ( 40. ( 41. ( 42. ( 43. (
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM 54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 15343 0. 23502 0. 00000	26 56, 067	6, 216 13, 177 0	54.
55. 01   05501   ULTRA SOUND 57. 00   05700   CT SCAN		0. 14783 0. 02497	0 77 2, 283	0 57	55. ( 57. (
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION		0. 07207 0. 08264		0 2, 069	
50. 00   06000   LABORATORY		0. 14588		35, 421	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 27676		1, 414	1
4. 00   06400   I NTRAVENOUS THERAPY		0. 00172	· ·	23	
6. 00   06600   PHYSI CAL THERAPY 7. 00   06700   OCCUPATI ONAL THERAPY		0. 44362 0. 2662		334, 416 204, 723	
7. 01   06701   AUDI OLOGY		0. 61086		204, 723	1
8. 00 06800 SPEECH PATHOLOGY		0. 33497		10, 897	1
9. 00   06900   ELECTROCARDI OLOGY		0.00000	00	0	69.
9. 01   06901   CARDI OLOGY		0. 12099		14, 918	1
1.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00   07200   IMPL. DEV. CHARGED TO PATIENT		0. 32802		22, 734 0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 14953 0. 38747		257, 144	
OUTPATIENT SERVICE COST CENTERS					
0.00  09000 CLINIC 0.01  09001 OTHER OUTPATIENT SERVICE COST CENTER		0.00000		0	
0. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER 0. 02   09002   CLINIC		0.00000		0	
0. 02   09002   CLI NI C 0. 03   09003   DERMATOLOGY   CLI NI C		0.00000		0	1
0. 04   09004 ENT CLINIC		0.00000		Ö	1
0. 05   09005 SURGERY CLINIC		0.00000		0	1
		0. 37583	36 0	0	90.
D. 07   09007   UROLOGY CLI NI C		0.00000		0	
D. 09 09009 GASTROENTEROLOGY CLINIC		1		0	90.
D. 09 O9009 GASTROENTEROLOGY CLINIC D. 11 O9011 NEUROLOGY CLINIC		0.00000		_	
D. 09   09009   GASTROENTEROLOGY CLINIC D. 11   09011   NEUROLOGY CLINIC D. 12   09012   0PTHAMOLOGY CLINIC		0.00000	00 0	0	
0. 09		0. 00000 0. 61283	00 0	0	90.
00. 09		0. 00000 0. 61283 0. 21556	00 0 33 0 57 0	0	90. 90.
0. 09   09009   GASTROENTEROLOGY CLINIC 0. 11   09011   NEUROLOGY CLINIC 0. 12   09012   OPTHAMOLOGY CLINIC 0. 13   09013   ALLERGY CLINIC		0. 00000 0. 61283	00 0 33 0 57 0 28 4, 360	0	90 90 91

95.00

904, 221 200. 00 201. 00 202. 00

2, 800, 971

2, 800, 971

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	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0104	Peri od: From 01/01/2022	Worksheet D-3	
				To 12/31/2022	Date/Time Prep 5/30/2023 4:58	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	

INPATI_ENT_ROUTINE_SERVICE_COST_CENTERS						5/30/2023 4:5	8 pm
INPATIENT ROUTINE SERVICE COST CENTERS			Ti tl	e XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description		Ratio of Cost	Inpatient	Inpati ent	
IMPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3		<b>'</b>		To Charges	Program		
INPATIENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3				'	9		
INPAIL ENT ROUTINE SERVICE COST CENTERS   1.00   2.00   3.00					onal goo		
INPATI ENT ROUTH NE SERVICE COST CENTERS   30.00   31.00   3				1 00	2 00		
30.00		INDATIENT DOUTINE CEDVICE COCT CENTEDS		1.00	2.00	3.00	
31. 00   03100   INTERSIVE CARE UNIT   0   40. 00   40.					05/ 043		20.00
0.0   0.4000   SUBPROVI DER - I PF   0   41.00   41.					· ·		
1.1							
42.00   04200   SUBROVI DER   0   42.00   0   43.00							
A3. 00   04300   NURSERY					_		
ANCILLARY SERVICE COST CENTERS							
SOLODIO	43.00	04300 NURSERY			0		43.00
S4 00   OS400   RADI OLOGY-DI AGNOSTIC   0.235026   19,892   4,675   54.00   55.00   0.500   OS00   RADI OLOGY-DI AGNOSTIC   0.000000   0.055.00   0.55.01		ANCILLARY SERVICE COST CENTERS					
55. 00   05.	50.00	05000 OPERATING ROOM		0. 15343	6 106, 410	16, 327	50. 00
55.0   05501   ULTRA SOUND   0.147839   13, 736   2.031   55.0   057.00   05700   CTSOTO CT SCAN   0.02497   101, 163   2.527   57.0   057.00   05700   CTSOTO CT SCAN   0.02497   101, 163   2.527   57.0   05700   CTSOTO CT SCAN   0.082049   112, 241   9, 277   59.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.0000000   0.000000   0.0000000   0.00000000	54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 23502	6 19, 892	4, 675	54.00
55.0   05501   ULTRA SOUND   0.147839   13, 736   2.031   55.0   057.00   05700   CTSOTO CT SCAN   0.02497   101, 163   2.527   57.0   057.00   05700   CTSOTO CT SCAN   0.02497   101, 163   2.527   57.0   05700   CTSOTO CT SCAN   0.082049   112, 241   9, 277   59.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.0000000   0.000000   0.0000000   0.00000000	55. 00	05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
57.00   05700   05700   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   0500000   050000000   05000000   050000000   050000000   0500000000						2 031	
SB 00   SB00   MARNETIC RESONANCE I MAGING (MRI)   0.072073   8.205   591   58.00				•	· ·		
59 00   05000   CARDI AC CATHETERI ZATI ON   0   082049   112   241   9   277   59 0   0   06000   06000   LABORATORY   0   145882   202   336   29   517   60 0   06 00   06 300   BLODD STORI NG, PROCESSI NG & TRANS.   0   2767644   12   315   3   408   63   00   06   00							
60.00   06000   LABORATORY   0. 145882   202, 336   29, 517   60.00							
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0, 276764   12, 315   3, 408   63.00   06400   INTRAVENOUS THERAPY   0, 001725   27, 264   47   64.00   06600   PHYSI CAL THERAPY   0, 443621   8, 224   3, 648   66.00   0700   0							
64.00   06400   INTRAVENOUS THERAPY   0.443621   8.224   3.648   66.00							
66.00   06600   06600   06700   0CCUPATI ONAL THERAPY   0.443621   8,224   3,688   66.00							
67. 00   06700   OCCUPATI (NAIL THERAPY   0.266212   5,837   1,554   67.00   67. 01   06701   AUDI OLOGY   0.610867   0 0   0.67.01   68. 00   06800   SPEECH PATHOLOGY   0.334974   321   108   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0.000000   0   0.69.00   69. 01   06901   CARDI OLOGY   0.120992   78,527   9,501   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.328026   77,884   25,548   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0.149530   0   0.72.00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130,532   50,578   73. 00   7300   DRUGS CHARGED TO PATIENTS   0.387475   130,532   50,578   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0.00000   70. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   0.00000   70. 02   09002   CLI NI C   0.000000   0   0   0.00000   70. 03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   0.00000   70. 04   09004   ENT CLI NI C   0.000000   0   0   0.00000   70. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0.00000   70. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   OSTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   OSTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   OSTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   OSTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 09. 09009   OSTROENTEROLOGY CLI NI C   0.000000   0   0   0.00000   70. 10   09011   NEUROLOGY CLI NI C   0.000000   0   0   0.00000   70. 10   09012   OFTHAMOLOGY CLI NI C   0.000000   0   0   0.00000   70. 10   09014   WOUND CAPE   0.000000   0   0.000000   0   0.000000   70. 10   09014   WOUND CAPE   0.0000000   0   0.000000   0   0.000000   70. 10   09000   OSTRONATION BEDS (NON-DISTINCT PART)   0.351063   0   0.0000000   0.000000   70. 10   0900000000000000000000000000000000							
67. 01   06701   AUDI OLOGY				0. 44362			66. 00
68. 00   06800   SPEECH PATHOLOGY   0.334974   321   108   68. 00   69. 00   06900   ELECTROCARDIOLOGY   0.120992   78. 527   9,501   69. 01   71. 00   71.				0. 26621	2 5, 837	1, 554	67. 00
69. 00 6900   CLECTROCARDIOLOGY   0.000000   0.0 69. 00 69. 00 69. 01 06901   CARDIOLOGY   78, 527   9, 501 69. 01 77. 00 07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0.328026 77, 884 25, 548 71. 00 07200   MPLL DEV. CHARGED TO PATIENTS   0.3487475   130, 532   50, 578 73. 00 07200   MPLL DEV. CHARGED TO PATIENTS   0.387475   130, 532   50, 578 73. 00 07200   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578 73. 00 07200   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578 73. 00 07200   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578 73. 00 07200   DRUGS CHARGED TO PATIENTS   0.0000000   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   0.00000000	67. 01	06701 AUDI OLOGY		0. 61086	7 0	0	67. 01
69.01   CARDI OLOGY   78, 527   9, 501   69, 01     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.328026   77, 884   25, 548   71. 00     72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0.149530   0   0.72. 00     73. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578     73. 00   09000   CLI NI C   0.000000   0   0   0     90. 01   09000   CLI NI C   0.000000   0   0   0     90. 02   09002   CLI NI C   0.000000   0   0   0     90. 03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   0     90. 04   09004   ENT CLI NI C   0.000000   0   0   0     90. 05   09005   SURGERY CLI NI C   0.000000   0   0   0     90. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0     90. 08   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0     90. 09   09009   O9009   GASTROENTEROLOGY CLI NI C   0.000000   0   0     90. 01   09011   NEUROLOGY CLI NI C   0.000000   0   0     90. 02   09012   OPTHAMOLOGY CLI NI C   0.000000   0   0     90. 13   09013   ALLERGY CLI NI C   0.000000   0   0     90. 13   09013   ALLERGY CLI NI C   0.000000   0   0     90. 13   09014   WOUND CARE   0.215567   0   0   0     90. 14   09014   WOUND CARE   0.232128   65, 392   15, 179     90. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0.232128   65, 392   15, 179     90. 00   09500   AMBULANCE SERVI CES   0.000000   0   0     90. 00   09500   AMBULANCE SERVI CES   0.000000   0   0     90. 10   00   OFTION CONTROL OF SERVI CES   0.000000   0   0     90. 10   00   00   00   00   00   00   00	68. 00	06800 SPEECH PATHOLOGY		0. 33497	4 321	108	68. 00
69.01   CARDI OLOGY   78, 527   9, 501   69, 01     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.328026   77, 884   25, 548   71. 00     72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0.149530   0   0.72. 00     73. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578     73. 00   000700   LIN C   0.000000   0   0   0     90. 01   09000   CLI NI C   0.000000   0   0   0     90. 02   09002   CLI NI C   0.000000   0   0   0     90. 03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   0     90. 04   09004   ENT CLI NI C   0.000000   0   0   0     90. 05   09005   SURGERY CLI NI C   0.000000   0   0   0     90. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0     90. 08   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0     90. 07   09007   UROLOGY CLI NI C   0.000000   0   0   0     90. 08   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   0     90. 01   09011   NEUROLOGY CLI NI C   0.000000   0   0   0     90. 11   09011   NEUROLOGY CLI NI C   0.000000   0   0   0     90. 12   09012   OPTHAMOLOGY CLI NI C   0.000000   0   0   0     90. 13   09013   ALLERGY CLI NI C   0.000000   0   0   0     90. 13   09013   ALLERGY CLI NI C   0.000000   0   0   0     90. 14   09014   WOUND CARE   0.232128   65, 392   15, 179     91. 00   09000   DIRER REIMBURSABLE COST CENTERS   0.000000   0   0     90. 07   07   07   07   07   07   07   07	69. 00	06900 ELECTROCARDI OLOGY		0.00000	0	0	69. 00
71. 00						9, 501	69. 01
72. 00   07200   MPL. DEV. CHARGED TO PATIENT   0.149530   0   0.72. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130, 532   50, 578   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0   0   0.00000   0   0							
73.00   07300   DRUGS CHARGED TO PATIENTS   0.387475   130,532   50,578   73.00   07300   DRUGS CHARGED TO PATIENTS   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   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   0.0000000   0.0000000   0.00000000							
90. 00   09000   CLI NI C   0.000000   0   0   90. 00     90. 01   09001   OTHER OUTPATIENT SERVICE COST CENTER   0.000000   0   0   90. 01     90. 02   09002   CLI NI C   0.000000   0   0   90. 01     90. 03   09003   DERMATOLOGY CLI NI C   0.000000   0   0   90. 03     90. 04   09004   ENT CLI NI C   0.000000   0   0   90. 03     90. 05   09005   SURGERY CLI NI C   0.000000   0   0   90. 05     90. 07   09007   UROLOGY CLI NI C   0.375836   0   0   90. 07     90. 09   09009   GASTROENTEROLOGY CLI NI C   0.000000   0   0   90. 07     90. 11   09011   NEUROLOGY CLI NI C   0.000000   0   0   90. 11     90. 12   09012   OFTHAMOLOGY CLI NI C   0.000000   0   0   90. 12     90. 13   09013   ALLERGY CLI NI C   0.000000   0   0   90. 12     90. 14   09014   WOUND CARE   0.215567   0   0   90. 14     91. 00   09100   EMERGENCY   0.232128   65, 392   15, 179   91. 00     92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.351063   0   0   92. 00     09500   AMBULANCE SERVI CES   970. 00     200. 00   Total (sum of lines 50 through 94 and 96 through 98)   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   0.000000   0   0.000000     00. 000000   0.000000   0.000000   0.00000000						_	
90. 00				0.30747	130, 332	30, 370	73.00
90. 01				0.00000			00 00
90. 02   09002   CLINIC   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. 03   90. 05   09005   SURGERY CLINIC   0.000000   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0.375836   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   90. 07   90. 11   09011   NEUROLOGY CLINIC   0.000000   0   0   90. 11   90. 12   09012   097HAMOLOGY CLINIC   0.000000   0   0   90. 11   90. 13   09013   ALLERGY CLINIC   0.612833   0   0   90. 13   90. 14   09014   WOUND CARE   0.215567   0   0   90. 14   91. 00   09100   EMERGENCY   0.232128   65, 392   15, 179   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0.351063   0   0   92. 00   00000   Total (sum of lines 50 through 94 and 96 through 98)   970, 279   174, 516   200. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   70. 000000   0   0   0   0.000000   0.000000   0.000000   0   0							
90. 03							
90. 04   09004   09004   ENT CLINIC   0.000000   0   0   90. 04   90. 05   09005   SURGERY CLINIC   0.000000   0   0   90. 05   90. 07   09007   UROLOGY CLINIC   0.375836   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0.000000   0   0   90. 07   90. 10   09011   09011   NEUROLOGY CLINIC   0.000000   0   0   90. 11   90. 12   09012   0PTHAMOLOGY CLINIC   0.000000   0   0   90. 11   90. 13   09013   ALLERGY CLINIC   0.612833   0   0   90. 12   90. 14   09014   WOUND CARE   0.215567   0   0   90. 14   91. 00   09100   EMERGENCY   0.232128   65, 392   15, 179   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.351063   0   0   95. 00   09500   AMBULANCE SERVICES   95. 00   200. 00   Total (sum of lines 50 through 94 and 96 through 98)   Cless PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00							
90. 05						_	
90. 07   09007   UROLOGY CLINIC   0. 375836   0   0   90. 07   90. 09   09009   GASTROENTEROLOGY CLINIC   0. 000000   0   0   90. 09   90. 11   09011   NEUROLOGY CLINIC   0. 000000   0   0   90. 11   90. 12   09012   OPTHAMOLOGY CLINIC   0. 000000   0   0   90. 12   90. 13   09013   ALLERGY CLINIC   0. 612833   0   0   90. 13   90. 14   09014   WOUND CARE   0. 215567   0   0   90. 14   91. 00   09100   EMERGENCY   0. 232128   65, 392   15, 179   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 351063   0   0   92. 00   95. 00   09500   AMBULANCE SERVICES   95. 00   200. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00							
90. 09						_	
90. 11	90. 07	09007 UROLOGY CLINIC		0. 37583	6 0	0	90. 07
90. 12	90. 09	09009 GASTROENTEROLOGY CLINIC		0.00000	0	0	90. 09
90. 12	90. 11	09011 NEUROLOGY CLINIC		0.00000	0	0	90. 11
90. 13   09013   ALLERGY CLINIC   0.612833   0   0   90. 13   90. 14   09014   WOUND CARE   0.215567   0   0   90. 14   91. 00   09100   EMERGENCY   0.232128   65, 392   15, 179   91. 00   09200   0				0.00000	0	0	90. 12
90. 14   09014   WOUND CARE   0. 215567   0 0 0 90. 14   91. 00   09100   EMERGENCY   0. 232128   65, 392   15, 179   91. 00   09200						0	
91. 00   09100   EMERGENCY   0. 232128   65, 392   15, 179   91. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 351063   0   0   92. 00   0THER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   970, 279   174, 516   200. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0   0   0   0   0   0				1			
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 351063   0   92. 00   0THER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   95. 00   201. 00   Less PBP Clinic Laboratory Services-Program only charges (line 61)   0   201. 00   201. 00   201. 00   0. 351063   0   0   92. 00   92. 00   0. 351063   0   0   92. 00   0. 351063   0   0   92. 00   0. 351063   0   0   92. 00   0. 351063   0   0   0. 351063   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0. 351063   0   0   0   0   0   0   0   0   0				1		_	
OTHER REIMBURSABLE COST CENTERS   95.00							
95. 00				0.33106	J <sub>1</sub> U	· U	72.00
200.00       Total (sum of lines 50 through 94 and 96 through 98)       970, 279       174, 516 200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00							05.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					070 070	474 547	
			(1)				
202.00   Net charges (line 200 minus line 201)   970,279   202.00			(IIne 61)		-		
	202.00	Net charges (line 200 minus line 201)		1	970, 279	1	202. 00

	Title XVIII Hospital	5/30/2023 4: 5	8 pm
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	0 4, 499, 583	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1, 764, 734	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octol 1 (see instructions)	per 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)	0 21, 392	2. 02 2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0	2. 04 3. 00
3. 00 4. 00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost reporting period (see instructions)	43. 22	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
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap new programs in accordance with 42 CFR 413.79(e)		6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0. 00 0. 00	7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)		7. 02
8.00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the correport straddles July 1, 2011, see instructions.	ost 0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus of minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.	0.00	10. 00 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 year ended on or after September 30, 190  The prior of the prior that year ended on or after September 30, 190  The prior that year ended on or after September 30, 190	97, 0.00 0.00	13. 00 14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00
	Adjustment for residents in initial years of the program (see instructions)	l	16. 00
17. 00	Adjustment for residents displaced by program or hospital closure	l	17. 00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	0. 00 0. 000000	18. 00 19. 00
20. 00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21. 00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)	0	22. 00 22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  (f)(1)(iv)(C).	0.00	23. 00
24. 00 25. 00	INCITION C).  IME FTE Resident Count Over Cap (see instructions)  If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0. 00 0. 00	24. 00 25. 00
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	
28. 00 28. 01	IME add-on adjustment amount (see instructions)	0	28. 00
29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)	0	28. 01 29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment	0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 92	30. 00
31.00	Percentage of Medicaid patient days (see instructions)	20. 70	31. 00
32.00	Sum of lines 30 and 31	23. 62	•
33. 00 34. 00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	8. 70 136, 249	33. 00 34. 00
	per oper er oriated strain of day addition to ( 3000 This trade to 1010)	1 150, 247	0 1. 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/30/2023 4:58	pared:
		Title XVIII	Hospi tal	PPS	о рііі
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
F 00	Uncompensated Care Payment Adjustment		7 102 000 710	/ 07/ 402 4FO	25 00
5. 00 5. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000117111	6, 874, 403, 459 0. 000123907	
5. 02	,	o, enter zero on this line		851, 785	
5. 03 6. 00	Pro rata share of the hospital UCP, including supplemental L	JCP (see instructions)	629, 966 844, 663	214, 697	35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary d	lischarges (lines 40 throu			
0.00	Total Medicare discharges (see instructions)		0		40.00
1. 00 1. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruc	ations)	0		41.0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.00
3. 00	Total Medicare ESRD inpatient days (see instructions)	Try For adjustment)	0.00		43. 0
4. 00	Ratio of average length of stay to one week (line 43 divided days)	d by line 41 divided by 7	0. 000000		44.00
5. 00	Average weekly cost for dialysis treatments (see instruction	ns)	0. 00		45.00
6. 00	Total additional payment (line 45 times line 44 times line 4	11. 01)	0		46.00
7.00	Subtotal (see instructions)		7, 266, 621		47. 00
8. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48. 00
	, (500 met. 400 mey			Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instruction	ns)		7, 266, 621	49. 0
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a			468, 911	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt	t. III, see instructions)		0	51.0
2. 00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52. 0
3. 00	Nursing and Allied Health Managed Care payment			0	53.0
4. 00 4. 01	Special add-on payments for new technologies Islet isolation add-on payment			93, 958 0	54. 0 54. 0
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.0
5. 01	Cellular therapy acquisition cost (see instructions)	0.7)		0	55. 0
6. 00	Cost of physicians' services in a teaching hospital (see int	tructi ons)		0	56.0
7. 00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58. 0
9.00	Total (sum of amounts on lines 49 through 58)			7, 829, 490	
0. 00 1. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	is line 60)		0 7, 829, 490	60. 0 61. 0
2. 00	Deductibles billed to program beneficiaries	as Title 00)		7, 027, 470	1
3. 00	Coinsurance billed to program beneficiaries			8, 169	
4. 00	Allowable bad debts (see instructions)			37, 028	
5. 00	Adjusted reimbursable bad debts (see instructions)			24, 068	
	Allowable bad debts for dual eligible beneficiaries (see ins			13, 179	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)		aa i natmuati ana)	7, 094, 345	
8. 00 9. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	68. 00 69. 00
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	r. (101 3011 300 That do thom	3)	0	70.0
0. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70. 50
0. 75	N95 respirator payment adjustment amount (see instructions)	•		0	70. 7!
0. 87	Demonstration payment adjustment amount before sequestration	1		0	70.8
0.88	SCH or MDH volume decrease adjustment (contractor use only)	atrusti ana)		0	70.8
0. 89 0. 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	STI UCTI ONS)		0	70. 8 70. 9
0. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	ı
0. 92	Bundled Model 1 discount amount (see instructions)			0	70. 9
0. 93	HVBP payment adjustment amount (see instructions)			0	70. 9
0. 73					

Health Financial Systems	WI THAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT S	ETTLEMENT	Provi der (	CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/30/2023 4:5	
		Ti tl	e XVIII	Hospi tal	PPS	•
·	<u> </u>		FFY	<sup>'</sup> (уууу)	Amount	
				0	1. 00	
	or federal fiscal year (yyyy) (Enter i al year for the period prior to 10/1)	n column 0		2021	731, 656	70. 96
	or federal fiscal year (yyyy) (Enter i			2022	286, 942	70. 97

		Title	XVIII	Hospi tal	PPS	
			FFY (	уууу)	Amount	
				)	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	20	21	731, 656	70. 96
	the corresponding federal year for the period prior to 10/1)				·	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	20	22	286, 942	70. 97
	the corresponding federal year for the period ending on or aft					
70. 98	Low Volume Payment-3				o	70. 98
70. 79	HAC adjustment amount (see instructions)				0	70. 99
71. 00		د <u>۱</u> ۵ ۲۸۱			1	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	39 & 70)			8, 082, 703	
71. 01	Sequestration adjustment (see instructions)				101, 842	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM or CHART pass-throughs					71. 03
72. 00	Interim payments				7, 772, 244	
72. 01	Interim payments-PARHM or CHART					72. 01
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM or CHART (for contractor use only)	)				73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			208, 617	74. 00
	73)					
74.01	Balance due provider/program-PARHM or CHART (see instructions)	)				74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			129, 763	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	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
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)			l ol	92.00
93. 00	Capital outlier reconciliation adjustment amount (see instruct				l ol	93.00
94. 00	The rate used to calculate the time value of money (see instru				0.00	
95. 00	1	uctions)			0.00	95.00
	Time value of money for capital related expenses (see instructions)	tions)				
96. 00	Trille varue or morey for capital related expenses (see fristruct	LI UIS)		Dr: or to 10/1		96. 00
					On/After 10/1	
				1 00	2 00	
	LICD Danier Danier America			1. 00	2.00	
100.00	HSP Bonus Payment Amount					100.00
100.00	HSP bonus amount (see instructions)			1.00		100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	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	5)		0	0. 0000000000	
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	5)		0. 000000000	0. 0000000000	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	s)		0. 000000000	0.0000000000	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			0. 0000000000	0.0000000000	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)	)	stment	0.0000000000000000000000000000000000000	0.0000000000	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)	) ration) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000	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) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000	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) RURA adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000	101. 00 102. 00 103. 00 104. 00
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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 factor (see instructions) 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) Adju: riod under t		0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000000000 0 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) Adju: riod under t		0.0000000000000000000000000000000000000	0. 0000000000 0 0. 0000000000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
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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)	nation) Adjuriod under t	he 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.000000000000 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) 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) Medicare target amount	nation) Adjuriod under t	he 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.00000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
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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) Medicare inpatient routine cost cap (line 202 times line 205)	nation) Adjuriod under t	he 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000000000 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. 00 206. 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) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	nation) Adjustion Adjustion Adjustion Adjustical Adjust	he 21st	0. 0000000000 0 0. 00000 0 0	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
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) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ration) Adjustion and and and and and and and and and an	he 21st	0. 0000000000 0 0. 00000 0 0	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. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 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) 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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjustion and and and and and and and and and an	he 21st	0. 0000000000 0 0. 00000 0 0	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. 00 207. 00 208. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 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) 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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjustion and and and and and and and and and an	he 21st	0. 0000000000 0 0. 00000 0 0	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. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 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 factor (see instructions) 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 1s 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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	first year of cuctions)	he 21st	0. 0000000000 0 0. 00000 0 0	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. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 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 factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	first year of cuctions)	he 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 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 factor (see instructions) 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 1s 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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	first year of cuctions)	he 21st	0. 0000000000 0 0. 00000 0 0	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. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 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 factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	ration) Adjustion and adjustic of the desired first year of the fi	ne 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.00000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 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) 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) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjustion and adjustic of the desired first year of the fi	ne 21st	0. 0000000000 0 0. 00000 0 0	0.0000000000 0.00000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00

| Period: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | Date/Time Prepared: | 5/30/2023 4:58 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0104

						0 12/31/2022	5/30/2023 4:58	
					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	through 4)	
1.00	DRG amounts other than outlier	0 1. 00	1. 00	2. 00	3.00	4.00	5. 00 0	1. 00
1.00	payments	1.00	U	U		, o	U	1.00
1.01	DRG amounts other than outlier	1. 01	4, 499, 583	0	4, 499, 583		4, 499, 583	1. 01
	payments for discharges							
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	1, 764, 734	0		1, 764, 734	1, 764, 734	1. 02
1.02	payments for discharges	1. 02	1, 704, 734	U		1, 704, 734	1, 704, 734	1.02
	occurring on or after October							
	1							
1.03	DRG for Federal specific	1. 03	0	0	C	)	0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.04	operating payment for Model 4	1.04	U	0		U	U	1.04
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
2.01	discharges (see instructions)	2.02		0				2 01
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	U	0	C	0	0	2. 01
2. 02	Outlier payments for	2. 03	21, 392	0	21, 392	,	21, 392	2. 02
02	discharges occurring prior to		21, 372	O	21,372	]	21, 372	2.02
	October 1 (see instructions)							
2.03	Outlier payments for	2. 04	0	0		0	0	2. 03
	di scharges occurring on or							
	after October 1 (see instructions)							
3. 00	Operating outlier	2. 01	0	0		0	0	3. 00
0.00	reconciliation	2.01	J	0			Ŭ	0.00
4.00	Managed care simulated	3. 00	0	0	C	0	0	4.00
	payments							
	Indirect Medical Education Adj							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0.000000		5. 00
6. 00	IME payment adjustment (see	22. 00	0	0	l c	0	0	6. 00
0.00	instructions)	22.00	o o	0			Ŭ	0.00
6. 01	IME payment adjustment for	22. 01	0	0	C	o	0	6. 01
	managed care (see							
	instructions)	L						
7 00	Indirect Medical Education Adjustment factor	ustment for the	0.000000	0.000000		0. 000000		7. 00
7. 00	(see instructions)	27.00	0.000000	0. 000000	0.00000	0.000000		7.00
8. 00	IME adjustment (see	28. 00	o	0		o	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	C	0	0	8. 01
	for managed care (see							
0.00	instructions)	29. 00	0	0			0	0.00
9. 00	Total IME payment (sum of lines 6 and 8)	29.00	U	Ü		U	U	9. 00
9. 01	Total IME payment for managed	29. 01	О	0	c	o	0	9. 01
	care (sum of lines 6.01 and							
	8. 01)	L						
10.00	Disproportionate Share Adjustmo		0.0070	0.0070	0.0070	0.0070		10.00
10.00	Allowable disproportionate share percentage (see	33. 00	0. 0870	0. 0870	0. 0870	0. 0870		10. 00
	instructions)							
11. 00	Di sproporti onate share	34.00	136, 249	0	97, 866	38, 383	136, 249	11. 00
	adjustment (see instructions)							
11. 01	Uncompensated care payments	36.00	844, 663	0	629, 966	214, 697	844, 663	11. 01
40.00	Additional payment for high per		D beneficiary		1	اما		40.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	C	0	0	12. 00
13. 00	Subtotal (see instructions)	47. 00	7, 266, 621	0	5, 248, 807	2, 017, 814	7, 266, 621	13. 00
14. 00	Hospital specific payments	48. 00	0	0	0, 2.0, 00	0	0	14. 00
	(completed by SCH and MDH,			· ·				
	small rural hospitals only.)							
45	(see instructions)	40.05					<b>-</b> 24: ::	45.55
15. 00	Total payment for inpatient	49. 00	7, 266, 621	0	5, 248, 807	2, 017, 814	7, 266, 621	15. 00
	operating costs (see instructions)							
16. 00	Payment for inpatient program	50. 00	468, 911	0	338, 325	130, 586	468, 911	16, 00
. 5. 66	capital (from Wkst. L, Pt. I,	]	.50, , , ,	0	330, 020	.55, 550	.55, 711	. 3. 30
	if applicable)							

Part A Exhibit 4
Date/Time Prepared:
5/30/2023 4:58 pm 12/31/2022 Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od to 10/01 On/After 10/01 E, Part A) line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 93, 958 93, 958 93, 958 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 5, 681, 090 2, 148, 400 7, 829, 490 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 465, 943 335, 357 130, 586 465, 943 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20.01 than outlier 21.00 Capital DRG outlier payments 2.00 2,968 2, 968 0 2, 968 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 C 0 25.00 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 468, 911 338, 325 130, 586 468, 911 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 1.00 2.00 3.00 4.00 5.00 0 27.00 Low volume adjustment factor 0.128788 0.133561 27.00 28.00 Low volume adjustment 70.96 731, 656 28.00 731, 656 (transfer amount to Wkst. E, Pt. A. line)

29.00

100.00

286, 942

286, 942

70. 97

29.00

Low volume adjustment

Pt. A, line) 100.00 Transfer low volume

(transfer amount to Wkst. E,

adjustments to Wkst. E, Pt. A.

From 01/01/2022 Part A Exhibit 5 Date/Time Prepared: 5/30/2023 4:58 pm 12/31/2022 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 4, 499, 583 DRG amounts other than outlier payments for 1.01 1.01 4, 499, 583 4, 499, 583 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 1, 764, 734 1, 764, 734 1, 764, 734 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** 2 02 Outlier payments for discharges occurring 2 03 21, 392 21, 392 21, 392 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 0 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 0.0870 0.0870 0.0870 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 136, 249 97.866 38. 383 136, 249 11.00 instructions) 11.01 629, 966 Uncompensated care payments 36, 00 844, 663 214, 697 844, 663 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 5, 248, 807 2, 017, 814 Subtotal (see instructions) 7, 266, 621 7, 266, 621 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 5, 248, 807 2, 017, 814 15.00 15.00 7, 266, 621 7, 266, 621 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 468.911 338 325 130 586 468, 911 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 93, 958 93, 958 93, 958 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions)

5, 681, 090

2. 148. 400

7, 829, 490 19. 00

19.00

**SUBTOTAL** 

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0104		Worksheet E

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION		TION EXHIBIT 5	Provider CO		Period: From 01/01/2022 To 12/31/2022		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	465, 943	335, 35	7 130, 586	465, 943	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	2, 968	2, 96	0 8	2, 968	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	468, 911	338, 32	130, 586	468, 911	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4.00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	731, 656	731, 65	66	731, 656	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	286, 942		286, 942	286, 942	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	0		0 0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-30, 240	-23, 88	-6, 354	-30, 240	31. 00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		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	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 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 From 01/01/2022 Part B To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm

		Title XVIII	Hospi tal	5/30/2023 4: 5 PPS	8 pm
		II ti o xviii	поэрг саг	110	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	·c)		13, 234	1. 00 2. 00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	5)		13, 016, 105 10, 812, 925	3.00
4. 00	Outlier payment (see instructions)			26, 364	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructio	ns)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)	ool 12 line 200		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, Organ acquisitions	cor. 13, 11he 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			13, 234	11.00
00	COMPUTATION OF LESSER OF COST OR CHARGES			10,201	1 00
	Reasonable charges				
12.00	Ancillary service charges			39, 132	
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			39, 132	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for paym	ont for sorvices on s	chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for pa			0	16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	yment for services on	r a chargebasis		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			39, 132	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only i	fline 18 exceeds lin	ne 11) (see	25, 898	19. 00
00.00	instructions)	C.1. 44 1.1.	40) (		00.00
20. 00	Excess of reasonable cost over customary charges (complete only i instructions)	T line ii exceeds iin	ie 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			13, 234	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruct	i ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			10, 839, 289	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	(6 0111		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24			2, 008, 132	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus   instructions)	the sum of lines 22	and 23] (See	8, 844, 391	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	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)			8, 844, 391	30. 00
31.00	Primary payer payments			1, 475	31. 00
32. 00	Subtotal (line 30 minus line 31)			8, 842, 916	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0	1 22 00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 114, 616	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			74, 500	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)		84, 210	
37.00	Subtotal (see instructions)	•		8, 917, 416	
38. 00	MSP-LCC reconciliation amount from PS&R			-258	38. 00
39. 00	MSP RECONCILIATION			-14	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	dovi oos (oss ! ==+= !	i one)	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replaced RECOVERY OF ACCELERATED DEPRECIATION	devices (see instruct	.1 0115)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			8, 917, 660	•
40. 01	Sequestration adjustment (see instructions)			112, 362	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs				40. 03
41. 00	Interim payments			8, 720, 246	41. 00
41. 01	Interim payments-PARHM or CHART				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)			05 050	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			85, 052	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2 c	chapter 1	0	44. 00
77.00	§115. 2	with omo rub. 10-2, C	mapter 1,		1 00
	TO BE COMPLETED BY CONTRACTOR				
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	
93.00	,			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0104	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pre 5/30/2023 4:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Peri od: From 01/01/2022	Worksheet E Part B
	Component CCN: 15-S104	To 12/31/2022	Date/Time Prepared: 5/30/2023 4:58 pm
	Title XVIII	Subprovi der -	PPS

000 M 000 00 000 00 01 00 000 E 000 L 000 S 000 T 000 A 000 0 000 T	ART B - MEDICAL AND OTHER HEALTH SERVICES edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructione 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	tions)		1. 00 1, 486 172 201 0 0 0. 000
000 M 000 00 000 00 01 00 000 E 000 L 000 S 000 T 000 A 000 0 000 T	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	tions)		1, 486 172 201 0 0 0. 000
000 M 000 00 000 00 01 00 000 E 000 L 000 S 000 T 000 A 000 0 000 T	edical and other services (see instructions) edical and other services reimbursed under OPPS (see instruct PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	tions)		172 201 0 0 0. 000
000 000 000 000 000 000 000 000 000 00	PPS payments utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	tions)		201 0 0 0. 000
00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	utlier payment (see instructions) utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)			0 0 0. 000
01 0 00 E 00 L 00 S 00 T 00 A . 00 0 . 00 T CO	utlier reconciliation amount (see instructions) nter the hospital specific payment to cost ratio (see instructions) ine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)			0 0. 000
00   E 00   L 00   S 00   T 00   A . 00   0 . 00   T C(	nter the hospital specific payment to cost ratio (see instrucine 2 times line 5 um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)			0. 000
00 S 00 T 00 A . 00 0 . 00 T C0 Ra	um of lines 3, 4, and 4.01, divided by line 6 ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	V, col. 13, line 200		0
00 T 00 A . 00 0 . 00 T C( R(	ransitional corridor payment (see instructions) ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	V, col. 13, line 200		
00 A . 00 0 . 00 T . 00 R . 00 A	ncillary service other pass through costs from Wkst. D, Pt. I rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	V, col. 13, line 200		0. 00
. 00 D . 00 T . 00 R . 00 A	rgan acquisitions otal cost (sum of lines 1 and 10) (see instructions)	v, cor. 13, title 200		0
. 00 T C0 R0	otal cost (sum of lines 1 and 10) (see instructions)			0
. 00 A				1, 486
. 00 A	SWILD FATTON OF EESSER OF COST OR CHARGES			
	easonable charges			
. 00 16	ncillary service charges	no 40)		3, 835
	rgan acquisition charges (from Wkst. D-4, Pt. III, col. 4, li otal reasonable charges (sum of lines 12 and 13)	ne 69)		0 3, 835
	ustomary charges			3, 033
	ggregate amount actually collected from patients liable for p	ayment for services on a ch	arge basis	0
	mounts that would have been realized from patients liable for		chargebasi s	0
1	ad such payment been made in accordance with 42 CFR §413.13(e	)		0.000000
	atio of line 15 to line 16 (not to exceed 1.000000) otal customary charges (see instructions)			0. 000000 3, 835
1	xcess of customary charges over reasonable cost (complete onl	vifline 18 exceeds line 1	1) (see	2, 349
i	nstructions)			
	xcess of reasonable cost over customary charges (complete onl	y if line 11 exceeds line 1	8) (see	0
1	nstructions) esser of cost or charges (see instructions)			1, 486
	nterns and residents (see instructions)			0
	ost of physicians' services in a teaching hospital (see instr	uctions)		0
	otal prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			201
	OMPUTATION OF REIMBURSEMENT SETTLEMENT			
1	eductibles and coinsurance amounts (for CAH, see instructions eductibles and Coinsurance amounts relating to amount on line		ons)	0
	ubtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•		1, 687
	nstructions)			.,
1	irect graduate medical education payments (from Wkst. E-4, li	ne 50)		0
1	SRD direct medical education costs (from Wkst. E-4, line 36)			0
	ubtotal (sum of lines 27 through 29) rimary payer payments			1, 687 0
	ubtotal (line 30 minus line 31)			1, 687
_	LOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		.,, 55.
	omposite rate ESRD (from Wkst. I-5, line 11)			0
	llowable bad debts (see instructions)			1, 484
1	djusted reimbursable bad debts (see instructions)	usti ans)		965 0
	llowable bad debts for dual eligible beneficiaries (see instr ubtotal (see instructions)	uctions)		2, 652
	SP-LCC reconciliation amount from PS&R			0
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
1	ioneer ACO demonstration payment adjustment (see instructions	)		_
	95 respirator payment adjustment amount (see instructions)			0
	emonstration payment adjustment amount before sequestration artial or full credits received from manufacturers for replac	ed devices (see instruction	(2)	0
	ECOVERY OF ACCELERATED DEPRECIATION	ed devices (see mistraction		0
1	ubtotal (see instructions)			2, 652
	equestration adjustment (see instructions)			34
	emonstration payment adjustment amount after sequestration			0
1	equestration adjustment-PARHM or CHART pass-throughs nterim payments			1, 271
	nterim payments nterim payments-PARHM or CHART			1, 2/1
	entative settlement (for contractors use only)			0
	entative settlement-PARHM or CHART (for contractor use only)			
1	alance due provider/program (see instructions)			1, 347
	alance due provider/program-PARHM (see instructions)	with ONG Dil 45 O		_ ا
	rotested amounts (nonallowable cost report items) in accordan 115.2	ce with CMS Pub. 15-2, chap	ter 1,	0
	D BE COMPLETED BY CONTRACTOR			
	riginal outlier amount (see instructions)			0
1	utlier reconciliation adjustment amount (see instructions)			0
1	he rate used to calculate the Time Value of Money			0.00
	ime Value of Money (see instructions) otal (sum of lines 91 and 93)			0

Health Financial Systems	WITHAM ME	MORI AL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der 0		Peri od:	Worksheet E	
					From 01/01/2022		
			Component	CCN: 15-S104	To 12/31/2022		
						5/30/2023 4:5	8 pm
			Ti tl	e XVIII	Subprovi der -	PPS	
					I PF		
						1. 00	
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days							200. 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 01/01/2022	Worksheet E Part B
	Component CCN: 15-5832	To 12/31/2022	Date/Time Prepared: 5/30/2023 4:58 pm
	Title XVIII	Skilled Nursing	PPS

PART B - MEDICAL AND OTHER HEALTH SERVICES    Medical and other services (see Instructions)
Medical and other services (see instructions)
Medical and other services reinbursed under OPPS (see instructions)   OpPs payments
Outlier reconciliation amount (see instructions)  Untlier reconciliation amount (see instructions)  Untlier reconciliation amount (see instructions)  Enter the hospital specific payment to cost ratio (see instructions)  Enter the hospital specific payment to cost ratio (see instructions)  In a company of the second of the
00 Dutlier payment (see instructions) 01 Untiler reconciliation amount (see instructions) 02 Enter the hospital specific payment to cost ratio (see instructions) 03 Enter the hospital specific payment to cost ratio (see instructions) 04 Inter 2 times line 5 05 Unio 2 times 11, s. 5 06 Unio 2 times 13, 4, and 4, 01, divided by line 6 05 Transitional corridor payment (see instructions) 06 On Organ acquisitions 07 Organ acquisitions 08 Organ acquisitions 09 On Organ acquisitions 00 Organ acquisitions 01 Organ acquisitions 01 Organ acquisitions 01 Organ acquisitions 02 ON Organ acquisitions 03 On Organ acquisitions 04 Organ acquisitions 04 Organ acquisitions 05 ON Organ acquisitions 06 On Organ acquisitions 07 On Organ acquisitions 08 On Organ acquisitions 09 On Organ acquisitions 09 On Organ acquisitions 09 On Organ acquisitions 09 On Organ acquisitions 00 On Organ acquisitions 00 On Organ acquisitions 00 On Organ acquisitions 00 On Organ acquisitions 01 On Organ acquisitions 02 On Organ acquisitions 03 On Organ acquisitions 04 On Organ acquisitions 05 On Organ acquisitions 06 On Organ acquisitions 07 On Organ acquisitions 08 On Organ acquisitions 09 On Organ acquisitions 00 On Orga
Until the reconcil lation amount (see instructions)  Enter the hospital specific payment to cost ratio (see instructions)  Line 2 time 1s 1s 5  OLID 1s 2 time 1s 1s 1s 5  Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 2 times 3, 4, and 4,01, divided by line 6  OLID 3 Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 3 Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 3 Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 3 Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 3 Sum of Ilmes 3, 4, and 4,01, divided by line 6  OLID 3 Ancillary service or the pass through costs from Wist. D. Pt. IV, col. 13, line 200  OLID 3 Sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 4, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 5, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 6, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 6, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 6, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 6, and 1s sum of Ilmes 1 and 10) (see instructions)  OLID 6, and 1s sum of Ilmes 1 and 1s sum of Ilmes 2 (for CAH, see instructions)  OLID 6, and 1s sum of Ilmes 1 and 1s sum of Ilmes 2 (for CAH, see instructions)  OLID 6, and 1s sum of Ilmes 1 and 1s sum of Ilmes 2 and 2s (see instructions)  OLID 7, and 1s sum of Ilmes 1 and 2 and instructions)  OLID 6, and 1s sum of Ilmes 2 and 2s (see instructions)  OLID 7, and 1s sum of Ilmes 2 and 2s (see instructions)  OLID 6, and 1s sum of Ilmes 2 and 1s (see instructions)  OLID 6, and 1s sum of Ilmes 2 and 1s (see instructions)  OLID 6, and 1s sum of Ilme
Description of the Respirate Specific payment to cost ratio (see instructions)  Line 2 times line 5  O  Sup of lines 3, 4, and 4.01, divided by line 6  Transitional corridor payment (see instructions)  O  O  O  O  O  O  O  O  O  O  O  O  O
Description
0   Transitional corridor payment (see instructions)
0 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0 Organ acquisitions 0 Organ acquisitions Reasonable charges 0 Ancillary service  0 Computer services on a charge services 0 Ancillary services on a charge services 0 Ancillary services on a charge servic
00 Organ acquisitions (2,378 COMPUTATION OF LESSER OF COST OR CHARGES (2,378 COMPUTATION OF LESSER OF COST OR CHARGES (2,378 COMPUTATION OF LESSER OF COST OR CHARGES (3,378 C
Total cost (Sum of lines 1 and 10) (See Instructions)
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) Customary charges Customary charges Customary charges Amounts that would have been realized from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a charge basis Of Amounts that would have been realized from patients liable for payment for services on a charge basis Of Amounts that would have been realized from patients liable for payment for services on a charge basis Of National Company (in the color of the
Reasonable charges O Ancil Irary service charges O Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) O Total reasonable charges (sum of lines 12 and 13) Customary charges O Ancil Iraresonable charges (sum of lines 12 and 13) Customary charges O Ancil Iraresonable charges (sum of lines 12 and 13) Customary charges O Ancil Iraresonable charges (sum of lines 12 and 13) O Ancil Iraresonable charges (sum of lines 12 and 13) O Ancil Iraresonable charges (sum of lines 12 and 13) O Ancil Iraresonable charges (sum of lines 12 and 13) O Ancil Iraresonable charges (see instructions) O Iraresonable charges (see instructions) O Iraresonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) O Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) O Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) O Lesser of cost or charges (see instructions) O Lost of physicians' services in a teaching hospital (see instructions) O Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) O D Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) O D Deductibles and coinsurance amounts (for CAH, see instructions) O D Excess of cost on surance amounts relating to amount on line 24 (for CAH, see instructions) O D Excess of cost on surance amounts relating to amount on line 24 (for CAH, see instructions) O D Excess of cost
00 Ancillary service charges (Tom Wkst. D-4, Pt. III, col. 4, line 69) 0 10 Total reasonable charges (Sum of lines 12 and 13) 15,358  10 Aggregate amount actually collected from patients liable for payment for services on a charge basis and such payment that would have been real ized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e)   10 Ratio of line 15 to line 15 (not to exceed 1.000000) 0.000000 10 Total customary charges (see instructions) 15,358 10 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 15,358 10 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 16,980 10 Excess of customary charges (see instructions) 17,378 11 Exesser of cost or charges (see instructions) 17,378 12 Exesser of customary charges (see instructions) 18,4378 13 Interns and residents (see instructions) 19,4378 14 Exesser of cost or charges (see instructions) 19,4378 16 Exesser of cost or charges (see instructions) 19,4378 17 Exesser of cost or charges (see instructions) 19,4378 18 Exesser of cost or charges (see instructions) 19,4378 19 Exesser of cost or charges (see instructions) 19,4378 10 Exesser of cost or charges (see instructions) 19,4378 10 Exesser of cost or charges (see instructions) 19,4378 10 Exesser of cost or charges (see instructions) 19,4378 11 Exesser of cost or charges (see instructions) 19,4378 12 Exesser of customary charges (something the see instructions) 19,4378 13 Exesser of cost or charges (see instructions) 19,4378 14 Exesser of cost or charges (see instructions) 19,4378 15 Exesser of cost or charges (see instructions) 19,4378 16 Exesser of cost or charges (see instructions) 19,4378 17 Exesser of cost or charges (see instructions) 19,4378 18 Exesser of cost or charges (see instructions) 19,4378 18 Exesser of cost or charges (see instructions) 19,4378 18 Exesser of cost or charges (see instructions) 19,4378 18 Exe
15,358   Customary charges   Sum of lines 12 and 13   Customary charges   Sum of lines 12 and 13   Customary charges   Sum of lines 12 and 13   Sage   Sum of lines 12 and 13   Sage   Sum of lines 14   Sage   Sum of lines 15   Sage   Sum of lines 16   Sage   S
Customary charges  O Aggregate amount actually collected from patients liable for payment for services on a charge basis o Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e)  OR Ratio of line 15 to line 16 (not to exceed 1.000000)  Total customary charges (see instructions)  Excess of customary charges (see instructions)  Excess of reasonable cost over reasonable cost (complete only if line 18 exceeds line 11) (see 10,980 instructions)  Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 11 instructions)  Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 11 instructions)  Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 11 instructions)  Iterser of cost or charges (see instructions)  Uniform and residents (see instructions)  Cost of physicians' services in a teaching hospital (see instructions)  Cost of physicians' services in a teaching hospital (see instructions)  Computation Or Rei BustResents TSTILEMENT  Deductibles and col nsurance amounts (for CAH, see instructions)  Deductibles and col nsurance amounts (for CAH, see instructions)  Deductibles and col nsurance amounts relating to amount on line 24 (for CAH, see instructions)  Direct graduate medical education payments (from Wkst. E-4, line 50)  Direct graduate medical education costs (from Wkst. E-4, line 50)  ESRO direct medical education costs (from Wkst. E-4, line 36)  Excess of customary charges  Destructions  Destructions  Destructions  Destructions  O Computation of the seed of the
00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 had such payment been made in accordance with 42 CFR §413.13(e) 0 Ratio of line 15 to line 16 (not to exceed 1.000000) 10tal customary charges (see instructions) 15,358 10tal customary charges (see instructions) 15,358 10tal customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 15,358 10tal customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 10tal customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 10tal customary charges (see instructions) 10tal customary charges (complete only if line 18 exceeds line 18) (see instructions) 10tal customary charges (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services in a teaching hospital (see instructions) 10tal customary services and coin surance amounts relating to amount on line 24 (for CAH, see instructions) 10tal customary services and coin surance amounts relating to amount on line 24 (for CAH, see instructions) 10tal customary services and coin surance amounts relating to amount on line 24 (for CAH, see instructions) 10tal customary services and coin surance amounts relating to amount on line 24 (for CAH, see instructions) 10tal customary services and coin surance amounts relating to amount on line 24 (for CAH, see instructions
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Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (see instructions)  MSP-LCC reconciliation amount from PS&R  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  NSF respirator payment adjustment amount (see instructions)  Demonstration payment adjustment amount before sequestration  Partial or full credits received from manufacturers for replaced devices (see instructions)  RECOVERY OF ACCELERATED DEPRECIATION  Subtotal (see instructions)  Sequestration adjustment (see instructions)  Sequestration adjustment (see instructions)
Allowable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (see instructions)  MSP-LCC reconciliation amount from PS&R  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  NSF respirator payment adjustment amount (see instructions)  Demonstration payment adjustment amount before sequestration  Partial or full credits received from manufacturers for replaced devices (see instructions)  RECOVERY OF ACCELERATED DEPRECIATION  Subtotal (see instructions)  Sequestration adjustment (see instructions)  55
00       Subtotal (see instructions)       4,378         00       MSP-LCC reconciliation amount from PS&R       0         00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         50       Pioneer ACO demonstration payment adjustment (see instructions)       0         75       N95 respirator payment adjustment amount (see instructions)       0         97       Demonstration payment adjustment amount before sequestration       0         98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0         99       RECOVERY OF ACCELERATED DEPRECIATION       0         00       Subtotal (see instructions)       4,378         01       Sequestration adjustment (see instructions)       55
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions) 0 Demonstration payment adjustment amount before sequestration 0 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 RECOVERY OF ACCELERATED DEPRECIATION 0 Subtotal (see instructions) 1 Sequestration adjustment (see instructions) 5 Sequestration adjustment (see instructions)
Fineer ACO demonstration payment adjustment (see instructions)  N95 respirator payment adjustment amount (see instructions)  Demonstration payment adjustment amount before sequestration  Partial or full credits received from manufacturers for replaced devices (see instructions)  RECOVERY OF ACCELERATED DEPRECIATION  Subtotal (see instructions)  Sequestration adjustment (see instructions)  Pioneer ACO demonstration payment adjustment (see instructions)  0  0  0  4,378  55
75 N95 respirator payment adjustment amount (see instructions)  97 Demonstration payment adjustment amount before sequestration  98 Partial or full credits received from manufacturers for replaced devices (see instructions)  99 RECOVERY OF ACCELERATED DEPRECIATION  90 Subtotal (see instructions)  90 Subtotal (see instructions)  91 Sequestration adjustment (see instructions)  92 Sequestration adjustment (see instructions)
97Demonstration payment adjustment amount before sequestration098Partial or full credits received from manufacturers for replaced devices (see instructions)099RECOVERY OF ACCELERATED DEPRECIATION000Subtotal (see instructions)4,37801Sequestration adjustment (see instructions)55
98 Partial or full credits received from manufacturers for replaced devices (see instructions) 99 RECOVERY OF ACCELERATED DEPRECIATION 00 Subtotal (see instructions) 01 Sequestration adjustment (see instructions) 55
99 RECOVERY OF ACCELERATED DEPRECIATION 00 Subtotal (see instructions) 01 Sequestration adjustment (see instructions) 03 Sequestration adjustment (see instructions)
00Subtotal (see instructions)4,37801Sequestration adjustment (see instructions)55
01 Sequestration adjustment (see instructions) 55
02 Demonstration payment adjustment amount after sequestration
O3 Sequestration adjustment-PARHM or CHART pass-throughs
OO   Interim payments   4,682
Ol   Interim payments-PARHM or CHART
00   Tentative settlement (for contractors use only) 0   Tentative settlement-PARHM or CHART (for contractor use only)
00 Balance due provider/program (see instructions)
01 Balance due provider/program-PARHM (see instructions)
00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2
TO BE COMPLETED BY CONTRACTOR
00 Original outlier amount (see instructions)
00 Outlier reconciliation adjustment amount (see instructions)
00 The rate used to calculate the Time Value of Money
00 Time Value of Money (see instructions)
00  Total (sum of lines 91 and 93)

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-5832	To 12/31/2022	Date/Time Pre	epared:
		·		5/30/2023 4: 5	8 pm
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

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

					5/30/2023 4: 58	3 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		7, 772, 24	4	8, 720, 246	1. 00
2.00	Interim payments payable on individual bills, either			o	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			ol	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER			0		3. 01
3. 02				0		3. 02
3. 04				o o		3. 04
3. 05				Ö		3. 05
3.03	Provider to Program			<u> </u>		5. 05
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51				Ö	l ol	3. 51
3. 52				Ö	0	3. 52
3.53				o	0	3. 53
3.54				o	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		7, 772, 24	4	8, 720, 246	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR					Г 00
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			ol	0	5. 01
5. 02	TERMINE TO THOUSEN			Ö	l ol	5. 02
5. 03				Ö	l ol	5. 03
	Provider to Program		•	•		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				o	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)			_	05	
6. 01	SETTLEMENT TO PROVIDER		208, 61		85, 052	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		7, 980, 86		8, 805, 298	7. 00
				Contractor Number	NPR Date	
		1	)	1. 00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
0.00	Maine of Sofiti detail			1	1	0.00

Component CCN: 15-S104

Title XVIII Subprovi der -

		Title	e XVIII	Subprovi der - I PF	PPS	
		Inpatien	nt Part A		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		1, 178, 985		1, 271	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,					
0.00	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01	ADJUSTMENTS TO PROVIDER		C		0	3. 01
3.02			C		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05			C		0	3. 05
0.50	Provi der to Program	I	1	T		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51 3. 52						3. 51 3. 52
3. 52						3. 52
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 178, 985		1, 271	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					- 00
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		l			
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02			l c		0	5. 02
5.03			C		0	5. 03
	Provider to Program					
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
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		6, 360		1, 347	6. 01
6. 02	SETTLEMENT TO PROGRAM		0,300		1, 347	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 185, 345		2, 618	7. 00
	, , , , , , , , , , , , , , , , , , , ,			Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	0	1. 00	2. 00	
8 NN	Name of Contractor	İ		1	l l	∣ ഉ∩∩

8.00 Name of Contractor

Component CCN: 15-5832

Title XVIII Skilled Nursing PPS

		11116	; AVIII 3	Facility	FF3	
		Inpatien	nt Part A		rt 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		1, 158, 723		4, 682	1. 00
2.00	Interim payments payable on individual bills, either		0		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		0		0	3. 01
3. 02	THE SECTION TO THE TREET		l o		0	3. 02
3. 03			0		l o	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	•	•			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		1 150 700		4 (00	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 158, 723		4, 682	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	L	l			
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. 01
5. 02			0		0	5. 02
5.03			0		0	5. 03
F F0	Provi der to Program	ı	1 0			
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51 5. 52						5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
3. 77	5. 50-5. 98)					3. //
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		359	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 158, 724		4, 323	7. 00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2. 00	8. 00
8.00	Name of Contractor	l				β. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0104	Peri od: From 01/01/2022	Worksheet E-1 Part II	
		To 12/31/2022		
	Title XVIII	Hospi tal	PPS	
			1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR				1
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION				4
1.00 Total hospital discharges as defined in AAR.	§4102 from Wkst. S-3, Pt. I col. 15 lin	e 14		1. 00
2.00 Medicare days (see instructions)				2. 00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, co	6. line 2			3. 00
4.00 Total inpatient days (see instructions)				4. 00
5.00 Total hospital charges from Wkst C, Pt. I,				5. 00
6.00 Total hospital charity care charges from Wk				6. 00
7.00 CAH only - The reasonable cost incurred for line 168	the purchase of certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00 Calculation of the HIT incentive payment (s	e instructions)			8.00
9.00 Sequestration adjustment amount (see instru				9. 00
10.00 Calculation of the HIT incentive payment af				10.00
INPATIENT HOSPITAL SERVICES UNDER THE LPPS &	<u> </u>			
30.00 Initial/interim HIT payment adjustment (see				30.00
31.00 Other Adjustment (specify)	· · · · · · · · · · · · · · · · · · ·			31.00
32.00 Balance due provider (line 8 (or line 10) m	nus line 30 and line 31) (see instructio	ns)		32. 00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	From 01/01/2022	
	Component CCN: 15-S104	To 12/31/2022	Date/Time Prepared: 5/30/2023 4:58 pm
	Title XVIII	Subprovi der -	PPS

	I PF	113	
		1 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1. 00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 280, 027	1. 00
2.00	Net IPF PPS Outlier Payments	20, 277	2. 00
3.00	Net IPF PPS ECT Payments	0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
5. 00	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  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
0.00	teaching program" (see instuctions)	0.00	0.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
	teaching program" (see instuctions)		
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. 657534	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, 300, 304	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		0	15. 00
16.00	Subtotal (see instructions)	1, 300, 304	16. 00
17. 00	Primary payer payments	0	17. 00
18. 00 19. 00	Subtotal (line 16 less line 17).  Deductibles	1, 300, 304 90, 248	
20. 00	Subtotal (line 18 minus line 19)	1, 210, 056	
21. 00		14, 004	
22. 00	Subtotal (line 20 minus line 21)	1, 196, 052	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6, 798	
24. 00	Adjusted reimbursable bad debts (see instructions)	4, 419	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26.00	Subtotal (sum of lines 22 and 24)	1, 200, 471	26. 00
27.00	Direct graduate medical education payments (see instructions)	0	27. 00
28.00	Other pass through costs (see instructions)	0	28. 00
29. 00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30. 00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 98	Recovery of accelerated depreciation.	0	30. 98
30. 99	Demonstration payment adjustment amount before sequestration	0	30. 99
31.00		1, 200, 471	
31. 01	Sequestration adjustment (see instructions)	15, 126	
31. 02 32. 00		0 1, 178, 985	31. 02 32. 00
32.00	Interim payments Tentative settlement (for contractor use only)	1, 178, 985	32.00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	6, 360	34. 00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0, 300	35. 00
33. 00	15115. 2		33.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	20, 277	50.00
51.00		0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52. 00
53.00	Time Value of Money (see instructions)	0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-10		
		0. 000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99. 01

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-5832	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VI	pared:	
		Title XVIII	Skilled Nursing Facility	PPS		
				1. 00		
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	IER HEALTH SERVICES FOR T	<u> </u>			
	SERVI CES					
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)					
1.00	Resource Utilization Group Payment (RUGS)			1, 268, 214	1. 00	
2.00	Routine service other pass through costs			0	2. 00	
3.00	Ancillary service other pass through costs			0	3. 00	
4.00	Subtotal (sum of lines 1 through 3)			1, 268, 214	4. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
5.00	Medical and other services (Do not use this line as vaccine of	costs are included in lin	e 1 of W/S E,		5. 00	
	Part B. This line is now shaded.)				, ,,,,	
6.00	Deducti bl e			0	6. 00	
7.00	Coinsurance			94, 527	7. 00	
8. 00 9. 00	Allowable bad debts (see instructions)	notrupti ana)		0	8. 00 9. 00	
10.00	Reimbursable bad debts for dual eligible beneficiaries (see i Adjusted reimbursable bad debts (see instructions)	ristructions)		0	10.00	
11. 00	Utilization review			0	11. 00	
12. 00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1	10 and 11)(see instruction	ne)	1, 173, 687		
	Inpatient primary payer payments	o and Try (see This true tro	113)	1, 173, 007	13. 00	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14. 00	
	Pioneer ACO demonstration payment adjustment (see instruction	าร)		0	14. 50	
14. 98	Recovery of accelerated depreciation.	.5)		0	14. 98	
	Demonstration payment adjustment amount before sequestration			0	14. 99	
	Subtotal (see instructions			1, 173, 687		
	Sequestration adjustment (see instructions)			14, 963		
	22. Demonstration payment adjustment amount of a conjugation					

0 15. 02 15. 75

16. 00 17. 00

18.00

0

1, 158, 723 0

15.02 Demonstration payment adjustment amount after sequestration

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

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,

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 01/01/2022 Part VII To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm

			Го 12/31/2022	Date/Time Pre 5/30/2023 4:5	
		Title XIX	Hospi tal	Cost	Орш
		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		453, 129		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		453, 129	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)		453, 129	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		856, 943		8. 00
9.00	Ancillary service charges		970, 279	0	
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)		1, 827, 222	0	12. 00
	CUSTOMARY CHARGES	· · · · · · · · · · · · · · · · · · ·			
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
44.00	basis				44.00
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 Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		1, 827, 222	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	1, 374, 093	0	1
17.00	line 4) (see instructions)	TI TITLE TO EXCEEUS	1, 374, 073	O	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 EXCECUS 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	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16		453, 129	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of		ers.		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
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		453, 129	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)		453, 129	0	
32.00	Deducti bl es		0	0	
33. 00			0	0	
34. 00	· ,		0	0	
35. 00 36. 00			453, 129	0	35. 00 36. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		433, 129	0	
	Subtotal (line 36 ± line 37)		453, 129	0	
	)   Subtotal (line 36 ± line 37) )   Direct graduate medical education payments (from Wkst. E-4)		433, 124 0	U	39.00
40. 00			453, 129	0	
41. 00			767, 078	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-313, 949	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	-313, 747	0	1
. 5. 55	chapter 1, §115.2			O	.5. 55
			, ,		•

Heal th	Financial Systems WITHAM MEMOR	RIAL HOSPITAL	In Lie	u of Form CMS-2	552-10
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0104	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 4:58	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or s	sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see in	nstructi ons)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see ins	tructions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instruction	ons)		0	6.00
7.00	Time value of money for capital related expenses (see ins	tructions)		0	7.00

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 Period: From 01/

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 4:58 pm

OH y)					5/30/2023 4:5	8 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	38, 989, 316	O	O	0	1.00
2. 00	Temporary investments	37, 014, 164		ő		
3. 00	Notes recei vabl e	0		ol	Ö	1
4.00	Accounts receivable	21, 382, 950	0	o	0	1
5.00	Other recei vable	2, 466, 570	0	o	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	o	0	6. 00
7.00	Inventory	4, 312, 838	0	0	0	7. 00
8.00	Prepai d expenses	0	0	0	0	
9. 00	Other current assets	2, 070, 154		0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	106, 235, 992	0	0	0	11. 00
12. 00	FIXED ASSETS Land	0	O	ol	0	12. 00
13. 00	Land improvements	6, 139, 271		0		13. 00
14. 00	Accumulated depreciation	0, 137, 271	0	0	0	1
15. 00	Bui I di ngs	229, 550	Ö	ol	Ö	
16. 00	Accumulated depreciation	0	O	ō	Ō	
17.00	Leasehold improvements	0	0	o	0	17. 00
18.00	Accumul ated depreciation	0	0	o	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	
23. 00	Major movable equipment	214, 700, 831		0	0	
24. 00	Accumulated depreciation	-110, 650, 712	0	0	0	
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	
26. 00 27. 00	Accumulated depreciation HIT designated Assets		0	0	0	1
28. 00	Accumulated depreciation		0	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e		Ö	Ö	Ö	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	110, 418, 940	-	ol		1
	OTHER ASSETS			· · · · · · · · · · · · · · · · · · ·		
31.00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	
34.00	Other assets	23, 151, 276		0	0	1
35. 00	Total other assets (sum of lines 31-34)	23, 151, 276		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	239, 806, 208	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	5, 519, 409	0	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	10, 075, 489		0	0	1
39. 00	Payroll taxes payable	10, 073, 489	0	0		
40. 00	Notes and Loans payable (short term)	12, 226	0	Ö	Ö	
41. 00	Deferred income	12, 220	Ö	ol	Ö	
42. 00	Accel erated payments	0		آ ۔	1	42. 00
43.00	Due to other funds	0	0	o	0	
44.00	Other current liabilities	10, 254, 216	0	o	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	25, 861, 340	0	0	0	45. 00
	LONG TERM LIABILITIES	1				
46. 00	Mortgage payable	0		0		1
47. 00	Notes payable	0		0		
48. 00	Unsecured Loans	0	1	0	l e	1
49. 00	Other long term liabilities	21, 196, 231		0	0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49)	21, 196, 231 47, 057, 571		0	0	
31.00	Total liabilities (sum of lines 45 and 50)  CAPITAL ACCOUNTS	47,037,371	l o	<u> </u>	U	31.00
52. 00	General fund balance	192, 748, 637				52. 00
53. 00	Specific purpose fund	172, 740, 037	0			53. 00
54. 00	Donor created - endowment fund balance - restricted			ol		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			ō		55. 00
56. 00	Governing body created - endowment fund balance			Ō	1	56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	192, 748, 637		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	239, 806, 208	0	0	0	60. 00
	[59]	I	I I	I	I	I

Provider CCN: 15-0104

					То	12/31/2022	Date/Time Prep 5/30/2023 4:58	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	Э ріп
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	209, 824, 465			7.00		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		-17, 075, 828			· ·		2. 00
3.00	Total (sum of line 1 and line 2)		192, 748, 637			0		3. 00
4.00	Additions (credit adjustments) (specify)	o	,,		0		0	4. 00
5.00		O			0		0	5. 00
6.00		0			0		0	6. 00
7.00		O			0		0	7. 00
8.00		O			0		0	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)		192, 748, 637			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		192, 748, 637			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endownierre Tana	TTant	Tuna				
		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	T		O					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	U	0		0			11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0					12. 00 13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)		U		0			18.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				Ĭ			. 7. 00
	1 (			'				

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

				To 12/31/2022		Date/Time Prepared: 5/30/2023 4:58 pm	
	Cost Center Description		Inpatient	Out	tpati ent	Total	5 <u> </u> 5
			1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES					0.00	
	General Inpatient Routine Services						
1.00	Hospi tal		15, 691, 17	8		15, 691, 178	1.00
2.00	UBPROVI DER - I PF		2, 916, 47	1	İ	2, 916, 471	2.00
3.00	SUBPROVI DER - I RF			О	İ	0	3.00
4.00	SUBPROVI DER			О	İ	0	4.00
5.00	Swing bed - SNF			О	İ	0	5.00
6.00	Swing bed - NF			О	İ	0	6.00
7.00	SKILLED NURSING FACILITY		2, 554, 57	О	İ	2, 554, 570	7.00
8.00	NURSING FACILITY				İ		8.00
9.00	OTHER LONG TERM CARE				İ		9.00
10.00	Total general inpatient care services (sum of lines 1-9)		21, 162, 21	9		21, 162, 219	10.00
	Intensive Care Type Inpatient Hospital Services	•					
11.00	INTENSIVE CARE UNIT		6, 323, 53	7		6, 323, 537	11.00
12.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	6, 323, 53	7		6, 323, 537	16.00
	11-15)						
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		27, 485, 75	6		27, 485, 756	17.00
18. 00	Ancillary services		72, 405, 18	5 40	09, 319, 609	481, 724, 794	18. 00
19. 00	Outpatient services			0	30, 557	30, 557	19.00
20. 00	RURAL HEALTH CLINIC			0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULANCE SERVICES			0	4, 165, 332	4, 165, 332	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	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.		99, 890, 94	1 41	13, 515, 498	513, 406, 439	28. 00
	G-3, line 1)						
PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 176,947,592							29. 00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)			0 17	76, 947, 592		29. 00 30. 00
31.00	ADD (SPECIFF)			0	ł		31. 00
32.00				0	1		32. 00
33. 00				0	1		33. 00
34. 00				0	1		34. 00
35. 00				0			35. 00
36. 00	Total additions (sum of lines 30-35)			~	o		36. 00
37. 00	DEDUCT (SPECIFY)			0	Ĭ		37. 00
38. 00	525001 (6120111)			o o			38. 00
39. 00				0	İ		39. 00
40. 00				0	1		40. 00
41. 00				0			41. 00
42. 00	Total deductions (sum of lines 37-41)				o		42. 00
43. 00				17	76, 947, 592		43. 00
	to Wkst. G-3, line 4)						

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provi der CCN: 15-0104	Peri od:	Worksheet G-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/30/2023 4:5	
	· · · · · · · · · · · · · · · · · · ·				3/30/2023 4.3	o piii
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				513, 406, 439	1. 00
2.00	Less contractual allowances and discounts on				354, 889, 145	•
3.00	Net patient revenues (line 1 minus line 2)				158, 517, 294	3. 00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line 4	3)		176, 947, 592	4. 00
5.00	Net income from service to patients (line 3 m				-18, 430, 298	5. 00
	OTHER I NCOME	<u> </u>				
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7. 00
8.00	Revenues from telephone and other miscellaneous communication services				0	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				0	10.00
11. 00	Rebates and refunds of expenses				0	11. 00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gues	sts			0	14. 00
15.00	Revenue from rental of living quarters				0	15. 00
16.00					0	16. 00
17.00	Revenue from sale of drugs to other than pati	ents	·		0	17. 00
18.00	Revenue from sale of medical records and abst	racts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, an	nd canteen			0	20.00
21.00	Rental of vending machines				0	21. 00
22.00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	OTHER OPERATING INCOM				6, 304, 993	24. 00
24. 01	NON-OPERATING INCOME				-9, 255, 557	24. 01
24. 50	COVI D-19 PHE Funding				4, 305, 034	24. 50
05 00	T				4 05 4 470	1 05 00

1, 354, 470 25. 00 -17, 075, 828 26. 00

-17, 075, 828 29. 00

28 26.00 0 27.00 0 28.00

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 OTHER EXPENSES (SPECIFY)
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)

Heal th	Financial Systems WITHAM MEMORIAL	HOSDI TAI	Inlia	u of Form CMS-2	2552_10		
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 15-0104			pared:		
	PPS						
	1. 00						
	PART I - FULLY PROSPECTIVE METHOD						
4 00	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier	465, 943					
1. 01	Model 4 BPCI Capital DRG other than outlier		0				
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			2, 968 0			
	Total inpatient days divided by number of days in the cost re	26. 99					
3. 00 4. 00	Number of interns & residents (see instructions)	26. 99 0. 00	•				
5.00	Indirect medical education percentage (see instructions)		0.00				
6. 00	Indirect medical education percentage (see histructions)	columns 1 and	0.00				
0.00	1.01) (see instructions)	e sum of fittes f and f. of	, corumns i and	Ü	0.00		
7. 00	Percentage of SSI recipient patient days to Medicare Part A p	0. 00	7. 00				
8. 00	30) (see instructions)	ictions)		0.00	8. 00		
9. 00					9.00		
10. 00					10.00		
11. 00	Disproportionate share adjustment (see instructions)	•)		0.00			
	7   Total prospective capital payments (see instructions)				12. 00		
12.00	Total prospective capital payments (see mistractions)	,		400, 711	12.00		
	PART II - PAYMENT UNDER REASONABLE COST		1. 00				
1.00	Program inpatient routine capital cost (see instructions)				1.00		
2.00	Program inpatient ancillary capital cost (see instructions)				2. 00		
3.00	Total inpatient program capital cost (line 1 plus line 2)				3. 00		
4.00	Capital cost payment factor (see instructions)			0	4. 00		
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00		
	DART LLL COMPUTATION OF EVOCETION DAMAGNE			1. 00			
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS		1	0	1 00		
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstance	and (and imptruptions)		0			
3. 00		les (see mistructions)		0			
4. 00	Net program inpatient capital costs (line 1 minus line 2)			0.00	1 0.00		
5. 00	Applicable exception percentage (see instructions)  Capital cost for comparison to payments (line 3 x line 4)			0.00			
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)				6.00		
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				7.00		
8. 00	Capital minimum payment level (line 5 plus line 7)						
9. 00	Current year capital payments (from Part I, line 12, as appli	cable)		0			
10. 00	Current year comparison of capital minimum payment level to c		less line 9)	0			
11. 00	Carryover of accumulated capital minimum payment level over of			0			
	Worksheet L, Part III, line 14)			_			
12.00				0			
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)			0			
14. 00	Carryover of accumulated capital minimum payment level over of (if line 12 is negative, enter the amount on this line)	0	14. 00				
15. 00					15. 00		
16. 00							
	Current year exception offset amount (see instructions)			0	17. 00		
	, , , , , , , , , , , , , , , , , , , ,		'	_			