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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 1:52 pm] Manually prepared cost report use only If 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 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. 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 01/01/2023 and ending 12/31/2023 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	SIGNATURE 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 SENIOR VP/CFO				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	
F	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	111, 416		0	-342, 388	1.00
2.00	SUBPROVI DER - I PF	0	10, 032	-432		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER (OTHER)						4.00
5. 00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7. 00	SKILLED NURSING FACILITY	0	372	-159		0	7.00
200.00	TOTAL	0	121, 820	50, 213	0	-342, 388	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.

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2605 N. LEBANON STREET 1.00 PO Box: 1.00 State: IN 2.00 City: LEBANON Zi p Code: 46052-County: BOONE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal WITHAM MEMORIAL 150104 26900 07/01/1966 Ν Р 0 3.00 1 HOSPI TAI Subprovi der - IPF WITHAM HOSPITAL 4.00 15S104 26900 4 01/01/2000 Ν Ρ Ν 4.00 **GEROPSYCH** 5 00 Subprovi der - IRF 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF WITHAM HOSPITAL ECU 155832 26900 05/07/2015 Р 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14 00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring 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) 22.02 Is this a newly merged hospital that requires a final UCP to be N Ν 22.02 determined at cost report settlement? (see instructions) 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 on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

22.04

23 00

3

Ν

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

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

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

yes or "N" for no.

ves or "N" for no.

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qual i fi cati on Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N 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. IME 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) 61.01 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) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year'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 Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	WI THAM	MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2023	Worksheet S-2 Part I	
			To		Date/Time Pre 5/30/2024 1:5	
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te 1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after			-This base year	is your cost	reporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the num	s yes, or your facili [.] nber of unweighted nom	ty trained residents n-primary care	0.00	0.00	0. 000000	64. 00
resident FTEs attributable to re settings. Enter in column 2 the resident FTEs that trained in yo	e number of unweighted our hospital. Enter in	d non-primary care n column 3 the ratio				
of (column 1 divided by (column	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	65. 00
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Settinç				
beginning on or after July 1, 20 66.00 Enter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66. 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit	unweighted non-prima al. Enter in column (ry care resident 3 the ratio of				
(column 1 divided by (column 1 +	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	47.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			C. 00	3.00	3. 353300	07.00

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 76.00 0 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

muspi I.	NI AND HOODITAL HEALTH CARE COMBLEV IDENTIFICATION DATA	AL HOSPITAL	CN: 1E 0104	Period:	u of Form CMS	
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		From 01/01/2023 To 12/31/2023	Worksheet S- Part I Date/Time Pr 5/30/2024 1:	epared:
				V 1 00	XIX	4
	Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			1. 00 Y	2. 00 Y	98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Υ	98.0
98. 02	Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 0
	Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.0
	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.0
	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98.0
	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Υ	98.0
	Rural Providers Does this hospital qualify as a CAH?			N		105. 0
06. 00	If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		. ,	nt N		106. 0
	Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct	nn 1. (see ins you train I&F PF and/or IRF	structions) Rs in an	N		107. 0
07. 01	If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for I&R training programs? Enter "Y" for yes instructions)	t eligible for				107. 0
	Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physical	edul e? See 42		Respi ratory	108.0
		1. 00	2. 00	3. 00	4.00	1
	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 0
					1.00	
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	1. 00 N	110.0
	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no.	If yes, ough 215, as	N	110.00
11.00	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or or which sheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in	Community period? Enter the column 2.	1.00 N		110.00
11. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or or which sheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in	Community period? Enter enter the column 2.	If yes, bugh 215, as	N 2. 00	
11.00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particidemonstration. In column 3, enter the date the hospital ce	"Y" for yes or prksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in dditional beds to the properting column 1 is pating in the	Community period? Enter the column 2.	1.00 N	N	111.0
11. 00 12. 00 15. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, orticipating in dditional beds with Model eporting column 1 is pating in the cased or "N" for no B, or E only) 93" percent (includes	Community period? Enter enter the n column 2. s; and/or "C"	If yes, bugh 215, as	2. 00 3. 00	111.00
111. 00 112. 00 115. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particidemonstration. In column 3, enter the date the hospital ceparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care	"Y" for yes or orksheet E-2, I the Frontier (cost reporting column 1 is Y, articipating in dditional beds alth Model reporting column 1 is pating in the cased or "N" for no B, or E only) 93" percent (includes ers) based on for yes or	Community period? Enter enter the column 2. s; and/or "C"	If yes, bugh 215, as	2. 00 3. 00	

Health Financial Systems	WI THAM MEMOR	IAL HOSPITAL		In	Lieu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CC	CN: 15-0104	Period: From 01/01/2 To 12/31/2		repared:
					1. 00	
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no no		1.00 N	147. 00
148.00 Was there a change in the order o					N N	148. 00
149.00 Was there a change to the simplif				or no.	N	149.00
-	-	Part A	Part B	Title V	Title XIX	
		1. 00	2. 00	3. 00	4. 00	
Does this facility contain a provor 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 159. 00 SNF		N.	,	N.	N.	158.00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N	N N	N N	159. 00 160. 00
161.00CMHC		IN	N N	N N	N N	161. 00
TOT. COCCURRE			IN IN	14	1.00	101.00
Multicampus					1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has c	one or more camp	uses in dif	ferent CBSAs?	N	165. 00
	Name	County	State 2	Zip Code CBS	A FTE/Campus	
	0	1. 00	2. 00	3.00 4.0		
166.00 ffline 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)					0.0	00 166. 00
					1.00	_
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvestr	nent Act	1.00	
167.00 Is this provider a meaningful use					Y	167. 00
168.00 If this provider is a CAH (line 1				"), enter the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user, do	oes this provide	er qualify f	or a hardship		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	user (line 167 is "Y") ar				the 9.	99169.00
transition factor. (see instructi	ons)			Dani ani a	- F 11	
				Begi nni n 1. 00	g Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR	beginning date and ending	date for the r	eporti ng	1.00	2.00	170. 00
period respectively (mm/dd/yyyy)				4.22	0.00	
171 00 lf line 147 is "V" doss +bis pro	vidor have any days for :	ndi vi dual c. anna	llod in	1. 00 N	2. 00	0171.00
171.00 f line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt umn 1. If column 1 is yes	t. I, line 2, co	ol. 6? Enter	,		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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 1:52 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 Ν 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 N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 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 Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 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 Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 N 7 00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 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 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 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 A Part B Y/N Date Y/N 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? Ν 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) Was the cost report prepared using the PS&R Report for 07/01/2022 07/01/2022 17.00 Υ Υ 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 18.00 Ν 18.00 N Report data for additional claims that have been billed 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 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems WITHAM MEMORIA		CN 15 0104			S-2552-10
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CCN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/30/2024 1	repared:
		Descr	iption	Y/N	Y/N	
20.00	16.114/47.1		0	1.00	3. 00	00.00
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
	roper t data for other boson be the other day do then to	Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)			
	Capital Related Cost			1		
	Have assets been relifed for Medicare purposes? If yes, see					22.00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sars made du	ring the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entered lf yes, see instructions	ed into during	this cost re	eporting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period	? If yes, see		25. 00
2/ 22	instructions.			16		0, 60
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost report	ing period?	ir yes, see		26.00
27. 00		e cost reporti	ng period? I	f yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cos	t reporting		28.00
	period? If yes, see instructions.			5		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service I	Reserve Fund)		29.00
30. 00			debt? If ve	s. see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	,	,			31.00
	instructions.					
22 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi cos furni sh	od through c	ontractual		32.00
32.00	arrangements with suppliers of services? If yes, see instru		led thi ough c	onti actuai		32.00
33. 00			ng to compet	itive bidding? If		33.00
	no, see instructions.			_		
24.00	Provi der-Based Physi ci ans		11			
34.00	Were services furnished at the provider facility under an allf yes, see instructions.	arrangement wi	th provider-	based pnysicians?		34.00
35. 00	If line 34 is yes, were there new agreements or amended exi	sting agreeme	nts with the	provi der-based		35.00
00.00	physicians during the cost reporting period? If yes, see in			provider based		00.00
				Y/N	Date	
	Homo Offi co Costo			1.00	2. 00	
	Home Office Costs Were home office costs claimed on the cost report?					36.00
36 00	If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37.00
	If yes, see instructions.		5.11.00			1 07.00
37. 00				f		38.00
37. 00 38. 00	the provider? If yes, enter in column 2 the fiscal year end	d of the home	offi ce.			
37. 00 38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	d of the home er chain compo	office. nents? If ye:	S,		39.00
37. 00 38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	d of the home er chain compo	office. nents? If ye:	S,		39. 00
37. 00 38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	d of the home er chain compo	office. nents? If ye:	S,		39. 00
37. 00 38. 00 39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	d of the home er chain compo home office?	office. nents? If ye:	S,	00	39. 00
37. 00 38. 00 39. 00 40. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	d of the home er chain compo home office?	office. nents? If ye: If yes, see	2.	00	39.00
37. 00 38. 00 39. 00 40. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	d of the home er chain compo home office?	office. nents? If ye: If yes, see	S,	00	39.00
37. 00 38. 00 39. 00 40. 00 41. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home er chain compo home office?	office. nents? If yes If yes, see	2.	00	38. 00 39. 00 40. 00
37. 00 38. 00 39. 00 40. 00	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	d of the home er chain compo home office?	office. nents? If yes If yes, see	2.	00	39.00

Heal th Fi	nancial Systems	WITHAM MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 1:5	pared:
				3. 00			
Cos	st Report Preparer Contact Information			0.00			
he	nter the first name, last name and the teld by the cost report preparer in column espectively.		MANAGER				41.00
	nter the employer/company name of the coreparer.	ost report					42.00
43. 00 En	ter the telephone number and email addr port preparer in columns 1 and 2, respe						43. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared:
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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0104

					1	o 12/31/2023	Date/Time Pre 5/30/2024 1:5	
							1/P Days /	Z piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH 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, 410	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 Subprovi der							3.00
4. 00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospi tal Adul ts & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			34	12, 410	0.00	0	7. 00
0.00	beds) (see instructions)	24 00		4.	F 046	0.00		0.00
8. 00	INTENSIVE CARE UNIT	31. 00		16	5, 840	0.00	0	8.00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00						12.00
13.00	NURSERY	43. 00			40.050	0.00	0	13.00
14.00	Total (see instructions)			50	18, 250	0.00	0	14.00
15.00	CAH visits					0.00	0	15.00
15. 10	REH hours and visits	40.00		10	2 (5)	0. 00	0	15. 10
16.00	SUBPROVIDER - I PF	40.00	l .	10 0			0	16.00
17.00	SUBPROVIDER - IRF	41.00	ı	0				17.00
18. 00 19. 00	SUBPROVI DER	42. 00 44. 00		18	1		0	18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44.00		18	6, 570	,	U	20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPICE							24.00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	69.00		78			O	27.00
28. 00	Observation Bed Days			70			0	1
29. 00	Ambulance Trips						O	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	(32.00
32. 01	Total ancillary labor & delivery room							32.01
02.01	outpatient days (see instructions)							52.5.
33. 00								33.00
33. 01	LTCH site neutral days and discharges							33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	(0	
		1		- 1	'	" 1		•

Provider CCN: 15-0104

Period: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm

						5/30/2024 1:5	2 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
				•		'	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 010	199	6, 860)		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, 703	1, 784				2.00
3.00	HMO IPF Subprovider	764	0				3.00
4.00	HMO IRF Subprovider	O	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C			6.00
7.00	Total Adults and Peds. (exclude observation	2, 010	199	6, 860			7.00
	beds) (see instructions)			·			
8.00	INTENSIVE CARE UNIT	484	32	1, 971			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	731			13.00
14. 00	Total (see instructions)	2, 494	231	9, 562		614. 11	1
15. 00	CAH visits	-,	0	(15.00
15. 10	REH hours and visits	ol	0	ď			15. 10
16. 00	SUBPROVI DER - I PF	1, 185	0	2, 280	0. 00	10. 38	1
17. 00	SUBPROVI DER - I RF	0	0	-,,			1
18. 00	SUBPROVI DER		0	ď			1
19. 00	SKILLED NURSING FACILITY	2, 195	0	4, 377		12. 90	
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)			17	,		24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
27. 00	Total (sum of lines 14-26)	Ĭ	ŭ		0. 00		
28. 00	Observation Bed Days		15	2, 009		007.07	28.00
29. 00	Ambul ance Trips	992	10	2,007			29.00
30.00	Employee discount days (see instruction)	,,,,		114			30.00
31. 00	Employee discount days (see Thisti detroit)						31.00
32. 00	Labor & delivery days (see instructions)	0	84	121			32.00
32. 00	Total ancillary labor & delivery room		04	'2'			32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33.00
	Temporary Expansi on COVID-19 PHE Acute Care	o	0	C			34.00
5 7. 00	1. Simportary Expansion Source 17 The Moute Care	١	O		1	ı	1 5 1. 55

 Health Financial
 Systems
 WITHAM

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

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				11	0 12/31/2023	5/30/2024 1:5	
		Full Time		Di sch	arges	0,00,2021 110	
		Equi val ents			3		
	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		C	669	55	2, 180	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)			566	423		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
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						13.00
14.00	Total (see instructions)	0.00	C	669	55	2, 180	14. 00
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - I PF	0.00	C		0	200	
17. 00	SUBPROVIDER - IRF	0.00	C	_	0	0	17. 00
18. 00	SUBPROVI DER	0.00	C)	0	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	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
26.00	RURAL HEALTH CLINIC						26.00
		0.00					26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0.00					20. 23
28.00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Histruction)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32. 00
3Z. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
33. 00	LTCH site neutral days and discharges			0			33. 00
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
2 20	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			1			

	Financial Systems		WITHAM MEMORI				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	F	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	5/30/2024 1:5 Average Hourly Wage (col. 4 ÷ col. 5)	2 piii
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	72, 996, 995	0	72, 996, 995	968, 977. 00	75. 33	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A -		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0	0	0		0. 00 0. 00	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0. 00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0. 00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0.00	8. 00
9. 00	SNF	44.00	1, 077, 511	7, 937		· ·	33. 18	ı
10. 00	Excluded area salaries (see instructions)		37, 461, 358	0	37, 461, 358	649, 727. 00	57. 66	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		6, 061, 741	0	6, 061, 741	66, 643. 00	90. 96	11.00
12. 00	Care Contract Labor: Top Level		0	0			0.00	12.00
12.00	management and other management and administrative		3	S		0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		0	0	0	0. 00	0.00	13.00
14. 00	A - Administrative Home office and/or related organization salaries and		O	0	0	0. 00	0.00	14.00
14. 01	wage-related costs Home office salaries		0	0	0	0.00	0.00	14. 01
14. 02	Related organization salaries		0	Ö	0	0. 00	0. 00	14.02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	О	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	0	О	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0.00	0.00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		14, 699, 225	0	14, 699, 225			17. 00
18. 00	Wage-related costs (other)							18. 00
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		7, 295, 064 0	0	7, 295, 064 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. 00 24. 00
25. 00	Interns & residents (in an		Ö	0	ő			25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Rel ated organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							
	19 5. 4.54 (56) 6/	I I			1			'

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0104 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 407, 626 -245, 765 161, 861 15, 164. 00 10. 67 26.00 27.00 Administrative & General 5.00 8,074,503 106, 490 8, 180, 993 222, 795. 00 36. 72 27.00 28. 00 0.00 0.00 28.00 Administrative & General under 0 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 739, 843 3, 536 743, 379 20, 687. 00 35. 93 30.00 2,077.00 . Laundry & Linen Service 43, 475 43, 475 20. 93 31.00 31.00 8.00 32.00 Housekeepi ng 21. 05 9.00 543, 041 5,000 548, 041 26, 041. 00 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 835, 346 -440, 875 394, 471 22, 203. 00 17.77 34.00 35.00 Dietary under contract (see C 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 442, 573 442, 573 16, 454. 00 26. 90 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 9, 059. 00 Nursing Administration 6, 890 55. 35 38.00 38.00 13.00 494, 482 501, 372 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 14, 446. 00 40.00 Pharmacy 15.00 685, 612 685, 612 47.46 40.00 Medical Records & Medical Records Library 1, 091, 603 2, 288 41.00 16.00 1, 089, 315 37, 818. 00 28. 86 41. 00

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

1103F1 1	AL WASE FINDEX THEORIMATION			. Frovider C		From 01/01/2023 To 12/31/2023	Part III Date/Time Pre 5/30/2024 1:5	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		72, 996, 995	0	72, 996, 99	968, 977. 00	75. 33	1.00
	instructions)							
2.00	Excluded area salaries (see		38, 538, 869	7, 937	38, 546, 80	682, 445. 00	56. 48	2.00
	instructions)							
3.00	Subtotal salaries (line 1		34, 458, 126	-7, 937	34, 450, 18	9 286, 532. 00	120. 23	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 061, 741	0	6, 061, 74	1 66, 643. 00	90. 96	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		14, 699, 225	0	14, 699, 22	0.00	42. 67	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		55, 219, 092	-7, 937	55, 211, 15	5 353, 175. 00	156. 33	6.00
7.00	Total overhead cost (see		12, 913, 243	-119, 863	12, 793, 38	386, 744. 00	33. 08	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 01/01/2023 Part IV	
		To 12/31/2023 Date/Time Prepared:	

	To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
		Amount	2 0111
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 196, 428	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)	9, 862, 058	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 817, 199	9. 00
10.00	Dental, Hearing and Vision Plan	345, 846	
11. 00	Life Insurance (If employee is owner or beneficiary)	76, 637	
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	221, 333	
14.00		0	14.00
15. 00		588, 217	15.00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumulative portion)		
47.00	TAXES	4 700 040	47.00
17. 00		4, 730, 362	
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00		156, 209	
20. 00		0	20.00
	OTHER		
21. 00		0	21. 00
22.00	instructions))		22.00
22. 00 23. 00		0	22. 00 23. 00
24. 00		Ŭ	24.00
24. UU	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	21, 994, 289	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
23.00	Johnson Wilder Republic 30010 (Greatin)	ı	20.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/30/2024 1:5	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				

	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6, 061, 741	21, 994, 289	1.00
2.00	Hospi tal	6, 061, 741	21, 994, 289	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	NURSI NG FACI LI TY			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 FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18. 00	Other	0	0	18. 00

105PI	TAL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023		-				
			10 12/31/2023	5/30/2024 1: 5					
				1.00					
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1				
1. 00	Cost to charge ratio (see instructions)			0. 203940	1.00				
	Medicaid (see instructions for each line)			0.200.10	1				
2. 00	Net revenue from Medicaid			8, 750, 469	2.00				
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00				
1. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental pay		cai d?	N .	4.00				
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Med	i cai d		1, 724, 304	5.00				
5. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)			78, 639, 132 16, 037, 665					
3. 00	Difference between net revenue and costs for Medicaid program (see in	structions)		5, 562, 892					
J. 00	Children's Health Insurance Program (CHIP) (see instructions for each			0,002,072	0.0				
9. 00	Net revenue from stand-alone CHIP	,		0	9.00				
10.00				0	10.0				
11. 00				0					
12.00			`	0	12.0				
12 00	Other state or local government indigent care program (see instruction				l 13.0				
3. 00 4. 00	Net revenue from state or local indigent care program (Not included of Charges for patients covered under state or local indigent care program).								
4.00	10)	all (NOT THE due	a III IIIles o oi		14.0				
5. 00	1 '/			0	15.0				
6.00					16.0				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)								
7 00			ligent care progra		17.0				
	Private grants, donations, or endowment income restricted to funding	charity care	ligent care progra	0					
18.00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	charity care I operations		0 0	18.0				
18.00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita	charity care I operations		0 0					
18.00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care I operations	ams (sum of lines	0 0	18.0				
18.00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig	charity care I operations ent care progra Uninsured patients	ams (sum of lines I Insured patients	0 0 5, 562, 892 Total (col. 1 + col. 2)	18.0				
8. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid , CHIP and state and local indig 8, 12 and 16)	charity care I operations ent care progra	ams (sum of lines	0 0 5, 562, 892 Total (col . 1	18.0				
8. 00 9. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line)	charity care I operations ent care progra Uninsurec patients 1.00	Insured patients 2.00	0 0 5,562,892 Total (col. 1 + col. 2) 3.00	18. C				
8. 00 9. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	charity care I operations ent care progra Uninsurec patients 1.00 3,773,	nms (sum of lines I Insured patients 2.00 917 894,366	0 0 5,562,892 Total (col. 1 + col. 2) 3.00	18. C 19. C				
8. 00 9. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospita Total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	charity care I operations ent care progra Uninsurec patients 1.00 3,773,	nms (sum of lines I Insured patients 2.00	0 0 5,562,892 Total (col. 1 + col. 2) 3.00	18. 0 19. 0				
8. 00 9. 00 20. 00 21. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital total unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769,	nms (sum of lines I Insured patients 2.00	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107	18. 0 19. 0 20. 0 21. 0				
8. 00 9. 00 0. 00 11. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769,	Insured patients 2.00 894,366 871,454 0 0	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107	20. 0 21. 0				
8. 00 9. 00 20. 00 21. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769,	Insured patients 2.00 894,366 871,454 0 0	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107	20. 0 21. 0				
8. 00 9. 00 20. 00 21. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769,	Insured patients 2.00 894,366 871,454 0 0	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107	20. 0 21. 0				
8. 00 9. 00 0. 00 1. 00 2. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769,	I Insured patients 2.00 894, 366 871, 454	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107	20. 0 21. 0 23. 0				
8. 00 9. 00 0. 00 1. 00 2. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days to	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	I Insured patients 2.00 894, 366 871, 454	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107	20. 0 21. 0 23. 0				
8. 00 9. 00 20. 00 21. 00 22. 00 24. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 N	20. 0 21. 0 22. 0 23. 0				
8. 00 9. 00 1. 00 1. 00 2. 00 3. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indistay limit	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 N	20. 0 21. 0 22. 0 23. 0				
8. 00 9. 00 0. 00 11. 00 22. 00 4. 00 5. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care prograficated in the program of	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 0 28, 782	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0				
8. 00 9. 00 00. 00 11. 00 22. 00 24. 00 25. 01 16. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prografine 24 is yes, enter the charges for patient days beyond the indistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 0 28, 782 10, 591, 751	20. 0 21. 0 22. 0 23. 0 24. 0 25. 0 26. 0				
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00 16. 00 17. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indistaly limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 0 28, 782 10, 591, 751 180, 703	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0				
8. 00 9. 00 0. 00 11. 00 22. 00 33. 00 44. 00 55. 00 16. 00 17. 00 17. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769,	Insured patients 2.00 894,366 653 871,454 of stay limit	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 0 28, 782 10, 591, 751 180, 703 278, 004	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 27. 0				
25. 00 25. 01 26. 00 27. 00 27. 01 28. 00	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days be imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769, eyond a length m? gent care progra	mms (sum of lines I Insured patients 2.00 917 894,366 653 871,454 0 0 653 871,454 of stay limit ram's length of	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 28, 782 10, 591, 751 180, 703 278, 004 10, 313, 747	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 27. 0 28. 0				
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 25. 01 26. 00 27. 00 27. 01	Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospital unreimbursed cost for Medicaid, CHIP and state and local indig 8, 12 and 16) Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounts (sinstructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prograff line 24 is yes, enter the charges for patient days beyond the indistay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	charity care I operations ent care progra Uninsured patients 1.00 3,773, 769, 769, eyond a length m? gent care progra	mms (sum of lines I Insured patients 2.00 917 894,366 653 871,454 0 0 653 871,454 of stay limit ram's length of	0 0 5, 562, 892 Total (col. 1 + col. 2) 3.00 4, 668, 283 1, 641, 107 0 1, 641, 107 1.00 N 0 28, 782 10, 591, 751 180, 703 278, 004	20. 0 21. 0 22. 0 23. 0 25. 0 26. 0 27. 0 28. 0 29. 0				

Heal th	Financial Systems WITHAM MEMORIAL H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
		Provi der CC	CN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:	
					1. 00		
	PART II - HOSPITAL DATA				1.00		
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1.00	Cost to charge ratio (see instructions)				0. 193600	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid						
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			ai d?		4. 00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d			5.00	
6.00	Medicaid charges					6.00	
7. 00 8. 00	Medicaid cost (line 1 times line 6)	(coo instru	ictions)			7. 00 8. 00	
8.00	Difference between net revenue and costs for Medicaid program Children's Health Insurance Program (CHIP) (see instructions f					8.00	
9. 00	Net revenue from stand-alone CHIP	or each fir	ie)			9.00	
10.00	Stand-alone CHIP charges					10.00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00	
12. 00	Difference between net revenue and costs for stand-alone CHIP	(see instru	uctions)			12.00	
	Other state or local government indigent care program (see ins	tructions f	or each line)	•		
13.00	Net revenue from state or local indigent care program (Not inc	luded on li	nes 2, 5 or	9)		13. 00	
14.00	Charges for patients covered under state or local indigent car					14. 00	
	10)						
15. 00	State or local indigent care program cost (line 1 times line 1					15.00	
16. 00	Difference between net revenue and costs for state or local in					16. 00	
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/Local Indi	gent care progra	ams (see		
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	fundi na lehar	sity caro			17. 00	
18. 00	Government grants, appropriations or transfers for support of	-	,			18.00	
19. 00				s (sum of lines		19.00	
	8, 12 and 16)	9	p9	(
			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
			1. 00	2. 00	3. 00		
00.00	Uncompensated care cost (see instructions for each line)	` 1	0.770.0	17 004 077	4 ((0,000	00.00	
20.00	Charity care charges and uninsured discounts (see instructions	·	3, 773, 9	· ·		1	
21. 00	Cost of patients approved for charity care and uninsured disco instructions)	unts (see	730, 6	871, 156	1, 601, 786	21.00	
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00	
22.00	charity care	011 43			Ĭ	22.00	
23. 00	1		730, 6	871, 156	1, 601, 786	23. 00	
					1. 00		
24.00	Does the amount on line 20 col. 2, include charges for patient		nd a Length o	f stay limit	N	24. 00	
25. 00	imposed on patients covered by Medicaid or other indigent care Ifline 24 is yes, enter the charges for patient days beyond t		t care progra	ım's length of	0	25. 00	
25 01	stay limit						
25. 01 26. 00							
26.00							
27. 00	` '				261, 683		
28. 00	,				10, 330, 068		
	Cost of non-Medicare and non-reimbursable Medicare bad debt am	ounts (see	instructions	;)	2, 091, 490		
	Cost of uncompensated care (line 23, col. 3, plus line 29)			,	3, 693, 276		
	Total unreimbursed and uncompensated care cost (line 19 plus I	ine 30)			3, 693, 276		
		•			•	•	

Chief Chief Chief		FINANCIAI SYSTEMS	WITHAM MEMURIA		N. 15 0104 F		Worksheet A	1002 10
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provider CC		Period: From 01/01/2023	worksneet A	
Cost Center Description								
Company Comp		Cost Center Description	Sal ari es	Other	Total (col 1	Reclassificat		2 pm
CENSEAL SERVICE COST CENTERS 1,000 2,000 4,000 5,000 1,000		cost center bescription	Sararres	other				
SINDRAL SERVICE DOST CRITERS					,			
CONTRIBUTION CONT						·		
1.00 1000 NAR CAP REL COSTS-BLUG S FIXI 1.00 1.0			1. 00	2. 00	3. 00	4. 00	5. 00	
2.00 0.0000 INPR CAP REL COSTS-IMBRE COULTY 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 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	1 00			4 005 107	4 005 10	247.074	F 1F2 1F1	1 00
3.00 DOSDO OTHER CAPT FILE RELATED COSTS 1,00 0.0				1				1
4.0.0 DOCKOOL PURPLAYER BENEFIT IS DEPARTMENT 407, 628 17, 147, 218 17, 554, 1844 774, 638 77, 744 28, 709, 407 47, 700 700				0	-	.,,		
Doctor D			407, 626	17, 147, 218	•	1 1		
0.00 0.000 DURISHEFF MIRE		1 1						
9.00 00900 DUSENCEP ING		1 1	739, 843	4, 195, 850	4, 935, 693		4, 809, 337	
10.00 01000 DETARY								
11.00 0100 CAFETERIA 0 0 0 60.6, 245 6.05								1
13.00 01300 MURSING ADMINISTRATION				1, 678, 609				1
15.00 OSOD PHARMACY 0.85, 0.12 12, 851, 881 13, 837, 492 -12, 168, 508 1, 368, 925 15.00 OSOD PHARMACY 0.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00 1.00 1, 714, 89.00			-1	161 763	-			
0.00								
30.00 03000 ADULTS & PEDIATRICS 3,991,413 1,999,914 5,991,327 -343,395 5,947,972 30.00 40.00 04000 SUBPROVIDER - 1 PF 1,270,029 155,035 1,425,064 -29,999 1,395,465 40.00		1 1						1
33.0 0 30100 INTERSIVE CARE UNIT 1,912,467 518,174 2,030,641 -187,001 1,843,880 31.0 41.0 0 0 40100 SURPROVIDER - I RF 0 0 0 0 0 0 0 0 41.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 0 0 43.0 0 40200 SURPROVIDER - I RF 0 0 0 0 0 0 0 0 0								
10.00 04000 SUBPROVIDER - I I I F 1,270,029 155,039 1,425,064 2-29,99 1,395,465 40.00 42.00 0420		1 1						
11.00 04100 SUBPROVI DER IRF 0								
42 00 04200 NURSERY 0 0 0 0 0 0 0 24 20			1, 270, 029	155, 035	1, 425, 064	-29, 599		
43.00 04300 NURSERY 0,0 0,0 0,0 0,0 0,4 43.00 04400 SKILLED NURSING FACILITY 1,077,511 524,700 1,602,231 7-9,565 1,522,666 50.00 50500 OPERATINE ROWM 2,284,636 7,225,883 9,510,519 -5,991,060 4,119,459 50.00 05000 OPERATINE ROWM 1,745,194 3,351,495 5,096,689 -631,461 4,465,228 54.00 55.00 05000 RADIOLOGY-THERREPUTIC 0,0			0	0	(
44. 00 04400 SKILLED RUPSING FACILITY 1,077,511 524,720 1,602,231 -79,565 1,522,666 44, 01			0	0	(
MACILLARY SERVICE COST CENTERS			1, 077, 511	524, 720	1, 602, 231	-79, 565	-	
54 00 05400 RADIOLOSY-DIAGNOSTIC 1,745,194 3,351,495 5,096,689 -631,461 4,465,228 54,005 0550 05500 RADIOLOSY-TIREAPEUTIC 0 0 0 0 0 0 0 0 0						<u>'</u>		1
55 00 05500 ADDIOLOGY-THERAPEUTIC 0 0 0 0 55 0.55 0.7			2, 284, 636				4, 119, 459	50.00
55.00 05500 ULTRA SOUND 518, 915 669, 501 1, 199, 416 -34, 163 1, 165, 255 55.0				3, 351, 495				1
57 00 05700 CT SCAN 399, 354 479, 700 819, 144 -32, 816 786, 328 \$7.00 \$7.00 05900 CARDIA CATHETER IZATION 329, 129 313, 951 64, 68, 589 -1, 430, 498 228, 091 \$9.00 6300 06300 LADORATORY \$0.00 1336, 473 1, 322, 116 1, 658, 589 -1, 430, 498 228, 091 \$9.00 6300 06300 LADORATORY \$0.00 5000 LADORATORY \$0.00 5000 1000 5000 1000 5000 1000 5000 1000 5000 1000 5000 1000 5000 64, 00 6400 1000 1			٩	0	-	-		
58. 00 OSBOQ MAGNETIC RESONANCE I MAGI NG (WRI) 329, 129 313, 951 643, 080 -22, 568 620, 512 58, 00 599, 00 599, 00 CARDI NG CATHETER I ZATI ON 336, 473 1, 322, 116 1, 430, 499 228, 091 59, 00 60, 00 0 0 0 0 0 0 0 0			· ·					1
59.00 OSSPOO CARDINAC CATHETERIZATION 336, 473 1,322, 110 1,658, 589 -1,430, 498 228, 091 59, 00 OSO								1
0.0 0.0								
63.00 06.300 BLOOD STORING, PROCESSING & TRANS. 0 8.3, 135 83, 135 -5 83, 130 0.3, 0 64.00								
66.00 06600 PHYSI CAL THERAPY 1,428,842 431,360 1,860,202 1,545 1,861,747 66.00 67.00 06700 0CUPATIONAL THERAPY 369,745 124,825 494,567 -126 494,441 67.00 67.00 06701 AUDIOLOGY 228,381 141,229 369,610 -18,402 351,208 67.00 68.00 06800 SPECEH PATHOLOGY 778,176 15,758 193,394 2,773 196,707 68.00 069000 06900 06900 06900 069000 069000 06900 0690		1 1						1
67.00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06701	64.00	06400 I NTRAVENOUS THERAPY	0	0	(o	0	64.00
67.01 06701 AUDIOLOGY 228, 381 141, 229 369, 610 -18, 402 351, 208 67, 068, 00 680, 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0								1
68.00 06800 SPECH PATHOLOGY 178, 176 15, 758 193, 934 2, 773 196, 707 68.00 69.00								1
69.00								
69.01			1/8, 1/6	15, /58				1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 -534, 737 -534, 737 3, 837, 607 3, 302, 870 71. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 4, 535, 240 4, 535, 240 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		1 1	1 662 951	777 915	-	-		
73. 00 07300 DRUGS CHARGED TO PATLENTS								
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 77.07 78. 00 07800 CAR T-CELL I IMMUNDTHERAPY 0 0 0 0 0 0 0 78. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	72.00		o	0	(4, 535, 240	4, 535, 240	72.00
78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0	0	(11, 705, 939		
OUTPATI ENT SERVI CE COST CENTERS		07700 ALLOGENEIC HSCT ACQUISITION	- 1	-				
90. 00 09000 CLINIC	78. 00		0	0	(0	0	78.00
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90. 02 09002 CLINIC			l l	0		-		
90. 03 09003 DERMATOLOGY CLINIC 0 3,407 3,407 0 3,407 90. 05 90. 04 09004 ENT CLINIC 0 0 0 0 0 0 90. 05 09005 SURGERY CLINIC 0 391 391 -391 0 90. 05 90. 07 09007 UROLOGY CLINIC 53,244 450 53,694 -293 53,401 90. 05 90. 09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 90. 11 09011 NEUROLOGY CLINIC 0 0 0 0 0 0 0 90. 12 09012 OPTHAMOLOGY CLINIC 0 10,620 10,620 -4,034 6,586 90. 17 90. 13 09013 ALLERGY CLINIC 0 10,620 10,620 -4,034 6,586 90. 17 90. 14 09014 WOUND CARE 268,333 467,635 735,968 -296,154 439,814 90. 17 91. 00 09100 DERGEROCY 3,130,439 4,974,992 8,105,431 -426,329 7,679,102 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 2,506,262 582,227 3,088,489 -131,670 2,956,819 95. 00 95. 00 09500 MBULANCE SERVICES 2,506,262 582,227 3,088,489 -131,670 2,956,819 95. 00 95. 00 09100 DI TREATMENT PROGRAM 0 0 0 0 0 0 90. 00 SUBTOTALS (SUM OF LINES 1 through 117) 39,311,928 93,522,137 132,834,065 323,966 133,158,031 18. 00 192. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 0 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 0 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 0 0 0 194. 00 07951 CAFE/BOUTI QUE 3,991 23,936 27,927 -434 44,522,034 194. 01 194. 01 07951 CAFE/BOUTI QUE 3,991 23,936 27,927 -434 44,089 194. 01 194. 02 07952 CHER NONREIMB 0 44,837 44,837 -748 44,089 194. 01 194. 02 07953 CAFE/BOUTI QUE 30,8302 2,676,293 2,984,595 0 2,984,595 94. 05 95. 95. 96. 10 10 10 10 10 10 10 10		1 1	l l	Ö	(ol ol		
90. 05 09005 SURGERY CLINIC 0 391 391 -391 0 90. 05 90. 07 90. 07 90. 07 90. 07 90. 09 90. 0			- 1	3, 407	3, 407	r ol		
90. 07			О	- 1	,	ή "Ι		
90. 09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 0 0 0 0 0		1 1	9					
90. 11			53, 244	450	53, 694	-293		
90. 12			0	0	(
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90. 14		1 1	66 278					1
91. 00		1 1						
OTHER REIMBURSABLE COST CENTERS 2,506,262 582,227 3,088,489 -131,670 2,956,819 95.00 10200 0P101D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0								1
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
102. 00 102.00 OPI 0I D TREATMENT PROGRAM O O O O O O O O O								
SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 39, 311, 928 93, 522, 137 132, 834, 065 323, 966 133, 158, 031 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 33, 372, 774 11, 472, 044 44, 844, 818 -322, 784 44, 522, 034 192. 00 194. 00 07950 THORNTOWN OFFI CE BUI LDI NG 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTI QUE 3, 991 23, 936 27, 927 -434 27, 493 194. 01 194. 02 07952 OTHER NONREI MB 0 44, 837 44, 837 -748 44, 089 194. 01 194. 03 07953 RETAI L PHARMACY 308, 302 2, 676, 293 2, 984, 595 0 2, 984, 595 194. 03								
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 39, 311, 928 93, 522, 137 132, 834, 065 323, 966 133, 158, 031 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 0 190. 00 192.	102.00		0	0	() 0	0	102.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 0 190.00	118 00		30 311 028	03 522 137	132 834 065	323 066	133 150 031	118 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 0 0 190. 00	110.00	MONREI MRIIRSARI E COST CENTERS	39, 311, 920	93, 322, 137	132, 034, 003	323, 900	133, 136, 031]116.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 33, 372, 774 11, 472, 044 44, 844, 818 -322, 784 44, 522, 034 192. 00 194. 00 19	190. 00		O	nl	(ol ol	n	190.00
194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194. 00 194. 01 07951 CAFE/BOUTI QUE 3, 991 23, 936 27, 927 -434 27, 493 194. 00 194. 02 07952 OTHER NONREI MB 0 44, 837 44, 837 -748 44, 089 194. 00 194. 03 07953 RETAI L PHARMACY 308, 302 2, 676, 293 2, 984, 595 0 2, 984, 595 194. 00				11, 472, 044	44, 844, 818	-322, 784		
194. 01 07951 CAFE/BOUTI QUE 3, 991 23, 936 27, 927 -434 27, 493 194. 00 194. 02 07952 OTHER NONREI MB 0 44, 837 44, 837 -748 44, 089 194. 00 194. 03 07953 RETAI L PHARMACY 308, 302 2, 676, 293 2, 984, 595 0 2, 984, 595 194. 00			o	0			0	194.00
194. 03 07953 RETALL PHARMACY 308, 302 2, 676, 293 2, 984, 595 0 2, 984, 595 194. 03			3, 991					
			0					
- 200 DOI:		1 1						
200. 00 TOTAL (30iii 01 ETNES 110 till ddgil 177) 72,776,775 101,757,247 100,730,242 0 100,730,242		" LIULAL COUNTUE LINES LIX TOPOURO 1991	72, 996, 995	107, 739, 247	1σU, /36, 242	<u>4</u> 0	18U, 736, 242	µ∠UU. UU

Provi der CCN: 15-0104

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm

				5/30/2024 1:5	2 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		6. 00	Allocation 7.00	_	
GENE	ERAL SERVICE COST CENTERS	3. 33			
	00 NEW CAP REL COSTS-BLDG & FIXT	-130, 905		1	1.00
1	OO NEW CAP REL COSTS-MVBLE EQUIP	-391	4, 160, 333		2.00
	DO OTHER CAPITAL RELATED COSTS DO EMPLOYEE BENEFITS DEPARTMENT	0 -5, 083, 795	0 12, 745, 687		3. 00 4. 00
	DO ADMINISTRATIVE & GENERAL	-9, 444, 332	18, 666, 617		5.00
•	OO OPERATION OF PLANT	-101, 792			7.00
	DO LAUNDRY & LINEN SERVICE	0	593, 680	l .	8. 00
	DO HOUSEKEEPI NG	0	1, 076, 679	l .	9.00
	00 DI ETARY 00 CAFETERI A	-371, 172 0	1, 313, 079 801, 080		10.00
	DO NURSING ADMINISTRATION	0	662, 450		13.00
	DO PHARMACY	-76, 979	1, 291, 946	l .	15.00
16. 00 0160	DO MEDICAL RECORDS & LIBRARY	-1, 553	1, 746, 307	7	16. 00
	ATIENT ROUTINE SERVICE COST CENTERS			T.	
	DO ADULTS & PEDIATRICS	0	5, 547, 972		30.00
	DO INTENSIVE CARE UNIT DO SUBPROVIDER - IPF	0	1, 843, 580 1, 395, 465		31. 00 40. 00
	00 SUBPROVI DER - I RF	0	1, 373, 403		41.00
	OO SUBPROVI DER	0	0		42.00
1	DO NURSERY	0	0		43.00
	DO SKILLED NURSING FACILITY	-3	1, 522, 663	3	44.00
	LLARY SERVICE COST CENTERS DO OPERATING ROOM	0	4, 119, 459	l	50.00
•	DO RADI OLOGY-DI AGNOSTI C	-4, 553	4, 460, 675	•	54.00
	DO RADI OLOGY-THERAPEUTI C	0	0		55.00
	D1 ULTRA SOUND	0	1, 165, 253	3	55. 01
	OO CT SCAN	0	786, 328	1	57.00
	DO MAGNETIC RESONANCE IMAGING (MRI) DO CARDIAC CATHETERIZATION	0	620, 512 228, 091	1	58. 00 59. 00
•	DO LABORATORY	-271, 920	7, 314, 583		60.00
•	DO BLOOD STORING, PROCESSING & TRANS.	0	83, 130		63.00
	00 I NTRAVENOUS THERAPY	0	0		64.00
	DO PHYSI CAL THERAPY	0	1, 861, 747	l .	66.00
	OO OCCUPATI ONAL THERAPY	105 515	494, 441	l .	67.00
	01 AUDI OLOGY 00 SPEECH PATHOLOGY	-185, 515 0	165, 693 196, 707	l .	67. 01 68. 00
	DO ELECTROCARDI OLOGY	0	170, 707		69.00
	D1 CARDI OLOGY	0	2, 097, 901		69. 01
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 302, 870		71.00
	OO I MPL. DEV. CHARGED TO PATIENT	0	4, 535, 240		72.00
	DO DRUGS CHARGED TO PATIENTS DO ALLOGENEIC HSCT ACQUISITION	0	11, 705, 939 0		73. 00 77. 00
	OO CAR T-CELL IMMUNOTHERAPY	0	0	1	78.00
	PATIENT SERVICE COST CENTERS		<u> </u>		1
90.00 0900		0	0	1	90.00
•	OTHER OUTPATIENT SERVICE COST CENTER	0	-	1	90.01
	D2 CLINIC D3 DERMATOLOGY CLINIC	0 -3, 407	0 0		90. 02 90. 03
•	D4 ENT CLINIC	-3, 407	0	1	90.03
	D5 SURGERY CLINIC	Ö	Ö	1	90.05
	D7 UROLOGY CLINIC	-21, 632	31, 769		90.07
1	09 GASTROENTEROLOGY CLINIC	0	0		90.09
	11 NEUROLOGY CLINIC 12 OPTHAMOLOGY CLINIC	0	0		90. 11
•	13 ALLERGY CLINIC	-6, 586 0	110, 094		90. 12
	14 WOUND CARE	-111, 931	327, 883		90. 14
	DO EMERGENCY	-2, 602, 200		1	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	ER REIMBURSABLE COST CENTERS	10.005	0.000.704		05.00
	DO AMBULANCE SERVICES DO OPIOID TREATMENT PROGRAM	-18, 035 0			95. 00 102. 00
	CIAL PURPOSE COST CENTERS	<u> </u>		'i	1.02.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-18, 436, 701	114, 721, 330		118. 00
	REIMBURSABLE COST CENTERS				
	OO GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	1	190.00
	DO PHYSICIANS' PRIVATE OFFICES 50 THORNTOWN OFFICE BUILDING	-7, 160 0	44, 514, 874	 	192. 00 194. 00
	51 CAFE/BOUTI QUE	0	27, 493	3	194.00
	52 OTHER NONREIMB		44, 089	l .	194. 02
194. 03 079	53 RETAIL PHARMACY	0	2, 984, 595	5	194. 03
200. 00	TOTAL (SUM OF LINES 118 through 199)	-18, 443, 861	162, 292, 381		200.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm Provider CCN: 15-0104

					0, 00, 20,	24 1:52 pm
	Cost Center	Increases	Col ami	Other		
-	2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - INSURANCE RECLASS	0.00	1. 00	0.00		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	425, 014		1.00
	FLXT					
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	52 <u>7, 1</u> 73		2. 00
	O DOMESTEDIA DEGLACO		0	952, 187		
1 00	B - CAFETERIA RECLASS	11. 00	442, 573	250 507		1 00
1. 00	CAFETERI A		44 <u>2, 5</u> 73 442, 573	<u>358, 507</u> 358, 507		1.00
	C - MME DEPRECIATION RECLASS		442, 373	330, 307		
1.00	NEW CAP REL COSTS-MVBLE	2. 00	0	4, 160, 724		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 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	ol Ol	0		7.00
8. 00		0.00	o	0		8.00
9. 00		0. 00	o	Ö		9. 00
10.00		0. 00	О	0		10.00
11.00		0. 00	0	0		11.00
12.00		0.00	0	0		12. 00
13.00		0. 00	0	0		13. 00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
16.00		0.00	0	0		17.00
18. 00		0.00	o	0		18. 00
19. 00		0. 00	o	Ö		19.00
20.00		0. 00	o	Ö		20.00
21.00		0. 00	0	0		21.00
22.00		0. 00	0	0		22. 00
23.00		0. 00	0	0		23. 00
24. 00		0. 00	0	0		24.00
25.00		0.00	0	0		25.00
26. 00		0.00	0	0		26.00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	o	0		29.00
30.00		0.00	o	Ö		30.00
31. 00		0.00	Ö	O		31.00
32.00		0. 00	o	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 37. 00		0. 00 0. 00	0	0		36. 00 37. 00
38.00		0.00	ol	0		38.00
39. 00		0. 00	o	Ö		39.00
40.00		0.00	Ö	0		40.00
41.00		0. 00	o	0		41.00
	0		0	4, 160, 724		
	D - DRUGS RECLASS					
1. 00	DRUGS CHARGED TO PATIENTS		0	12, 137, 409		1.00
	E - IMPLANTABLES RECLASS		0	12, 137, 409		
1. 00	I MPL. DEV. CHARGED TO	72.00	ol	4, 535, 240		1.00
1.00	PATI ENT	72.00	ď	4, 333, 240		1.00
2. 00		0. 00	О	О		2.00
3. 00		0. 00	Ö	Ö		3. 00
4.00		0. 00	o	O		4.00
5.00		0.00	o	0		5. 00
6.00		0.00	o	0		6.00
7. 00		000	0	0		7.00
	U CHARCEARLE MEDICAL CURREN	EC DECLACE	0	4, 535, 240		
1 00	F - CHARGEABLE MEDICAL SUPPLIEMEDICAL SUPPLIES CHARGED TO		ol	2 044 220		1 00
1. 00	PATIENTS	71. 00	٩	3, 864, 229		1.00
2. 00	I THE LINES	0.00	o	0		2.00
3. 00		0. 00	o	Ö		3.00
4. 00		0. 00	Ö	Ö		4.00
5.00		0. 00	o	0		5.00
6.00		0.00	0	0		6.00
7. 00		0.00	0	0		7.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provider CCN: 15-0104

					5/30/2024	1: 52 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5		
0.00	2. 00	3.00	4. 00	5. 00		0.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	Ö	Ö		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	0	0		16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20.00		0.00	0	0		20.00
21. 00		0.00	0	Ö		21.00
22. 00		0.00	o	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0. 00	0	0		24.00
25.00		0. 00	0	0		25. 00
26.00		0.00	0	0		26.00
27. 00		0. 00 0. 00	0	0		27. 00
28. 00 29. 00		0.00	ol Ol	0		28. 00 29. 00
30.00		0.00	0	0		30.00
31. 00		0.00	ő	Ö		31.00
32.00		0.00	O	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. 00	0	0		36.00 37.00
37. 00			0	0 3,864,229		37.00
	G - BONUS RECLASS		<u> </u>	0,001,227		
1.00	ADMINISTRATIVE & GENERAL	5. 00	106, 490	0		1.00
2.00	OPERATION OF PLANT	7. 00	3, 536	0		2.00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	0	0		3. 00
4. 00	HOUSEKEEPI NG	9. 00	5, 000	0		4.00
5. 00	DI ETARY	10.00	1, 698	0		5.00
6. 00 7. 00	NURSING ADMINISTRATION PHARMACY	13. 00 15. 00	6, 890 0	0		6. 00 7. 00
8. 00	MEDICAL RECORDS & LIBRARY	16. 00	2, 288	0		8.00
9. 00	ADULTS & PEDIATRICS	30.00	17, 498	0		9. 00
10.00	INTENSIVE CARE UNIT	31. 00	15, 428	0		10.00
11.00	SUBPROVI DER - I PF	40. 00	0	0		11.00
12.00	SKILLED NURSING FACILITY	44. 00	7, 937	0		12. 00
13.00	OPERATING ROOM	50.00	9, 428	0		13.00
14.00	RADI OLOGY-DI AGNOSTI C	54.00	4, 053	0		14.00
15. 00 16. 00	ULTRA SOUND CT SCAN	55. 01 57. 00	33, 578 0	0		15. 00 16. 00
17. 00	MAGNETIC RESONANCE I MAGING	58.00	0	0		17. 00
	(MRI)	55.55	9	1		55
18.00	CARDI AC CATHETERI ZATI ON	59. 00	0	0		18. 00
19.00	LABORATORY	60.00	7, 614	0		19. 00
20.00	PHYSI CAL THERAPY	66.00	5, 824	0		20.00
21. 00	OCCUPATI ONAL THERAPY	67.00	0	0		21.00
22. 00 23. 00	AUDI OLOGY SPEECH PATHOLOGY	67. 01 68. 00	0 2, 773	0		22. 00 23. 00
24. 00	CARDI OLOGY	69. 01	2, 773	0		24.00
25. 00	DRUGS CHARGED TO PATIENTS	73. 00	2, 771	0		25.00
26. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	Ö	Ö		26. 00
27.00	UROLOGY CLINIC	90. 07	О	0		27.00
28. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	0		28. 00
29.00	ALLERGY CLINIC	90. 13	0	0		29. 00
30.00	WOUND CARE	90. 14	100	0		30.00
31. 00 32. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	12, 859	0		31.00 32.00
JZ. UU	0	75.00	00 245, 765	— — <u> </u>		32.00
500.00	Grand Total: Increases		688, 338	26, 008, 296		500.00
	•	'	1			'

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0104

						5/30/2024	1:52 pm
		Decreases		0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - INSURANCE RECLASS	7.00	8.00	9.00	10.00		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	952, 187	12		1.00
2.00		000	0_	0			2. 00
	0		0	952, 187			
1. 00	B - CAFETERI A RECLASS DI ETARY	10. 00	442, 573	358, 507	0		1.00
1.00	0		442, 573	358, 507			1.00
	C - MME DEPRECIATION RECLASS		,	220,221			
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	177, 050	9		1.00
2 00	FLXT	4. 00	0	5, 677	,		2.00
2. 00 3. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	5. 00	0	1, 612, 163			2. 00 3. 00
4. 00	OPERATION OF PLANT	7. 00	o	129, 671			4.00
5.00	LAUNDRY & LINEN SERVICE	8. 00	О	445	1		5. 00
6.00	HOUSEKEEPI NG	9. 00	0	1, 349	1		6.00
7. 00 8. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	30, 099 685			7. 00 8. 00
9. 00	PHARMACY	15. 00	0	3, 201			9.00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	Ö	3, 215			10.00
11. 00	ADULTS & PEDIATRICS	30. 00	O	96, 010			11.00
12.00	INTENSIVE CARE UNIT	31. 00	0	75, 422			12.00
13. 00 14. 00	SUBPROVIDER - IPF SKILLED NURSING FACILITY	40. 00 44. 00	0	10, 256 48, 451	1		13. 00 14. 00
15. 00	OPERATING ROOM	50.00	0	375, 288			15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	320, 132	1		16. 00
17.00	ULTRA SOUND	55. 01	0	62, 830			17. 00
18.00	CT SCAN	57. 00	0	18, 995	1		18.00
19. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	17, 926	0		19. 00
20. 00	CARDIAC CATHETERIZATION	59. 00	0	130, 283	0		20.00
21. 00	LABORATORY	60.00	Ö	231, 084	1		21. 00
22. 00	BLOOD STORING, PROCESSING &	63. 00	0	0	0		22. 00
00.00	TRANS.			0.405			00.00
23. 00 24. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0	3, 135 77	1		23. 00 24. 00
25. 00	AUDI OLOGY	67. 01	o	18, 371			25.00
26. 00	CARDI OLOGY	69. 01	Ö	324, 165			26.00
27. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	6, 798	0		27. 00
20.00	PATIENTS	72 00	0	E40			20.00
28. 00 29. 00	DRUGS CHARGED TO PATIENTS PHYSICIANS' PRIVATE OFFICES	73. 00 192. 00	0	542 4, 150			28. 00 29. 00
30.00	ENT CLINIC	90. 04	Ö	4, 130			30.00
31.00	SURGERY CLINIC	90. 05	0	391	0		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	4, 034	1		33.00
35.00	WOUND CARE	90. 13	0	647 19, 238			34. 00 35. 00
36. 00	EMERGENCY	91. 00	Ö	78, 835	1		36.00
37.00	AMBULANCE SERVICES	95. 00	0	108, 976	0		37.00
38. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	239, 658			38.00
39. 00 40. 00	CAFE/BOUTI QUE OTHER NONREI MB	194. 01 194. 02	0	434 748			39. 00 40. 00
41. 00	RETAIL PHARMACY	194. 02	0	740			41.00
00	0			4, 160, 724			55
	D - DRUGS RECLASS						
1. 00	PHARMACY	1500	0	<u>12, 137, 409</u>			1.00
	E - IMPLANTABLES RECLASS		U	12, 137, 409	'		
1. 00	INTENSIVE CARE UNIT	31. 00	ol	2, 580	0		1.00
2.00	OPERATING ROOM	50.00	O	3, 067, 869	1		2.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	235, 425	1		3. 00
4. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	519, 422			4.00
5. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	O	19, 824	0		5. 00
6. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	430, 920	0		6. 00
7. 00	WOUND CARE	90. 14	0_	259, 200	1		7.00
	0			4, 535, 240			
	F - CHARGEABLE MEDICAL SUPPLI						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 093			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	15, 384 221			2. 00 3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	0	149			4.00
5. 00	HOUSEKEEPI NG	9. 00	Ö	593	1		5. 00
6. 00	DI ETARY	10. 00	o	223	o		6. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 1:52 pm Provider CCN: 15-0104

						5/30/2024 1:	52 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
7.00	PHARMACY	15. 00	0	27, 958	0		7.00
8. 00	MEDI CAL RECORDS & LI BRARY	16.00	0	73	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	264, 843	0	l	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	124, 487	0	l l	10.00
11. 00 12. 00	SUBPROVIDER - IPF	40. 00 44. 00	0	19, 343	0	l	11. 00 12. 00
13. 00	SKILLED NURSING FACILITY OPERATING ROOM	50.00	0	39, 051 1, 957, 331	0	l l	13.00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	79, 957	0	I	14. 00
15. 00	ULTRA SOUND	55. 01	0	4, 911	0	l	15. 00
16. 00	CT SCAN	57. 00	0	13, 821	0	l	16.00
17. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	4, 642	0	l	17. 00
	(MRI)						
18.00	CARDI AC CATHETERI ZATI ON	59. 00	0	780, 793	0		18. 00
19.00	LABORATORY	60.00	0	26, 493	0		19. 00
20.00	BLOOD STORING, PROCESSING &	63. 00	0	5	0		20.00
	TRANS.						
21. 00	PHYSI CAL THERAPY	66. 00	0	1, 144	0	l	21.00
22. 00	OCCUPATIONAL THERAPY	67. 00	0	49	0	l l	22. 00
23.00	AUDI OLOGY	67. 01	0	31	0	l l	23. 00
24. 00	CARDI OLOGY	69. 01	0	21, 571	0	l l	24.00
25. 00	DRUGS CHARGED TO PATIENTS PHYSICIANS' PRIVATE OFFICES	73.00	0	کا 1 410	0		25. 00
26. 00 27. 00	ENT CLINIC	192. 00 90. 04	0	2, 418 0	0	1	26. 00 27. 00
28.00	SURGERY CLINIC	90.04	0	0	0		28.00
29. 00	UROLOGY CLINIC	90.03	0	0	0	1	29. 00
30.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	166	0		30.00
31. 00	ALLERGY CLINIC	90. 13	0	216	0	l I	31.00
32.00	WOUND CARE	90. 14	0	17, 816	0		32.00
33.00	EMERGENCY	91.00	0	360, 353	0		33.00
34.00	AMBULANCE SERVICES	95. 00	0	22, 694	0		34.00
35.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	76, 392	0		35.00
36.00	CAFE/BOUTI QUE	194. 01	0	0	0		36.00
37.00	RETAIL PHARMACY	1 <u>94.</u> 03	0	0	0		37.00
	0		0	3, 864, 229			
4 00	G - BONUS RECLASS	4 00	045.775				4 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	245, 765 0	0			1.00
2. 00 3. 00		0.00	0	0			2. 00 3. 00
4. 00		0.00	0	0		l l	4. 00
5. 00		0.00	0	0	0	l l	5. 00
6. 00		0.00	0	0		I	6. 00
7.00		0.00	0	0	0		7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0	0	0		9. 00
10.00		0.00	0	0	0	l l	10.00
11.00		0.00	0	0	0	1	11.00
12.00		0. 00	0	0	0	l l	12. 00
13. 00		0.00	0			l .	13.00
14.00		0.00	0				14.00
15.00		0.00	0	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0	0		16. 00 17. 00
18. 00		0.00	0	0			18.00
19. 00		0.00	0	0	0		19. 00
20. 00		0.00	0	0			20.00
21. 00		0.00	0	0	0		21.00
22. 00		0.00	0	0			22. 00
23.00		0.00	0	0	0		23. 00
24.00		0.00	0	0	0		24. 00
25.00		0.00	0	0	0		25. 00
26.00		0. 00	0	0	0		26. 00
27. 00		0. 00	0	0	0		27. 00
28. 00		0. 00	0	0	0		28. 00
29. 00		0.00	0	0	0		29. 00
30.00		0.00	0	0	0	l l	30.00
31.00		0.00	0	0	0	l control of the cont	31.00
32. 00			<u></u> <u>0</u> 245, 765	0	0	1	32. 00
500 00	Grand Total: Decreases		688, 338				500.00
555.00	10. aa. 10 tai . Deel eases	1	000, 000	20,000,270	ľ	I	1 000.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS WITHAM MEMORIAL HOSPITAL Provider CCN: 15-0104

| Period: | Worksheet A-7 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				Ic	12/31/2023	Date/lime Pre 5/30/2024 1:5	
				Acqui si ti ons		0,00,2021 110	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	2, 895, 261	0	0	0	0	1.00
2. 00	Land Improvements	3, 068, 610	57, 650	0	57, 650	0	2.00
3. 00	Buildings and Fixtures	133, 034, 143	2, 176, 495	0	2, 176, 495	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5. 00	Fixed Equipment	5, 170, 672	12, 509	0	12, 509	0	5.00
6.00	Movable Equipment	76, 496, 016	3, 724, 063	0	3, 724, 063	0	6.00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	220, 664, 702	5, 970, 717	0	5, 970, 717	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	,
10.00	Total (line 8 minus line 9)	220, 664, 702	5, 970, 717	0	5, 970, 717	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANALYSIS OF SUMMERS IN SARITAL ASSE	6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				
1.00	Land	2, 895, 261	0				1.00
2. 00	Land Improvements	3, 126, 260	0				2.00
3.00	Buildings and Fixtures	135, 210, 638	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	5, 183, 181	0				5.00
6. 00	Movable Equipment	80, 220, 079	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	226, 635, 419	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	226, 635, 419	0				10.00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0104	Peri od:	Worksheet A-7	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
			SI	JMMARY OF CAP	Ι ΤΔΙ	373072024 1.3	Z pili
			30	JIMINATOT OAT	TIAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
	•	'			(see	instructions)	
					instructions)		
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 905, 187	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, 905, 187	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4, 905, 187			ļ	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00

0 0

4, 905, 187

3.00

3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0104	Peri od: Worksheet A-		
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/30/2024 1:5	
	·	COMF	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPI				
				5 (
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see instructions)	Insurance	
			Leases	(col. 1 -	Thistructions)		
				col . 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FLXT	146, 415, 340	l .	146, 415, 34		0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	80, 220, 079	l .	80, 220, 07		0	2.00
3. 00	Total (sum of lines 1-2)	226, 635, 419		226, 635, 41		0	3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			.I	. 700 407		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0)	0 4, 728, 137	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0)	0 4, 160, 333		2.00
3. 00	Total (sum of lines 1-2)	0		NMARY OF CAPI	8, 888, 470	0	3. 00
			50	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
	·		(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				_		
1.00	NEW CAP REL COSTS-BLDG & FIXT	-130, 905		1	0	5, 022, 246	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	ı	1	0	4, 160, 333	2.00
3. 00	Total (sum of lines 1-2)	-130, 905	425, 014	·1	0	9, 182, 579	3. 00

In Lieu of Form CMS-2552-10 Health Financial Systems WITHAM MEMORIAL HOSPITAL ADJUSTMENTS TO EXPENSES Provider CCN: 15-0104 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt ONEW CAP REL COSTS-MVBLE 2.00 Investment income - NEW CAP 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) 6 00 Rental of provider space by 0 00 6 00 suppliers (chapter 8) 7.00 Tel ephone services (pay В -4, 066 ADMINISTRATIVE & GENERAL 5.00 7.00 stations excluded) (chapter 21) 8.00 Television and radio service 0 8.00 0.00 0 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 10.00 Provi der-based physi ci an A-8-2 -2, 875, 617 10.00 adjustment Sale of scrap, waste, etc. 11.00 0 0.00 11.00 (chapter 23) 12.00 Related organization A-8-1 0 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -345, 122 DI ETARY 14 00 В 10 00 14 00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 17.00 Sale of drugs to other than 0.00 pati ents 18.00 Sale of medical records and -1,553 MEDICAL RECORDS & LIBRARY 16.00 18.00 В abstracts 19.00 Nursing and allied health 19.00 0.00 0 0 education (tuition, fees, books, etc.) 20.00 Vending machines -1, 278 DI ETARY 10.00 20.00 21.00 Income from imposition of 0.00 21.00

Provider CCN: 15-0104

				Fr To	rom 01/01/2023 12/31/2023	Date/Time Pre	
				Expense Classification on	Worksheet A	5/30/2024 1:5	2 pm
				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32.00
33. 00	HOSPITAL ADMINISTRAT	Α	О	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	SPONSORSHI PS/DO BANK FEES	А	О	OPERATING ROOM	50. 00	0	33. 01
33. 02 33. 03	HEARING AID COSTS BANK FEES	A A		AUDI OLOGY ADMI NI STRATI VE & GENERAL	67. 01 5. 00	0	
33. 04	LOBBYING EXPENSE-IHA DUES	Ä	-5, 557	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
	COSTS					_	
33. 07 33. 08	SELF INSURANCE CLAIMS PAID HAF FEE	B A		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	12 0	1
33. 09	WIT EXTENDED CARE UNIT OTHER OPERATI	А	-3	SKILLED NURSING FACILITY	44. 00	0	33. 09
33. 10	WIT AMBULANCE EDUCATION REIMBURSEM	А	-8, 650	AMBULANCE SERVICES	95. 00	0	33. 10
33. 11	WIT AMBULANCE OTHER OPERATING REVE	В	-6, 208	AMBULANCE SERVICES	95. 00	0	33. 11
33. 12	WIT AMBULANCE INSURANCE CLAIM PROC	В	-1, 680	AMBULANCE SERVICES	95. 00	0	33. 12
33. 13	WIT DERMATOLOGY CLINIC RENTAL REVENU	А	-3, 407	DERMATOLOGY CLINIC	90. 03	0	33. 13
33. 14	WIT SURGERY CLINIC RENTAL REVENUE	А	-391	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 14
33. 15	WIT UROLOGY CLINIC RENTAL REVENUE	А	-21, 632	UROLOGY CLINIC	90. 07	0	33. 15
33. 16	WIT GASTROENTEROLOGY CLI RENTAL REVE	А	-7, 160	PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 16
33. 17	WIT DIALYSIS CENTER RENTAL REVENUE	А	-111, 931	WOUND CARE	90. 14	0	33. 17
33. 18	WIT EYE INSTITUTE RENTAL REVENUE	А	-6, 586	OPTHAMOLOGY CLINIC	90. 12	0	33. 18
33. 19	WIT RADIOLOGY LB PURCHASING REBATE	В	-4, 553	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 19
33. 20	WIT PHARMACY LB PURCHASING DISCOUNTS	В	-74, 391	PHARMACY	15. 00	0	33. 20
33. 21	WIT PHARMACY LB OTHER OPERATING REVE	А	-2, 588	PHARMACY	15. 00	0	33. 21
33. 22	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 22
33. 23	WIT EDUCATION COVID VACCINE	А	-47, 029	ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	WIT EDUCATION OTHER OPERATING REVE	А	-192	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 25
33. 26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 26
33. 27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	33. 27
33. 28	WIT DIETARY HOME DELIVERED MEALS	В	-21, 884	DI ETARY	10. 00	0	33. 28
33. 29	WIT DIETARY CICOA MEAL VOUCHERS	В	-2, 096	DI ETARY	10. 00	0	33. 29
33. 30	WIT DIETARY OTHER OPERATING REVE	В	-792	DI ETARY	10. 00	0	33. 30
33. 31	WIT PLANT OPERATIONS LB WATER FOUNTA	В	-171	OPERATION OF PLANT	7. 00	0	33. 31
33. 32	WIT PLANT OPERATIONS LB PURCHASING R	В	-866	OPERATION OF PLANT	7. 00	0	33. 32
33. 33	WIT PLANT OPERATIONS LB ELECTRIC CAR	А	-1, 115	OPERATION OF PLANT	7. 00	0	33. 33

Provider CCN: 15-0104 Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				To	12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		Expense Classification on Worksheet A					Z piii
		To/From Which the Amount is to be Adjusted					
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
33. 34	WIT PLANT OPERATIONS LB KEY REVENUE	В	-50	OPERATION OF PLANT	7. 00	0	33. 34
33. 35	WIT PLANT OPERATIONS LB OTHER	А	-18, 225	OPERATION OF PLANT	7. 00	0	33. 35
33. 36	OPERAT WIT PLANT OPERATIONS LB	В	-81, 365	OPERATION OF PLANT	7. 00	0	33. 36
33. 37	INSURANCE CL WIT FINANCE MATERIALS MG	В	-41, 859	ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38	PURCHASING WIT FINANCE MATERIALS MG	В		ADMINISTRATIVE & GENERAL	5. 00	0	
	PURCHASI NG						
33. 39	WIT FINANCE ACCOUNTING PURCHASING DI	В	-2, 817	ADMINISTRATIVE & GENERAL	5. 00	0	33. 39
33. 40	WIT FINANCE ACCOUNTING REVENUE SHARE	А	-22, 724	ADMINISTRATIVE & GENERAL	5. 00	0	33. 40
33. 41	WIT FINANCE HOSPITAL BIL	В	-285	ADMINISTRATIVE & GENERAL	5. 00	0	33. 41
33. 42	RETURNED CH WIT FINANCE HOSPITAL BIL CASH	В	189	ADMINISTRATIVE & GENERAL	5. 00	0	33. 42
33. 43	(SHORT OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 43
33. 44	(3)	В	72 021	ADMINISTRATIVE & GENERAL		0	
	WIT FINANCE INFORMATION FEDERAL FUND				5. 00		
33. 45	WIT ADMIN HOSPITAL LAND LEASE REVENU	В	-20, 484	ADMINISTRATIVE & GENERAL	5. 00	10	33. 45
33. 46	WIT ADMIN HOSPITAL MANAGEMENT FEE RE	В	-28, 947	ADMINISTRATIVE & GENERAL	5. 00	0	33. 46
33. 47	WIT ADMIN HOSPITAL OTHER	В	-975	ADMINISTRATIVE & GENERAL	5. 00	0	33. 47
33. 48	OPERATING R WIT ADMIN HOSPITAL INTEREST ON	В	-6, 000	ADMINISTRATIVE & GENERAL	5. 00	11	33. 48
33. 49	INVES WIT ADMIN-FINANCE CASH (SHORT)	В	-9	ADMINISTRATIVE & GENERAL	5. 00	0	33. 49
33. 50	OVER WIT ADMIN-FINANCE OTHER	В	-10, 158	ADMINISTRATIVE & GENERAL	5. 00	0	33. 50
33. 51	OPERATING RE WIT ADMIN-FINANCE UNRESTRICTED	В	-8 500	ADMINISTRATIVE & GENERAL	5. 00	0	33. 51
	CONTR					_	
33. 52	WIT HR EMPLOYEE BENEFITS EMPLOYEE DR	А		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	00.02
33. 53	WIT HR EMPLOYEE BENEFITS INTEREST ON	В	-961	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 53
33. 54	WIT HR WELLNESS PROGRAM OTHER OPERAT	В	-24, 817	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 54
33. 55	WIT INSURANCE REFUND-PCF	В	-15, 232	ADMINISTRATIVE & GENERAL	5. 00	0	33. 55
33. 56	WIT INSURANCE INSURANCE CLAIM	В	-500	ADMINISTRATIVE & GENERAL	5. 00	12	33. 56
33. 57	PROC VOL VOLUNTEERS VOLUNTEER MISC	В	-16, 109	ADMINISTRATIVE & GENERAL	5. 00	0	33. 57
33. 58	VOL VOLUNTEERS INTEREST ON	В	-65	ADMINISTRATIVE & GENERAL	5. 00	11	33. 58
33. 59	INVESTME BCH 2015 BOND INTEREST ON	А	-130, 730	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 59
33. 60	INVESTME BCH 2017 BOND INTEREST ON	В		FIXT NEW CAP REL COSTS-BLDG &	1. 00	11	33. 60
33. 61	INVESTME RECRUITING OFFSET-EH&W	А		FIXT EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 61
33. 62	RECRUITING OFFSET -A&G	А	-285	ADMINISTRATIVE & GENERAL	5. 00	0	33. 62
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-18, 443, 861				50.00
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽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.

Provider CCN: 15-0104

					'	10 12/31/202	5/30/2024 1:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		LABORATORY	271, 920	271, 920	0	C	0	1.00
2.00		EMERGENCY	2, 602, 200	2, 602, 200	0	C	0	2.00
3.00	95. 00	AMBULANCE SERVICES	1, 497	1, 497	0	C	o	3.00
4.00	0.00		0	0	0	C	o	4.00
5.00	0.00		0	0	0	C	o	5. 00
6.00	0.00		0	0	0	C	o	6.00
7.00	0.00		0	0	0	C	ol ol	7. 00
8.00	0.00		0	0	0	C	ol ol	8. 00
9.00	0. 00		0	0	0	C	ol ol	9. 00
10.00	0.00		0	0	0	C	ol ol	10.00
200.00			2, 875, 617	2, 875, 617	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		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		LABORATORY	0	0	0	C		
2.00		EMERGENCY	0	_	0	C	0	
3. 00		AMBULANCE SERVICES	0	0	0	C	0	
4. 00	0. 00		0	0	0	C	0	4. 00
5. 00	0. 00		0	0	0	C	0	5. 00
6. 00	0.00		0	0	0	C	0	6. 00
7. 00	0.00		0	0	0	C	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	
200.00	MI - 1 A 1	01.01(Dl	0	0	RCE	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE		Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	+	
1. 00		LABORATORY	13.00	0	17.00	271, 920		1.00
2. 00		EMERGENCY			0	1		2.00
3. 00		AMBULANCE SERVICES		0	0	1, 497		3.00
4. 00	0.00	4		0	0	1, 7,	,	4.00
5. 00	0.00		0	o o	0	Ĭ	,	5. 00
6. 00	0.00			0	0	Ì	,	6.00
7. 00	0.00		0	ő	0	Ĭ	,	7. 00
8. 00	0.00		0	o o	0	Ĭ	,	8.00
9. 00	0.00		0	_	0	٦	,	9.00
10. 00	0.00		1 0	ő	0	٦	,	10.00
200.00	0.00				0	2, 875, 617	,	200.00
200.00	ı	ı	1	1	1	2,0,0,017	1 1	

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

			10	12/31/2023	Date/lime Pre 5/30/2024 1:5		
			CAPI TAL REI	LATED COSTS		070072021 1.0	Pin Pin
			NEW DI DO A	150 100 5	545L0\((55		
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		Allocation	FIAI	EQUIP	DEPARTMENT		
		(from Wkst A			DELYKTIMENT		
		col. 7)					
	I	0	1. 00	2. 00	4. 00	4A	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	5, 022, 246	5, 022, 246				1.00
2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT	4, 160, 333	5, 022, 240	4, 160, 333			2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 745, 687	29, 560		12, 799, 734		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	18, 666, 617	388, 317		1, 437, 695	20, 814, 303	1
7. 00	00700 OPERATION OF PLANT	4, 707, 545	322, 488	267, 143	130, 638	5, 427, 814	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	593, 680	0		7, 640	601, 320	1
9.00	00900 HOUSEKEEPI NG	1, 076, 679	46, 365		96, 311	1, 257, 763	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 313, 079 801, 080	103, 784 0	1	69, 323 77, 776	1, 572, 158 878, 856	1
13. 00	01300 NURSING ADMINISTRATION	662, 450	0		88, 109	750, 559	1
15. 00	01500 PHARMACY	1, 291, 946	32, 039	· -	120, 487	1, 471, 012	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 746, 307	50, 611	41, 925	191, 834	2, 030, 677	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 547, 972	336, 632 92, 449		704, 510	6, 867, 973	
31. 00 40. 00	04000 SUBPROVI DER – I PF	1, 843, 580 1, 395, 465	92, 449 105, 849		268, 506 223, 190	2, 281, 118 1, 812, 187	
41. 00	04100 SUBPROVI DER - I RF	1, 373, 403	103, 047	07,003	223, 170	1, 012, 107	1
42. 00	04200 SUBPROVI DER	o	0	Ö	o	0	1
43.00	04300 NURSERY	o	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	1, 522, 663	80, 155	66, 399	190, 752	1, 859, 969	44. 00
E0.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4 110 450	250, 071	207 447	402 150	F 170 107	FO 00
50. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 119, 459 4, 460, 675	359, 071 328, 585		403, 150 307, 406	5, 179, 127 5, 368, 859	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0 320, 303		0	0, 300, 037	1
55. 01	05501 ULTRA SOUND	1, 165, 253	0	0	97, 093	1, 262, 346	1
57.00	05700 CT SCAN	786, 328	0	0	59, 637	845, 965	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	620, 512	28, 189		57, 840	729, 892	1
59.00	05900 CARDI AC CATHETERI ZATI ON	228, 091	23, 761		59, 130	330, 665	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	7, 314, 583 83, 130	165, 912 0	137, 438	546, 280 0	8, 164, 213 83, 130	1
64. 00	06400 I NTRAVENOUS THERAPY	03, 130	0	0	0	03, 130	1
66. 00	06600 PHYSI CAL THERAPY	1, 861, 747	148, 314	122, 861	252, 122	2, 385, 044	1
67. 00	06700 OCCUPATI ONAL THERAPY	494, 441	0	0	64, 978	559, 419	1
67. 01	06701 AUDI OLOGY	165, 693	14, 755		40, 135	232, 806	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	196, 707	0	0	31, 799	228, 506 0	68. 00 69. 00
69. 01	06901 CARDI OLOGY	2, 097, 901	15, 284	12, 661	292, 727	2, 418, 573	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 302, 870	0	0	0	3, 302, 870	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 535, 240	0	0	0	4, 535, 240	
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 705, 939	0	0	0	11, 705, 939	1
	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	1
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	l o	υĮ	0	76.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	
90. 02	09002 CLINIC	0	0	0	0	0	
90. 03 90. 04	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	0	0	0	0	
90.04	09005 SURGERY CLINIC	0	0	0	0	0	
90. 07	09007 UROLOGY CLINIC	31, 769	0	Ö	9, 357	41, 126	1
90. 09	09009 GASTROENTEROLOGY CLINIC	o	0	0	0	0	1
90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0	0	0	90. 12
90. 13	09013 ALLERGY CLINIC	110, 094	14, 755		11, 647	148, 719	
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	327, 883 5, 076, 902	124, 587 405, 915		47, 173 552, 391	602, 848 6, 371, 460	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,070,702	403, 713	330, 232	332, 371	0, 371, 400	1
	OTHER REIMBURSABLE COST CENTERS				, 		
	09500 AMBULANCE SERVI CES	2, 938, 784	78, 652		440, 440	3, 523, 029	1
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00		114, 721, 330	3, 296, 029	2, 730, 363	6, 880, 076	105, 645, 485	118.00
	NONREI MBURSABLE COST CENTERS	, , 2 1 , 000	5,2,0,027		3, 555, 576]
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10, 311		0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	44, 514, 874	1, 508, 521		5, 864, 777	53, 137, 807	
	007950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	27, 493	0 23, 397		0 701	70, 973	194. 00 194. 01
	207952 OTHER NONREI MB	44, 089	177, 379		0	368, 405	
	· · · ·		· · · · · · · · · · · · · · · · · · ·				

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023		
		CAPI TAL REI	_ATED 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	
194.03 07953 RETAIL PHARMACY	2, 984, 595	6, 609	5, 47	54, 180	3, 050, 859	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	162, 292, 381	5, 022, 246	4, 160, 33	3 12, 799, 734	162, 292, 381	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0104

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/30/2024 1:52 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & 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 & FIXT 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 20, 814, 303 5.00 6, 226, 354 7.00 00700 OPERATION OF PLANT 798, 540 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 88, 466 689, 786 8.00 00900 HOUSEKEEPI NG 185, 042 1, 510, 225 9 00 9 00 67 420 0 10.00 01000 DI ETARY 231, 296 150, 914 0 100, 777 2, 055, 145 10.00 01100 CAFETERI A 129, 297 11.00 0 33,600 11.00 13.00 01300 NURSING ADMINISTRATION 110, 422 C 0 15. 193 0 13.00 01500 PHARMACY 46, 588 0 30, 678 15.00 216, 415 0 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 298, 753 73, 595 67, 200 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 010, 416 489, 502 38, 102 510, 499 873, 734 30.00 03100 INTENSIVE CARE UNIT 335, 598 135, 569 31.00 134, 431 7.843 269, 884 31.00 04000 SUBPROVIDER - IPF 40.00 266, 609 153, 917 4,613 161, 210 312, 195 40.00 04100 SUBPROVI DER - I RF 41.00 0 0 41.00 04200 SUBPROVI DER 42.00 0 0 42.00 0 0 0 04300 NURSERY 43.00 Λ \cap 0 Λ 43.00 04400 SKILLED NURSING FACILITY 599, 332 44.00 44.00 273, 639 116, 555 4, 124 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 761, 953 90. 149 50.00 522, 130 30.094 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 789, 867 477, 801 54, 563 136, 153 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05501 ULTRA SOUND 185, 716 8.765 55.01 13, 125 0 55.01 57.00 05700 CT SCAN 124, 458 86, 614 13, 440 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 107, 382 40, 990 18, 499 58.00 12,856 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 48, 647 34, 551 25, 502 59.00 0 94, 699 60.00 06000 LABORATORY 1, 201, 119 241, 255 57.558 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 12, 230 1, 238 0 63.00 0 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06600 PHYSI CAL THERAPY 350, 888 215, 666 12, 388 20, 744 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 9, 934 67.00 82, 302 3,660 0 67.00 67.01 06701 AUDI OLOGY 34, 250 21, 456 1, 357 7, 304 0 67.01 06800 SPEECH PATHOLOGY 68.00 33, 618 1,554 4, 383 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 06901 CARDI OLOGY 69.01 355, 820 22, 225 38, 772 44, 118 0 69.01 485, 918 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16,802 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 667, 225 0 17,007 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 1, 722, 178 0 76, 104 Ω 73 00 31.847 77.00 07700 ALLOGENEIC HSCT ACQUISITION C 0 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLINIC 0 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 C 0 0 0 90.01 90.02 09002 CLI NI C 0 0 0 0 90.02 09003 DERMATOLOGY CLINIC 0 0 90.03 90.03 0 0 0 09004 ENT CLINIC 0 0 90 04 90 04 0 0 0 90.05 09005 SURGERY CLINIC 0 C 0 0 90.05 09007 UROLOGY CLINIC o 90.07 90.07 6.050 0 172 0 0 09009 GASTROENTEROLOGY CLINIC 90 09 90 09 C 0 0 0 90.11 09011 NEUROLOGY CLINIC 0 C 0 0 0 90.11 09012 OPTHAMOLOGY CLINIC 0 90.12 90.12 09013 ALLERGY CLINIC 21, 880 0 90.13 90.13 21, 456 612 0 9, 401 90.14 90 14 09014 WOUND CARE 88.691 181, 163 0 0 91.00 09100 EMERGENCY 937, 369 590, 247 66, 752 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 518.308 114, 368 6.134 0 Ω 95.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 12, 480, 362 3, 716, 230 689, 786 1, 431, 922 2, 055, 145 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190.00 2,774 14, 993 192.00 19200 PHYSICIANS' PRIVATE OFFICES 7, 817, 683 2, 193, 568 0 78, 303 0 192.00 194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 194, 00 0 0 194. 01 07951 CAFE/BOUTI QUE 10, 442 34,022 0 0 194, 01 194. 02 07952 OTHER NONREI MB 0 0 194. 02 54, 200 257, 930 0 194. 03 07953 RETAIL PHARMACY 448.842 9.611 0 0 0 194.03 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers C 0 201.00 202.00 TOTAL (sum lines 118 through 201) 20, 814, 303 6, 226, 354 689, 786 1, 510, 225 2, 055, 145 202. 00

Provider CCN: 15-0104

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:
5/30/2024 1:52 pm

COST Center Description
11.00
SENERAL SERVICE COST CENTERS
GENERAL SERVICE COST CENTERS 1.00 2.00 2.00 00200 NEW CAP REL COSTS-BUD & FIXT 5.00 00500 DAMIN STRATIVE & GENERAL 5.00 00500 DAMIN STRATIVE & GENERAL 7.00 00700 OPEDATION OF PLANT 8.00 00900 LAUMRY & LINEN SERVICE 9.00 10.00
1.00
4.00 00400 EMPLOYEE BENETITS DEPARTMENT 4.00 0000 ADMIN ISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00700 OPERATION OPE
5.00 OSGOO ADMIN STRATIVE & GENERAL
7. 00 00700 00PERATI ON OF PLANT
8. 00 OGBOO LAUNDRY & LINEN SERVICE
9.00 00900 HOUSEKEEPING
10.00
11.00
13. 00 01300 NURSI NG ADMIN ISTRATION 20, 156 896, 330 1, 805, 005 13. 00 15.
15. 00 01500 PHARMACY 01500 MEDI CAL RECORDS & LI BRARY 81,685 0 0 0 2,551,910 16. 00 01500 MEDI CAL RECORDS & LI BRARY 81,685 0 0 0 2,551,910 16. 00 01500 MEDI CAL RECORDS & LI BRARY 81,685 0 0 0 2,551,910 16. 00 01500 MEDI CAL RECORDS & LI BRARY 81,685 0 0 0 0 0 0 0 0 0
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRICS 274,760 176,697 136 627,111 10,868,930 30.00 31.00 03100 INTENSI VE CARE UNIT 22,278 72,009 42 130,390 3,389,162 31.00 04000 SUBPROVI DER - I PF 35,008 58,339 22 155,226 2,959,326 40.00 41.00 04000 SUBPROVI DER - I RF 0 0 0 0 0 0 0 42.00 42.00 04200 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0
31.00 03100 NTENSI VE CARE UNI T 22, 278 72,009 42 130,390 3,389,162 40.00 40.00 00 00 00 00 0
40. 00 04000 SUBPROVI DER - I PF
41. 00 04100 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 41. 00 0 0 0 0 0 0 0 0 0
42. 00 04200 SUBPROVI DER 0 0 0 0 0 0 0 0 42. 04. 04. 00 04. 00 0 0 0 0 0 0 0 0 0 0
44.00 04400 SKILLED NURSING FACILITY 0 69,594 26 0 2,923,239 44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI ING ROOM 24, 400 125, 776 2, 554 225, 077 6, 961, 260 50. 0 50. 0 0 0 0 0 0 0 0 0 0
50. 00 O5000 OFERATI NG ROOM 24, 400 125, 776 2, 554 225, 077 6, 961, 260 50. 0 54. 00 OS500 RADI OLOGY-DI AGNOSTI C 29, 704 15, 288 903 602, 276 7, 475, 414 54. 0 55. 00 OS500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 0 0 0 0 0 55. 0 0 55. 0 0 0 0 0 0 0 55. 0 0 55. 0 0 0 0 0 0 55. 0 0 55. 0 0 0 0 0 0 55. 0 0 0 0 0 0 0 55. 0 0 <td< td=""></td<>
54. 00 05400 RADI OLOGY-DI AGNOSTI C 29, 704 15, 288 903 602, 276 7, 475, 414 54. 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 0 55. 01 05501 ULTRA SOUND 3, 183 0 282 65, 195 1, 538, 612 55. 0 57. 00 05700 CT SCAN 4, 243 0 19, 220 74, 508 1, 168, 448 57. 0 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 10, 608 0 9, 808 40, 359 970, 394 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 18, 922 1, 633 0 459, 920 59. 0 60. 00 06000 LABORATORY 86, 990 0 1 62, 090 9, 907, 925 60. 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 67. 0 66. 0
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 55. 0 0 55. 0 0 0 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 55. 0 0 0 282 65, 195 1, 538, 612 55. 0 55. 0 0 19, 220 74, 508 1, 168, 448 57. 0 0 19, 220 74, 508 1, 168, 448 57. 0 0 19, 220 74, 508 1, 168, 448 57. 0 0 9, 808 40, 359 970, 394 58. 0 59. 0 0 0 459, 920 59. 0 0 459, 920 59. 0 0 459, 920 59. 0 0 0 459, 920 59. 0 0 0 459, 920 59. 0 0 0 0 0 0 0 0 0 0 0 0 0 0
55. 01 05501 ULTRA SOUND 3, 183 0 282 65, 195 1, 538, 612 55. 0 57. 00 05700 CT SCAN 4, 243 0 19, 220 74, 508 1, 168, 448 57. 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 10, 608 0 9, 808 40, 359 970, 394 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 18, 922 1, 633 0 459, 920 59. 0 60. 00 06000 LABORATORY 86, 990 0 1 62, 090 9, 907, 925 60. 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 96, 598 63. 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 96, 598 63. 0 67. 00 06700 OCCUPATI ONAL THERAPY 43, 495 62, 997 200 121, 076 3, 212, 498 66. 0 67. 01 06701 <td< td=""></td<>
57. 00 05700 CT SCAN 4, 243 0 19, 220 74, 508 1, 168, 448 57. 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 10, 608 0 9, 808 40, 359 970, 394 58. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 18, 922 1, 633 0 459, 920 59. 0 60. 00 06000 LABORATORY 86, 990 0 1 62, 090 9, 907, 925 60. 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 96, 598 63. 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 0 66. 00 06600 PHYSI CAL THERAPY 43, 495 62, 997 200 121, 076 3, 212, 498 66. 0 67. 01 06701 AUDI OLOGY 19, 095 14, 255 0 0 0 297, 178 68. 0 68. 00 06900
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 18, 922 1, 633 0 459, 920 59. 0 60. 00 06000 LABORATORY 86, 990 0 1 62, 090 9, 907, 925 60. 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 96, 598 63. 0 64. 00 06400 I NTRAVENOUS THERAPY 0 <t< td=""></t<>
60. 00 06000 LABORATORY 86, 990 0 1 62, 090 9, 907, 925 60. 00 63. 00 06400 STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 96, 598 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 64. 00 06600 PHYSI CAL THERAPY 43, 495 62, 997 200 121, 076 3, 212, 498 66. 00 06700 0CCUPATI ONAL THERAPY 18, 034 21, 241 0 52, 777 747, 367 67. 00 06701 AUDI OLOGY 19, 095 14, 255 0 0 330, 523 67. 00 06800 SPEECH PATHOLOGY 20, 156 8, 961 0 0 297, 178 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 06.
66. 00 06600 PHYSI CAL THERAPY 43, 495 62, 997 200 121, 076 3, 212, 498 66. 07 67. 00 06700 0CCUPATI ONAL THERAPY 18, 034 21, 241 0 52, 777 747, 367 67. 07 67. 01 06701 AUDI OLOGY 19, 095 14, 255 0 0 0 330, 523 67. 07 68. 00 06800 SPEECH PATHOLOGY 20, 156 8, 961 0 0 0 297, 178 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0
67. 00 06700 0CCUPATI ONAL THERAPY 18, 034 21, 241 0 52, 777 747, 367 67. 07. 07. 07. 07. 07. 07. 07. 07. 07. 0
68. 00 06800 SPEECH PATHOLOGY 20, 156 8, 961 0 0 297, 178 68. 00 69. 00 0 0 0 0 0 69. 00 69. 00 0 0 0 0 69. 00 6
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00
69. 01 06901 CARDI OLOGY 43, 495 84, 903 2, 853 116, 419 3, 127, 178 69. 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 22, 278 0 0 0 3, 827, 868 71. 072. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 22, 278 0 0 0 3,827,868 71. 072. 00 07200 MPL. DEV. CHARGED TO PATIENT 0 0 0 0 5, 219, 472 72. 073. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 1,174,874 0 14,710,942 73. 074. 075. 075. 075. 075. 075. 075. 075. 075
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 5,219,472 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1,174,874 0 14,710,942 73.00 77.00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 77.00 77
73.00 07300 DRUGS CHARGED TO PATIENTS 0 1,174,874 0 14,710,942 73.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 0 77.00 0 0 0 0 0 0 0 0 0
77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.0
78. 00 <u>07800 CAR T-CELL I I MMUNOTHERAPY</u> 0 0 0 78. 0
OUTPATIENT SERVICE COST CENTERS
90.00 09000 CLINIC
90. 01 09001 01REK 001 PATTENT SERVICE COST CENTER 0 0 0 0 90. 0
90. 03 09003 DERMATOLOGY CLINIC 0 0 0 0 90. 0
90.04 09004 ENT CLINIC 0 0 0 0 0 0 90.0
90. 05 09005 SURGERY CLINIC 0 0 0 0 90. C
90. 07 09007 UROLOGY CLINI C 0 0 47, 348 90. C
90. 09 09009 GASTROENTEROLOGY CLINI C
90. 11 09011 NEUROLOGY CLI NI C
90. 13 09013 ALLERGY CLINIC 0 3, 086 38 0 195, 791 90. 1
90. 14 09014 WOUND CARE 0 18,608 1,266 0 901,977 90. 1
91. 00 09100 EMERGENCY 67, 894 107, 288 9, 435 0 8, 150, 445 91. 0
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 0
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 137, 910 0 1,590 0 4,301,339 95. 0
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 0
SPECIAL PURPOSE COST CENTERS
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,005,684 857,964 1,224,883 2,272,504 93,789,154 118.0
NONREI MBURSABLE COST CENTERS
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 36, 619 190. 0
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 36, 069 38, 366 331, 890 279, 406 63, 913, 092 192. 00 194. 00 0 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 0 194. 00 0 0 0 194. 00 0 0 0 194. 00 0 0 0 0 194. 00 0 0 0 0 194. 00 0 0 0 0 194. 00 0 0 0 0 194. 00 0 0 0 0 194. 00 0 0 0 0 0 194. 00 0 0 0 0 0 194. 00 0 0 0 0 0 194. 00 0 0 0 0 0 194. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
194. 00 07950 THORNTOWN OFFICE BUILDING 0 0 0 0 194. 0 194. 01 07951 CAFE/BOUTI QUE 0 0 0 0 115, 437 194. 0
194. 02 07952 OTHER NONREI MB 0 0 0 680, 535 194. 0
194. 03 07953 RETAIL PHARMACY 0 0 248, 232 0 3, 757, 544 194. 0
200.00 Cross Foot Adjustments 0 200.00
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118 through 201) 1,041,753 896,330 1,805,005 2,551,910 162,292,381 202.00

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0104 Period: Worksheet B

Provider CCN: 15-0104 Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 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 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 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, 868, 930 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 3, 389, 162 31.00 04000 SUBPROVI DER - I PF 40.00 40 00 2, 959, 326 41.00 04100 SUBPROVI DER - I RF Ω 41.00 04200 SUBPROVI DER 0 42.00 0 42.00 0 04300 NURSERY 43.00 43.00 0 04400 SKILLED NURSING FACILITY 44.00 2, 923, 239 44.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 6, 961, 260 50.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 7, 475, 414 54 00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 55.01 05501 ULTRA SOUND 1, 538, 612 55.01 57.00 05700 CT SCAN 000000000000000 1, 168, 448 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 970 394 58 00 59.00 05900 CARDIAC CATHETERIZATION 459, 920 59.00 06000 LABORATORY 9, 907, 925 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 96, 598 63.00 64.00 06400 I NTRAVENOUS THERAPY 64 00 66.00 06600 PHYSI CAL THERAPY 3, 212, 498 66.00 06700 OCCUPATI ONAL THERAPY 747, 367 67.00 67.00 67.01 06701 AUDI OLOGY 330, 523 67.01 06800 SPEECH PATHOLOGY 68.00 297, 178 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 69.01 06901 CARDI OLOGY 3, 127, 178 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 827, 868 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 5, 219, 472 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 14, 710, 942 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90.00 09001 OTHER OUTPATIENT SERVICE COST CENTER 90.01 0000000000 90.01 0 90 02 09002 CLI NI C 0 90 02 90.03 09003 DERMATOLOGY CLINIC 90.03 0 09004 ENT CLINIC 90.04 0 90.04 09005 SURGERY CLINIC 90.05 90.05 90.07 09007 UROLOGY CLINIC 47, 348 90.07 90.09 09009 GASTROENTEROLOGY CLINIC 0 90.09 09011 NEUROLOGY CLINIC 90.11 90.11 0 09012 OPTHAMOLOGY CLINIC 90.12 90.12 90.13 09013 ALLERGY CLINIC 195, 791 90.13 09014 WOUND CARE 0 90.14 901, 977 90.14 0 09100 EMERGENCY 91.00 8, 150, 445 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 4, 301, 339 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 102 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 93, 789, 154 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190 00 0 36, 619 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 63, 913, 092 192.00 194.00 07950 THORNTOWN OFFICE BUILDING 0 0 C 194.00 194. 01 07951 CAFE/BOUTI QUE 115, 437 194. 01 194. 02 07952 OTHER NONREI MB 680, 535 194.02 194. 03 07953 RETAIL PHARMACY 3, 757, 544 194.03 200.00 Cross Foot Adjustments 200.00

Health Financial Systems	WITHAM MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/30/2024 1:5	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26. 00				
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	162, 292, 381				202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

				10	12/31/2023	5/30/2024 1:5	
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	Di rectly	NEW BLDG &	NEW MVBLE	Subtotal	EMPLOYEE	
		Assigned New Capital	FLXT	EQUI P		BENEFITS DEPARTMENT	
		Related Costs				DELAKTIMENT	
		0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS						
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	0	29, 560	24, 487	54, 047	54, 047	2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	388, 317		709, 991	6, 070	5.00
7. 00	00700 OPERATION OF PLANT	Ö	322, 488		589, 631	552	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	o	0		0	32	8. 00
9. 00	00900 HOUSEKEEPI NG	o	46, 365		84, 773	407	9. 00
10.00	01000 DI ETARY	0	103, 784	85, 972	189, 756	293	10.00
11. 00 13. 00	1 1	0	0	0	0	328 372	11. 00 13. 00
15. 00	1 1	0	32, 039	1 1	58, 579	509	15. 00
16. 00	1 1	Ö	50, 611	41, 925	92, 536	810	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	1 1	0	336, 632		615, 491	2, 975	30.00
31. 00 40. 00	03100 INTENSI VE CARE UNI T 04000 SUBPROVI DER - PF	0	92, 449 105, 849		169, 032 193, 532	1, 134 942	31. 00 40. 00
41. 00		o	103, 049	07,003	173, 332	0	41. 00
42. 00	04200 SUBPROVI DER	Ö	0	0	Ö	0	42.00
43.00		o	0	0	0	0	43.00
44. 00		0	80, 155	66, 399	146, 554	805	44. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	ol	359, 071	297, 447	656, 518	1, 702	50. 00
54. 00	1 1	0	328, 585		600, 778	1, 298	54.00
55.00		o	0	0	0	0	55.00
55. 01	05501 ULTRA SOUND	0	0	0	0	410	55. 01
57.00	1 1	0	0	0	0	252	57.00
58. 00 59. 00	` '	0	28, 189 23, 761		51, 540 43, 444	244 250	58. 00 59. 00
60.00	06000 LABORATORY	Ö	165, 912		303, 350	2, 307	60.00
63.00	1 1	o	0		0	0	63.00
64. 00		0	0		0	0	64.00
66.00	06600 PHYSI CAL THERAPY	0	148, 314	122, 861	271, 175	1, 065	66.00
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	0	14, 755	12, 223	26, 978	274 169	67. 00 67. 01
68. 00	1 1	o	0	0	20, 770	134	68. 00
69. 00	06900 ELECTROCARDI OLOGY	О	0	0	0	0	69. 00
69. 01	06901 CARDI OLOGY	0	15, 284	12, 661	27, 945	1, 236	
71. 00 72. 00		0	0	0	0	0	71. 00 72. 00
73.00	1 1	0	0	0	0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	Ö	0	0	Ö	0	77. 00
78. 00		0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	ol	0		ما	0	00.00
90.00	09000 CETNIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	90. 00 90. 01
90. 02		o	0		o	0	90. 02
90. 03		o	0	0	0	0	90. 03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90. 05 90. 07	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0	0	0	0 40	90. 05 90. 07
90.07		0	0	0	0	0	90.07
90. 11	09011 NEUROLOGY CLINIC	Ö	0	0	Ö	0	90. 11
90. 12	1 1	0	0	0	0	0	90. 12
90. 13		0	14, 755		26, 978	49	90. 13
90. 14 91. 00		0	124, 587 405, 915		227, 792 742, 167	199 2, 332	90. 14 91. 00
91.00	1 1	U	405, 915	330, 252	742, 167	2, 332	91.00
	OTHER REIMBURSABLE COST CENTERS				-		
	1 1	0	78, 652		143, 805		95.00
102.00	0 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118. 00		ol	3, 296, 029	2, 730, 363	6, 026, 392	29, 050	118. 00
	NONREI MBURSABLE COST CENTERS	-1	372:3732:	_, ,	3, 323, 312	2.7,000	
	0 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10, 311		18, 852		190.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 THORNTOWN OFFICE BUILDING	0	1, 508, 521 0		2, 758, 156	24, 765	192. 00 194. 00
	107950 THORNTOWN OFFICE BUILDING	0	23, 397		42, 779		194. 00 194. 01
194. 02	2 07952 OTHER NONREI MB	Ö	177, 379		324, 316	0	194. 02
194. 03	3 07953 RETAIL PHARMACY	o	6, 609	5, 475	12, 084	229	194. 03

Health Financial Systems	WITHAM MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od: From 01/01/2023	Worksheet B Part II		
				To 12/31/2023		pared:	
		CAPI TAL REI	ATED COSTS		5/30/2024 1: 5	2 piii	
Cost Center Description	Directly Assigned New	NEW BLDG & FLXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS		
	Capi tal Related Costs				DEPARTMENT		
	0	1. 00	2.00	2A	4. 00		
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	5, 022, 246	4, 160, 33	3 9, 182, 579	54, 047	202. 00	

Provider CCN: 15-0104

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm

					0 12/31/2023	5/30/2024 1:5	
Cost Center Des	scription	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST	CENTERS	3.00	7.00	0.00	7.00	10.00	
1. 00 00100 NEW CAP REL COS							1.00
2.00 00200 NEW CAP REL COS							2.00
4.00 00400 EMPLOYEE BENEFI							4.00
5. 00 00500 ADMI NI STRATI VE		716, 061	/47 /50				5.00
7. 00 00700 OPERATION OF PL		27, 470	617, 653				7. 00 8. 00
8. 00 00800 LAUNDRY & LI NEN 9. 00 00900 HOUSEKEEPI NG	N SERVICE	3, 043 6, 366	6, 688	3, 075 0	98, 234		9.00
10. 00 01000 DI ETARY		7, 957	14, 971	0	6, 555	219, 532	10.00
11. 00 01100 CAFETERI A		4, 448	0	1	2, 186	0	11.00
13.00 01300 NURSING ADMINIS	STRATION	3, 799	0	0	988	0	13.00
15.00 01500 PHARMACY		7, 445	4, 622	0	1, 995	0	15.00
16. 00 01600 MEDI CAL RECORDS		10, 277	7, 301	0	4, 371	0	16. 00
30.00 O3000 ADULTS & PEDIAT		24.750	40 EE0	170	22 200	02 222	20.00
30. 00 03000 ADULTS & PEDI AT 31. 00 03100 I NTENSI VE CARE		34, 759 11, 545	48, 558 13, 336	1	33, 208 8, 818	93, 333 28, 829	30. 00 31. 00
40. 00 04000 SUBPROVI DER - I		9, 171	15, 269	1	10, 486	33, 349	40.00
41. 00 04100 SUBPROVI DER - I		0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER		О	0	0	0	0	42. 00
43. 00 04300 NURSERY		0	0	0	0	0	43.00
44. 00 04400 SKI LLED NURSI NO		9, 413	11, 562	19	0	64, 021	44.00
50.00 OFERATING ROOM	SI CENIERS	27 212	F4 70F	421	1 057	0	F0 00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGN	JOSTI C	26, 212 27, 172	51, 795 47, 398		1, 957 8, 856	0	50. 00 54. 00
55. 00 05500 RADI OLOGY-THERA		27, 172	47, 370	0	0, 030	0	55.00
55. 01 05501 ULTRA SOUND	2011 0	6, 389	0	61	570	0	55. 01
57.00 05700 CT SCAN		4, 281	0	404	874	0	57.00
58.00 05800 MAGNETIC RESONA	ANCE IMAGING (MRI)	3, 694	4, 066		836	0	58. 00
59. 00 05900 CARDI AC CATHETE	ERI ZATI ON	1, 673	3, 427			0	59. 00
60. 00 06000 LABORATORY		41, 319	23, 932		3, 744	0	60.00
63. 00 06300 BLOOD STORING,		421	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THE 66. 00 06600 PHYSI CAL THERAF		0 12, 071	21, 394	0 58	1, 349	0	64. 00 66. 00
67. 00 06700 OCCUPATI ONAL TH		2, 831	21, 374	17	646	0	67.00
67. 01 06701 AUDI OLOGY	12.00	1, 178	2, 128	1	475	0	67. 01
68.00 06800 SPEECH PATHOLOG	GY	1, 156	0	i .	285	0	68.00
69. 00 06900 ELECTROCARDI OLO	OGY	0	0	0	0	0	69. 00
69. 01 06901 CARDI OLOGY		12, 240	2, 205	1	2, 870	0	69. 01
	ES CHARGED TO PATIENTS	16, 716	0	78	0	0	71.00
72. 00 07200 I MPL. DEV. CHAR 73. 00 07300 DRUGS CHARGED 1		22, 953	0	79	2 072	0	72. 00 73. 00
77. 00 07700 ALLOGENEI C HSC1		59, 244 0	0	355 0	2, 072 0	0	77.00
78. 00 07800 CAR T-CELL IMMU		Ö	0		0	0	78.00
OUTPATIENT SERVICE CO		- 1					
90. 00 09000 CLINIC		0	0	0	0	0	90. 00
	NT SERVICE COST CENTER	0	0	0	0	0	90. 01
90. 02 09002 CLI NI C	NI C	0	0	0	0	0	90. 02
90. 03 09003 DERMATOLOGY CLI 90. 04 09004 ENT CLINIC	NIC	0	0	0	0	0	90. 03 90. 04
90. 05 09005 SURGERY CLINIC		0	0	0	0	0	90.04
90. 07 09007 UROLOGY CLINIC		208	0	1	0	0	90. 07
90. 09 09009 GASTROENTEROLOG	GY CLINIC	0	0	0	0	0	90.09
90. 11 09011 NEUROLOGY CLINI		0	0	0	0	0	90. 11
90. 12 09012 OPTHAMOLOGY CLI	NIC	0	0	0	0	0	90. 12
90. 13 09013 ALLERGY CLINIC	•	753	2, 128		0	0	90. 13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY		3, 051 32, 246	17, 971 58, 552	1	0	0	90. 14 91. 00
	OS (NON-DISTINCT PART)	32, 240	56, 552	312	o _l	U	92.00
OTHER REIMBURSABLE CO							
95.00 09500 AMBULANCE SERVI		17, 830	11, 345	29		0	95. 00
102. 00 10200 OPI OI D TREATMEN		0	0	0	0	0	102. 00
SPECIAL PURPOSE COST 118.00 SUBTOTALS (SUM	OF LINES 1 through 117)	429, 331	368, 648	3, 075	93, 141	219, 532	110 00
NONREI MBURSABLE COST	CENTERS CENTERS	429, 331	300, 040	3,073	93, 141	219, 332	110.00
190. 00 19000 GIFT, FLOWER, (95	1, 487	0	0	0	190. 00
192.00 19200 PHYSI CI ANS' PRI	VATE OFFICES	268, 972	217, 603	1	5, 093	0	192. 00
194.00 07950 THORNTOWN OFFIC	CE BUILDING	o	0	0	0		194. 00
194. 01 07951 CAFE/BOUTI QUE		359	3, 375	1	0		194. 01
194. 02 07952 OTHER NONRELIMB	,	1, 864 15, 440	25, 587		0		194. 02
194.03 07953 RETAIL PHARMACY 200.00 Cross Foot Adju		15, 440	953	1	٩	0	194. 03 200. 00
201.00 Negative Cost (n	n	n	n	Λ	200.00
	es 118 through 201)	716, 061	617, 653	3, 075	98, 234	219, 532	
		'			•		

Provider CCN: 15-0104

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm

		04557501.4	AUUDOLNIO	10		5/30/2024 1: 5	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	PHARMACY	MEDICAL RECORDS &	Subtotal	
		44.00	N	15.00	LI BRARY	24.00	
	GENERAL SERVICE COST CENTERS	11. 00	13. 00	15. 00	16. 00	24. 00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A	6, 962					11.00
13.00	01300 NURSING ADMINISTRATION	135	5, 294				13.00
	01500 PHARMACY	269	0	- /	115 041		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	546	0	0	115, 841		16. 00
	03000 ADULTS & PEDIATRICS	1, 834	1, 044	6	28, 467	859, 853	30.00
	03100 I NTENSI VE CARE UNI T	149	l		5, 919	239, 226	1
	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	234	345		7, 046 0	270, 397 0	1
42. 00	04200 SUBPROVI DER	0	Ö	0	o	0	1
	04300 NURSERY	0	0	0	o	0	43.00
44. 00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	411	1	0	232, 786	44.00
50.00	05000 OPERATING ROOM	163	743	104	10, 217	749, 832	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	199	l e		27, 340	713, 423	
	05500 RADI OLOGY-THERAPEUTI C	0	0	-	0	0	55.00
55. 01 57. 00	05501 ULTRA SOUND 05700 CT SCAN	21 28	0	11 782	2, 959 3, 382	10, 421 10, 003	55. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	71	Ö		1, 832	62, 768	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	112		o	49, 091	59. 00
	06000 LABORATORY	581	0	0	2, 819	378, 349	1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		0	0	427 0	63. 00 64. 00
66. 00	06600 PHYSI CAL THERAPY	291	372		5, 496	313, 279	1
	06700 OCCUPATI ONAL THERAPY	121	125		2, 396	6, 410	1
67. 01 68. 00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	128 135	84 53	0	0 0	31, 146 1, 770	1
	06900 ELECTROCARDI OLOGY	0	0		Ö	1, 770	1
69. 01	06901 CARDI OLOGY	291	501	116	5, 285	52, 870	1
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	149	0	0	0	16, 943	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0 47, 789	0	23, 032 109, 460	1
	07700 ALLOGENEIC HSCT ACQUISITION	0	ő		o	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0	0	ol	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	1		0	0	
90. 02	09002 CLI NI C	0	0		o	0	90. 02
	09003 DERMATOLOGY CLINIC	0	0	0	0	0	
	09004 ENT CLINIC 09005 SURGERY CLINIC	0	0	0	0	0	
90. 07	09007 UROLOGY CLINIC	0	Ö	-	Ö	249	1
	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	
	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC	0	0		0	0	90. 11 90. 12
	09013 ALLERGY CLINIC	0	18		0	29, 931	1
90. 14	09014 WOUND CARE	0	110		О	249, 218	90. 14
	09100 EMERGENCY	454	634	384	0	837, 081	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	922			0	175, 856	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	6, 721	5, 067	49, 824	103, 158	5, 423, 821	118.00
	NONREI MBURSABLE COST CENTERS	2, . = .		, ==.	,	57 .= 57 5= 5	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	241 0	227	13, 499	12, 683 0	3, 301, 239 0	192. 00 194. 00
	07951 CAFE/BOUTI QUE	0	0		o		194. 00
194. 02	07952 OTHER NONREIMB	0	0	0	o	351, 767	194. 02
	07953 RETAIL PHARMACY	0	0	10, 096	0		194. 03
200. 00 201. 00		0	0	0	o		200. 00 201. 00
202.00		6, 962	5, 294		115, 841	9, 182, 579	

WITHAM MEMORIAL HOSPITAL

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 1:52 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0104

				5/30/2024 1:	52 pm
	Cost Center Description	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT				1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL				5.00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
15.00	01500 PHARMACY				15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	0	859, 853		30.00
31.00	03100 INTENSIVE CARE UNIT	0	239, 226		31.00
40.00	04000 SUBPROVI DER - I PF	0	270, 397		40.00
41.00	04100 SUBPROVI DER - I RF	0	0		41.00
42.00	04200 SUBPROVI DER	0	0		42.00
43.00	04300 NURSERY	0	0	•	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	232, 786		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	749, 832	•	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	713, 423	1	54.00
55.00		0	0	•	55.00
55. 01	05501 ULTRA SOUND	0	10, 421	•	55. 01
57.00	05700 CT SCAN	0	10, 003	•	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	62, 768	•	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	49, 091	•	59.00
60.00	06000 LABORATORY	0	378, 349	•	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	427		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	212 270	l .	64.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	313, 279 6, 410	•	66. 00 67. 00
67. 00	06701 AUDI OLOGY		31, 146	•	67.00
68. 00	06800 SPEECH PATHOLOGY		1, 770	•	68.00
69.00	06900 ELECTROCARDI OLOGY		1, 770		69.00
69. 01	06901 CARDI OLOGY		52, 870	•	69. 01
71. 00			16, 943	•	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		23, 032		72.00
73. 00			109, 460	1	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0		77.00
	07800 CAR T-CELL IMMUNOTHERAPY		0	•	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	91	<u> </u>		70.00
90.00	09000 CLI NI C	0	0		90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	o	0	•	90. 01
90.02	09002 CLI NI C	o	0		90. 02
90. 03	09003 DERMATOLOGY CLINIC	o	0		90. 03
90.04	09004 ENT CLINIC	o	0		90. 04
90.05	09005 SURGERY CLINIC	0	0		90. 05
90. 07	09007 UROLOGY CLINIC	0	249		90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	0	0		90. 09
90. 11	09011 NEUROLOGY CLI NI C	0	0	l .	90. 11
	09012 OPTHAMOLOGY CLINIC	0	0	l .	90. 12
90. 13	09013 ALLERGY CLINIC	0	29, 931	•	90. 13
	09014 WOUND CARE	0	249, 218	•	90. 14
	09100 EMERGENCY	0	837, 081		91.00
92.00		0			92. 00
05 -	OTHER REIMBURSABLE COST CENTERS	.1	,,		4
	09500 AMBULANCE SERVI CES	0	175, 856	•	95.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
110 5	SPECIAL PURPOSE COST CENTERS		F 400 00:		410 00
118.00		0	5, 423, 821		118. 00
100.00	NONREI MBURSABLE COST CENTERS		20. 404		100.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	20, 434	1	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 301, 239		192.00
	07950 THORNTOWN OFFICE BUILDING	0	0 44 E14	•	194.00
	07951 CAFE/BOUTI QUE		46, 516 251 767	1	194. 01 194. 02
	2 07952 0THER NONREIMB 3 07953 RETAIL PHARMACY		351, 767 38, 802		194. 02
200.00			38, 802		200.00
200.00	or oss root haj astilients	<u>, </u>	U	1	1200.00

Health Financial Systems	WITHAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/30/2024 1:5	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26. 00				
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	0	9, 182, 579				202.00

	LLOCATION - STATISTICAL BASIS	WITHAW WEWORTA	Provi der CO	CN: 15-0104 F	Peri od:	Worksheet B-1	
				F	rom 01/01/2023 o 12/31/2023	Dato/Timo Pro	narod:
				'	0 12/31/2023	5/30/2024 1:5	pareu: 2 pm
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
	cost center bescription	FIXT	EQUI P	BENEFITS	n	E & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
				SALARI ES)			
	CENEDAL SEDVICE COST CENTEDS	1. 00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	303, 947					1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	333,717	303, 947				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 789	1, 789		Į.		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	23, 501	23, 501				1
7.00	00700 OPERATION OF PLANT	19, 517	19, 517				1
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	0 2, 806	0 2, 806				
10.00	01000 DI ETARY	6, 281	6, 281				1
11. 00	01100 CAFETERI A	0	0			878, 856	
	01300 NURSING ADMINISTRATION	0	0				
15. 00	01500 PHARMACY	1, 939	1, 939				1
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 063	3, 063	1, 091, 603	8 0	2, 030, 677	16.00
30 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	20, 373	20, 373	4, 008, 911	0	6, 867, 973	30.00
31. 00	03100 NTENSI VE CARE UNI T	5, 595	5, 595				
40.00	04000 SUBPROVI DER - I PF	6, 406	6, 406				
41.00	04100 SUBPROVI DER - I RF	0	0	C	0	0	
42.00	04200 SUBPROVI DER	0	0	C	0		1
	04300 NURSERY	4 051	4 051	1 005 440	0		
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 851	4, 851	1, 085, 448	8 0	1, 859, 969	44.00
50. 00	05000 OPERATING ROOM	21, 731	21, 731	2, 294, 064	0	5, 179, 127	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 886	19, 886				1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		-		
55. 01	05501 ULTRA SOUND	0	0	552, 493		1, 262, 346	
57. 00 58. 00	05700 CT SCAN	1 704	1 70/			845, 965	
59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	1, 706 1, 438	1, 706 1, 438			729, 892 330, 665	
60.00	06000 LABORATORY	10, 041	10, 041				1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0		
66.00	06600 PHYSI CAL THERAPY	8, 976	8, 976			,	
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	893	0 893	369, 745 228, 381		559, 419 232, 806	
	06800 SPEECH PATHOLOGY	073	073			228, 506	
69. 00	06900 ELECTROCARDI OLOGY	o	Ö	,, c	o o		1
69. 01	06901 CARDI OLOGY	925	925	1, 665, 722	0	2, 418, 573	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0		
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0	.,	
	07700 ALLOGENEI CHSCT ACQUISITION	0	0			11, 705, 939 0	
	07800 CAR T-CELL IMMUNOTHERAPY	o	0				1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	C		0	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	C	0		
90. 02	09002 CLI NI C 09003 DERMATOLOGY CLI NI C	0	0		0	0	
90. 03	09004 ENT CLINIC	0	0		0	0	1
90. 05	09005 SURGERY CLINIC	O	0	C	0	0	1
90. 07	09007 UROLOGY CLINIC	O	0	53, 244	0	41, 126	90. 07
	09009 GASTROENTEROLOGY CLINIC	0	0	C	0	0	
90. 11	09011 NEUROLOGY CLINIC	0	0	C	0	0	
90. 12	O9012 OPTHAMOLOGY CLINIC O9013 ALLERGY CLINIC	893	893	66, 278		148, 719	90. 12 90. 13
	09014 WOUND CARE	7, 540	7, 540			602, 848	1
	09100 EMERGENCY	24, 566	24, 566				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05.00	OTHER REIMBURSABLE COST CENTERS	. 7.0	. 7.0	0.50/.0/0		0.500.000	
95.00	O9500 AMBULANCE SERVICES 10200 OPIOI DITREATMENT PROGRAM	4, 760 0	4, 760 0				102.00
102.00	SPECIAL PURPOSE COST CENTERS	l ol	U		<u>, </u>	0	1102.00
118.00		199, 476	199, 476	39, 150, 067	-20, 814, 303	84, 831, 182	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624				190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	91, 296	91, 296	33, 372, 774			
194 ()(NOTATION THORN TOWN THEFT OF RITTON IN	l Ol	0	ı C	0		194.00
		1 /1/	1 /14	2 001	0	מדם חד	19/1 01
194. 01	07951 CAFE/BOUTI QUE 07952 OTHER NONREI MB	1, 416 10, 735	1, 416 10, 735				194. 01 194. 02

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der 0	CCN: 15-0104	Peri od: From 01/01/2023	Worksheet B-1	
				To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
	CAPITAL RELAT	ED COSTS				·

						5/30/2024 1:5	2 pm
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
		FLXT	EQUI P	BENEFITS	n	E & GENERAL	
		(SQUARE	(SQUARE	DEPARTMENT		(ACCUM.	
		FEET)	FEET)	(GROSS		COST)	
			·	SALARI ES)		·	
		1. 00	2.00	4.00	5A	5. 00	
194. 03	07953 RETAIL PHARMACY	400	400	308, 302	0	3, 050, 859	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 022, 246	4, 160, 333	12, 799, 734		20, 814, 303	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 523427	13. 687692	0. 175736		0. 147120	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)			54, 047		716, 061	204.00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000742		0. 005061	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

Cost Center Description		FINANCIAI SYSTEMS	WITHAM MEMORI		CN. 15 0104 D		U OF FORM CMS-2	
SPECIAL PRINCE COST CENTER DEPUNT CONTROL CONT	COST A	LLUCATION - STATISTICAL BASIS		Provider C	F	rom 01/01/2023	Worksheet B-1	
COST Center Description					'	0 12/31/2023	5/30/2024 1: 5	
CRIMINAL SERVICE COST. CHITES		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
FREET CHARGES								
ENERAL SERVICE COST CENTERS			•		SERVI CE)	SERVED)	SERVED)	
STREAM STRAYCE COST CENTERS						10.00	44.00	
1.00 00100 NEW CAP REL COSTS - MUBLE FOUL P		CENEDAL CEDILICE COCT CENTEDO	7.00	8.00	9.00	10.00	11.00	
2.00 00200 NEW CAP REL COSTS-MANE E GUIP								1.00
0.0400 DIPLOYEE BENEFITS DEPARTMENT 250, 00 0500 AURIN ISTRATI VE & GEMERAL 250, 140 459, 886, 501 129, 223 45, 027 120, 00 0500 DIVERSEPHING 2, 806 0 129, 223 45, 027 13, 00 00 0500 DIVERSEPHING 2, 806 0 129, 223 45, 027 13, 00 0 0 13, 00 0 0 0 0 0 0 0 0 0								2.00
0.000 0.00								4.00
7.00 00700 DPERATION OF PLANT 259, 140 459, 886, 501 9.00 00900 DUSEKEFF ING 2, 806 0 129, 223 1.00 00900 DUSEKEFF ING 2, 806 0 129, 223 1.00 00900 DUSEKEFF ING 2, 806 0 2, 875 0 96 1.00 00900 DETARY 6, 281 0 0 8, 623 45, 027 1.00 01100 CARETERIA 0 0 0 2, 875 0 96 1.00 01100 DETARY 1.00 0100 DETARY 1.00 DETARY 1.00								5.00
8.00 00800 LAUNDRY & LITEN SERVICE 0 459, 866, 501 29, 223 10.00 1000 DIETARY 6, 281 0 8, 623 45, 027 11.00 1100 CAFETERIA 0 0 0 2, 875 0 98 13.00 13.00 0 1 13.00 0 1 13.00 0 1 13.00 0 1 13.00 1			259 140					7.00
9.00 00000 HOUSEKEEP ING 2,806 0 129,223 11.00 01000 DETARY 6,281 0 8,623 45,027 9 11.00 01000 DETARY 6,281 0 0 2,875 0 9 11.00 0100 DETARY 1,939 0 2,625 0 3 15.00 01500 PHANBACY 1,939 0 2,625 0 3 15.00 0 0 0 0 0 0 0 0 0			1	459 886 501				8.00
10.00 01000 DIETARY								9.00
11. 00 0 1000 CAFFERIA					1			10.00
13.00 01300 NURSING ADMINISTRATION 0 0 1, 300 0 1			1	0	1		982	
15.00 01500 PHARMACY 1,939 0 2,625 0 3 1,939 0 5,750 0 7 1,931 1,939 0 5,750 0 7 1,931 1,939 0 5,750 0 7 1,931 1			0	0	1		19	
16. 00 01600 MEDICAL RECORDS & LIBRARY 3, 06.3 0 5,750 0 7			1, 939	0	1		38	15.00
INPATI ENT ROUTH NE SERVICE COST CENTERS				0			77	16.00
13.1 0.0 0.3100 INTENSIVE CARE UNIT 5.595 5.228 B/T 11.600 5.913 2.24						<u> </u>		Ī
40. 00 04000 SUBPROVI DER - I PF 6, 406 3, 075, 00 13, 794 6, 840 32 41. 00 04100 SUBPROVI DER 0	30.00	03000 ADULTS & PEDIATRICS	20, 373	25, 401, 290	43, 681	19, 143	259	30.00
A1 DO 04100 SUBPROVI DER - 1 RF	31.00	03100 INTENSIVE CARE UNIT	5, 595	5, 228, 847	11, 600	5, 913	21	31.00
42.00 04-200 SUBROVI DER	40.00	04000 SUBPROVI DER - I PF	6, 406	3, 075, 004	13, 794	6, 840	33	40.00
43. 00 04300 NURSERY	41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
A	42.00		0	0	0	0	0	42.00
AMCILLARY SERVICE COST CENTERS	43.00	04300 NURSERY	0	0	1	0	0	43.00
50.00	44.00		4, 851	2, 749, 597	0	13, 131	0	44.00
54 00 OS400 RADI OLOGY-DI AGNOSTIC 19,886 36,375,100 11,650 0 0 0 0 0 0 0 0 0								
55. 00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0					1		23	
55.0 05501 ULTRA SOUND			1		1		28	
57.00 05700 CT SCAN 0 57,742,492 1,150 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,706 12,332,477 1,100 0 0 0 0 0 0 0 0 0				_	_	-	0	55.00
S80 OBSOON MAGNIETIC RESONANCE I MAGING (MRI)							3	55. 01
59. 00 05900 CARDIAC CATHETERIZATION 1, 438 17, 001, 459 0 0 0 0 0 0 0 0 0							4	57.00
60.00 06000 LABORATORY 10, 041 63, 162, 560 4, 925 0 86 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 825, 446 0 0 0 0 0 0 0 0 0							10	58.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 825,446 0 0 0 0 0 0 0 0 0						-	0	59.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0			1		1	0	82	60.00
66.00 06600 PHYSICAL THERAPY 8, 976 8, 258, 634 1, 775 0 4 67.00 06700 0CCUPATI ONAL THERAPY 0 2, 439, 762 850 0 1 67.01 06701 AUDI OLOGY 893 904, 612 625 0 1 68.00 06800 SPECH PATHOLOGY 0 1, 035, 723 375 0 0 69.01 06901 CARDI OLOGY 0 0 0 0 69.01 06901 CARDI OLOGY 925 25, 848, 314 3, 775 0 0 67.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 11, 201, 532 0 0 71.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 11, 201, 532 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 50, 736, 170 2, 725 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 50, 736, 170 2, 725 0 76.00 07300 CARDI OLOGY 0 0 0 0 77.00 07700 ALLOGENEI C HSCT ACQUISI TION 0 0 0 0 78.00 07800 CARDI CARDI OLOGY 0 0 0 79.00 07000 CLINIC 0 0 0 0 79.01 09001 OTHER OUTPATIENT SERVI CE COST CENTER 0 0 0 0 79.02 09002 CLINIC 0 0 0 0 79.03 09003 DRUGS CHARGED TO PATIENT 0 0 0 0 79.04 09004 ENT CLINIC 0 0 0 0 79.05 09005 SURGERY CLINIC 0 0 0 0 79.07 09007 UROLOGY CLINIC 0 0 0 79.08 09009 GASTROENTEROLOGY CLINIC 0 0 0 79.09 09009 GASTROENTEROLOGY CLINIC 0 0 0 79.01 09011 NEUROLOGY CLINIC 0 0 0 79.01 09014 WOUND CARE 7,540 6,267,099 0 0 79.01 09014 WOUND CARE 7,540 6,267,099 0 0 79.01 09014 WOUND CARE 7,540 6,267,099 0 0 79.01 09000 DESERVATION BEDS (NON-DISTINCT PART) 0 70.01 09010 DIREATMENT PROGRAM 0 0 0 70.01 09010 DIREATMENT PROGRAM 0 0 0 70.01 09010 OTHER PROBENSANE COST CENTERS 0 0 0 70.01 09010 OTHER PROGRAM 0 0 0 70.01 09010 OTHER PROSE MEDICAN 0 0 0 70.01 09010 OTHER PROGRAM 0 0 0 0 70.01 0			0	825, 446	0	0	0	63.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 2, 439, 762 850 0 1 67. 01 06701 AUDI OLOGY 893 904, 612 625 0 1 68. 00 06800 SPEECH PATHOLOGY 0 1, 035, 723 375 0 0 69. 01 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 01 06901 CARDI OLOGY 925 25, 848, 314 3, 775 0 0 69. 01 06901 CARDI OLOGY 925 25, 848, 314 3, 775 0 0 69. 01 06901 CARDI OLOGY 925 25, 848, 314 3, 775 0 0 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 11, 201, 532 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 11, 337, 757 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 50, 736, 170 2, 725 0 77. 00 07700 ALLOGENEIC HSCT ACQUI SI TION 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 79. 01 094001 OTHER OUTPATI ENT SERVI CE COST CENTERS 90. 00 090002 CLINIC 0 0 0 0 90. 01 090002 OTHER OUTPATI ENT SERVI CE COST CENTER 0 0 0 0 90. 02 090002 LINIC 0 0 0 0 90. 03 09003 DERMATOLOGY CLINIC 0 0 0 0 90. 05 09005 SURGERY CLINIC 0 0 0 0 90. 05 09005 SURGERY CLINIC 0 0 0 0 90. 07 09007 UROLOGY CLINIC 0 0 0 0 90. 08 09009 GASTROENTEROLOGY CLINIC 0 0 0 0 90. 01 09011 TUROLOGY CLINIC 0 0 0 0 90. 02 09012 OTHAMOLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0 0 90. 01 09011 DEUROLOGY CLINIC 0 0 0			0	0	0	0	0	64.00
67. 01 06701 AUDIOLOGY 893 904, 612 625 0 1 68. 00 06800 SPEECH PATHOLOGY 0 1, 035, 723 375 0 0 69. 01 06900 CLECTROCARDIOLOGY 0 0 0 0 69. 01 06901 CARDIOLOGY 925 25, 848, 314 3, 775 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 11, 201, 532 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 11, 337, 757 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 50, 736, 170 2, 725 0 77. 00 07300 CLORENIC SCAT CAQUIS IT 10 N 0 0 0 78. 00 07300 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 79. 0. 00 09000 CLINIC 0 0 0 0 79. 0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 79. 0. 02 09002 CLINIC 0 0 0 0 79. 0. 03 09003 DERMATOLOGY CLINIC 0 0 0 0 79. 04 09004 ENT CLINIC 0 0 0 0 79. 05 09005 SURGERY CLINIC 0 0 0 0 79. 07 09007 UROLOGY CLINIC 0 0 0 0 79. 07 09007 UROLOGY CLINIC 0 0 0 79. 09. 07 09007 UROLOGY CLINIC 0 0 0 79. 09. 07 09007 UROLOGY CLINIC 0 0 0 79. 11 09011 NEUROLOGY CLINIC 0 0 0 79. 12 09012 OPTHAMOLOGY CLINIC 0 0 0 79. 13 09013 ALERGY CLINIC 0 0 0 79. 14 09014 WOUND CARE 7, 540 6, 267, 099 0 79. 15 09012 OPTHAMOLOGY CLINIC 0 0 0 79. 16 09014 WOUND CARE 7, 540 6, 267, 099 0 79. 10 09000 OSSERVATI ON BOES (NON-DISTINCT PART) 79. 00 09500 OSSERVATI ON BOES (NON-DISTINCT PART) 79. 00 09500 AMBULANCE SERVICES 4, 760 4, 089, 469 0 0 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 00 70. 100 00 00 00 70. 100 00 00 00 70. 100 00 00 00 70. 100 00 0							41	66.00
68.00 06800 SPEECH PATHOLOGY 0 1,035,723 375 0 1 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0							17	67.00
69. 00 06900 ELECTROCARDI OLOGY 925 25,848,314 3,775 0 4 4 71.00 70100 MEDIC CARDI OLOGY 925 25,848,314 3,775 0 4 71.00 70100 MEDIC CAL SUPPLIES CHARGED TO PATIENTS 0 11,201,532 0 0 0 0 2 72.00 72.00 MPL. DEV. CHARGED TO PATIENTS 0 11,337,757 0 0 0 0 0 0 0 0 0					1		18 19	67. 01 68. 00
69. 01			0	1,035,725	1	0	0	69.00
71. 00		l l	025	25 848 314		0	41	69.01
72. 00			1			0	21	71.00
73. 00		l l	1		1		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0			1		l .	o o	0	73.00
78. 00				00,700,770			0	77.00
OUTPATIENT SERVICE COST CENTERS O				0	Ō	o	0	
90. 00				_	-	-1		1
90. 02	90.00		0	0	0	0	0	90.00
90. 03	90. 01		0	0	0	o	0	90. 01
90. 04	90. 02	09002 CLI NI C	0	0	0	o	0	90.02
90. 05	90. 03	09003 DERMATOLOGY CLINIC	0	0	0	o	0	90.03
90. 07	90.04	09004 ENT CLINIC	0	0	0	o	0	90.04
90. 09	90. 05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90. 11	90. 07		0	114, 426	0	0	0	90.07
90. 12	90. 09		0	0	0	0	0	90.09
90. 13	90. 11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90. 11
90. 14			0	0	0	0	0	90. 12
91. 00					1	0	0	90. 13
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 4,760 4,089,469 0 0 13 102. 00 10200 0PI OI D TREATMENT PROGRAM 0 0 0 0 SPECI AL PURPOSE COST CENTERS					1	0	0	90. 14
OTHER REIMBURSABLE COST CENTERS 95. 00			24, 566	44, 501, 640	0	0	64	91.00
95. 00 09500 AMBULANCE SERVI CES 4, 760 4, 089, 469 0 0 13 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0								92.00
102.00 DI OLD TREATMENT PROGRAM O O O O SPECIAL PURPOSE COST CENTERS					1			
SPECIAL PURPOSE COST CENTERS			1	4, 089, 469	1		130	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 154.669 459.886.501 122.523 45.027 94			0	0	0	0	0	102.00
- 118.00		SPECIAL PURPOSE COST CENTERS	15. ((0)	450 004 504	100 500	45.007	0.10	
	118.00		154, 669	459, 886, 501	122, 523	45, 027	948	118. 00
NONREI MBURSABLE COST CENTERS 100 001100001CLET FLOWER COSES SUOD & CANTEEN 424	100.00		404	^			^	100 00
				0		0		190.00
			1	0				192. 00 194. 00
			_	0				194.00
				0				194.01
194. 02 07952 OTHER NONREI MB 10, 735 0 0 0 194. 03 07953 RETAI L PHARMACY 400 0 0 0				0				194. 02
200.00 Cross Foot Adjustments			400	U	1	١		200.00
201.00 Negative Cost Centers								200.00
		1.10941.10 0001 0011010	l .	<u> </u>	I	<u> </u>	<u> </u>	

Health Fina	ncial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO		CAFETERI A	
			LINEN SERVICE	(HOURS OF	(MEALS	(MEALS	
		(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)	
		FEET)	CHARGES)				
		7. 00	8. 00	9. 00	10. 00	11. 00	
202. 00	Cost to be allocated (per Wkst. B,	6, 226, 354	689, 786	1, 510, 22	5 2, 055, 145	1, 041, 753	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	24. 026989	0. 001500	11. 68696	7 45. 642503	1, 060. 848269	203.00
204.00	Cost to be allocated (per Wkst. B,	617, 653	3, 075	98, 23	4 219, 532	6, 962	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2. 383472	0. 000007	0. 76019	0 4. 875564	7. 089613	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
'		•	•	•	•	•	•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0104

					5/30/2024 1:	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	(COSTED	RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DIRECT NRSING HRS)		(TIME SPENT)		
		13. 00	15. 00	16. 00		
	GENERAL SERVICE COST CENTERS	10.00	10.00	10.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	403, 125				13.00
15. 00		0	18, 647, 146			15. 00
16.00		0	0			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00		79, 470	1, 408			30. 00
31.00		32, 386	434			31.00
40.00		26, 238	231	2, 500		40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	0		41.00
43. 00	04300 NURSERY		0			42. 00 43. 00
44. 00		31, 300	265			44. 00
	ANCILLARY SERVICE COST CENTERS	0.7000		<u> </u>		
50.00		56, 568	26, 380	3, 625		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 876	9, 332	9, 700		54.00
55.00		0	0	-		55. 00
55. 01	05501 ULTRA SOUND	0	2, 912			55. 01
57.00	05700 CT SCAN	0	198, 553			57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	8, 510	101, 322			58. 00 59. 00
60.00	1 1	0, 310	16, 867 15			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0			63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	Ö		64.00
66.00	1	28, 333	2, 062	1, 950		66.00
67.00	06700 OCCUPATI ONAL THERAPY	9, 553	0	850		67. 00
67. 01	06701 AUDI OLOGY	6, 411	0	0		67. 01
68. 00	06800 SPEECH PATHOLOGY	4, 030	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0		69.00
69. 01 71. 00	06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	38, 185	29, 471 0			69. 01 71. 00
71.00			0			71.00
73. 00		0	12, 137, 408			73.00
77. 00		0	0			77. 00
78. 00	1	0	0			78. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0	0			90.00
90. 01	1	0	0	0		90. 01
90. 02 90. 03	09002 CLI NI C 09003 DERMATOLOGY CLI NI C	0	0	0		90. 02 90. 03
90.03	1		0			90.03
90. 05	09005 SURGERY CLINIC		0	0		90.05
90. 07		l ol	0	Ö		90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	0	0	0		90. 09
90. 11	09011 NEUROLOGY CLINIC	0	0	0		90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0	0		90. 12
	09013 ALLERGY CLINIC	1, 388	395			90. 13
90. 14		8, 369	13, 076			90. 14
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	48, 253	97, 467	0		91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS					92.00
95. 00	09500 AMBULANCE SERVICES	0	16, 431	0		95.00
	10200 OPI OI D TREATMENT PROGRAM	l ő	0			102.00
	SPECIAL PURPOSE COST CENTERS	,		·		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	385, 870	12, 654, 029	36, 600		118. 00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	17, 255	3, 428, 683			192.00
	DO7950 THORNTOWN OFFICE BUILDING 1 07951 CAFE/BOUTIQUE		0	0 0		194. 00 194. 01
	207952 OTHER NONREIMB		0			194.01
	3 07953 RETALL PHARMACY		2, 564, 434			194. 02
200.00			_, 50 ., .01			200.00
	· · · · · · · · · · · · · · · · · · ·	·				

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

				'	5/30/2024 1:	
	Cost Center Description	NURSI NG	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	(COSTED	RECORDS &		
		N	REQUIS.)	LI BRARY		
		(DI RECT		(TIME		
		NRSING HRS)		SPENT)		
		13. 00	15. 00	16.00		
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	896, 330	1, 805, 005	2, 551, 910		202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 223454	0. 096798	62. 090268		203.00
204.00	Cost to be allocated (per Wkst. B,	5, 294	73, 419	115, 841		204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 013132	0. 003937	2. 818516		205.00
	[11]					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00						207. 00
	Parts III and IV)					

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm

					10 12/31/2023	5/30/2024 1: 5	2 pm
			Title	: XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost center beserver on	(from Wkst.	Adj .	lotal oosts	Di sal I owance	10141 00313	
		B, Part I,	rag .		Di Sai i Gwariec		
		col . 26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30.00	03000 ADULTS & PEDIATRICS	10, 868, 930		10, 868, 93	0 0	10, 868, 930	30.00
31.00	03100 INTENSIVE CARE UNIT					.,	31.00
		3, 389, 162		3, 389, 16			
40.00	04000 SUBPROVI DER - I PF	2, 959, 326		2, 959, 32		_, ,	
41.00	04100 SUBPROVI DER – I RF	0			0	Ĭ	41.00
42.00	04200 SUBPROVI DER	0			0	0	42.00
43.00	04300 NURSERY	0			0 0	-	43.00
44.00	04400 SKILLED NURSING FACILITY	2, 923, 239		2, 923, 23	9 0	2, 923, 239	44.00
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATING ROOM	6, 961, 260		6, 961, 26			
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 475, 414		7, 475, 41			
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
55. 01	05501 ULTRA SOUND	1, 538, 612		1, 538, 61	2 0	1, 538, 612	55. 01
57.00	05700 CT SCAN	1, 168, 448		1, 168, 44	8 0	1, 168, 448	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	970, 394		970, 39	4 0	970, 394	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	459, 920		459, 92	0 0	459, 920	59.00
60.00	06000 LABORATORY	9, 907, 925		9, 907, 92	5 0	9, 907, 925	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	96, 598		96, 59	8 0	96, 598	63.00
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	· ·	64.00
66. 00	06600 PHYSI CAL THERAPY	3, 212, 498	0	3, 212, 49			
67. 00	06700 OCCUPATI ONAL THERAPY	747, 367	0				67.00
67. 01	06701 AUDI OLOGY	330, 523	0				1
68. 00	06800 SPEECH PATHOLOGY	297, 178	0	297, 17			
69. 00	06900 ELECTROCARDI OLOGY	277, 170	0	2//, 1/	0 0		1
69. 01	06901 CARDI OLOGY	3, 127, 178		3, 127, 17	-	_	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	I					
71.00		3, 827, 868		3, 827, 86			
	07200 I MPL. DEV. CHARGED TO PATIENT	5, 219, 472		5, 219, 47		5, 219, 472	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 710, 942		14, 710, 94		,	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0		77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0			0		90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0			0 0		90. 01
90. 02	09002 CLI NI C	0			0	-	90.02
90. 03	09003 DERMATOLOGY CLINIC	0			0	-	90. 03
90.04	09004 ENT CLINIC	0			0	-	90. 04
90.05	09005 SURGERY CLINIC	0			0		90.05
90. 07	09007 UROLOGY CLINIC	47, 348		47, 34	8 0	47, 348	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	0			0	0	90. 09
90. 11	09011 NEUROLOGY CLINIC	0			0 0	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0			0 0	0	90. 12
90. 13	09013 ALLERGY CLINIC	195, 791		195, 79	1 0	195, 791	90. 13
90. 14	09014 WOUND CARE	901, 977		901, 97	7 0	901, 977	90. 14
91.00	09100 EMERGENCY	8, 150, 445		8, 150, 44			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 462, 030		2, 462, 03	0	2, 462, 030	92.00
	OTHER REIMBURSABLE COST CENTERS	,,		, , , , , , , , , , , , , , , , , , , ,	<u> </u>	,, 500	1
95 00	09500 AMBULANCE SERVICES	4, 301, 339		4, 301, 33	9 0	4, 301, 339	95, 00
	10200 OPIOID TREATMENT PROGRAM	n			0		102.00
200.00		96, 251, 184	0	96, 251, 18			
201.00	,	2, 462, 030	O	2, 462, 03		2, 462, 030	
202.00	I I	93, 789, 154	0				
202.00	Total (See Mistructions)	75, 707, 134	U	J 73, 707, 10	اب اب	1 75, 707, 134	1202.00

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm Provider CCN: 15-0104

					10 12/31/2023	5/30/2024 1: 5	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. (Cost or Other	TEFRA	
	· ·	·	·	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				*		
	03000 ADULTS & PEDIATRICS	17, 880, 072		17, 880, 07	2		30.00
31.00	03100 INTENSIVE CARE UNIT	5, 228, 847		5, 228, 84	7		31.00
40.00	04000 SUBPROVI DER - I PF	3, 075, 004		3, 075, 00	4		40.00
41.00	04100 SUBPROVI DER - I RF	ol			o		41.00
	04200 SUBPROVI DER	l ol			ol		42.00
	04300 NURSERY	ol			o		43.00
	04400 SKILLED NURSING FACILITY	2, 749, 597		2, 749, 59	7		44.00
	ANCILLARY SERVICE COST CENTERS				·		
	05000 OPERATING ROOM	8, 758, 389	51, 340, 723	60, 099, 11	2 0. 115830	0.000000	50.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 793, 939	34, 581, 161	36, 375, 10		0. 000000	l
	05500 RADI OLOGY-THERAPEUTI C	0	0.,00.,.01		0. 000000	0. 000000	
1	05501 ULTRA SOUND	664, 346	8, 085, 769	8, 750, 11		0. 000000	1
4	05700 CT SCAN	7, 746, 725	49, 995, 767			0. 000000	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	816, 004	11, 516, 473			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 756, 472	12, 244, 987			0. 000000	
4	06000 LABORATORY	12, 070, 539	51, 092, 021			0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	477, 796	347, 650			0.000000	
	06400 INTRAVENOUS THERAPY	477,790	347,030		0. 000000	0.000000	
	06600 PHYSI CAL THERAPY	1, 857, 586	6, 401, 048			0.000000	
	06700 OCCUPATI ONAL THERAPY	1, 757, 432	682, 330			0.00000	67.00
	06700 OCCOPATIONAL THERAPT	1, 757, 432	904, 612			0.00000	67.00
	06800 SPEECH PATHOLOGY	107 5/1				0.00000	
		187, 561	848, 162			l e	1
	06900 ELECTROCARDI OLOGY	(570 550	10 2/0 7/4		0.000000	0.000000	69.00
	06901 CARDI OLOGY	6, 579, 550	19, 268, 764			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 891, 827	8, 309, 705			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 152, 737	9, 185, 020			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	8, 982, 110	41, 754, 060	1		0.000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0.000000	0.000000	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS			ı	0 00000		
	09000 CLINIC	0	0		0.000000	0.000000	1
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0.000000	0.000000	
	09002 CLI NI C	0	0		0. 000000	0.000000	l
	09003 DERMATOLOGY CLINIC	0	0		0.000000	0.000000	90. 03
	09004 ENT CLINIC	0	0		0.000000	0.000000	
	09005 SURGERY CLINIC	0	0		0. 000000	0. 000000	1
	09007 UROLOGY CLINIC	0	114, 426	114, 42		0. 000000	
	09009 GASTROENTEROLOGY CLINIC	0	0		0. 000000	0.000000	
	09011 NEUROLOGY CLINIC	0	0		0. 000000	0.000000	90. 11
	09012 OPTHAMOLOGY CLINIC	0	0	l	0. 000000	0.000000	l .
	09013 ALLERGY CLINIC	0	407, 864	407, 86	0. 480040	0. 000000	90. 13
	09014 WOUND CARE	11, 900	6, 255, 199			0.000000	90. 14
91.00	09100 EMERGENCY	5, 520, 656	38, 980, 984	44, 501, 64	0. 183149	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	186, 232	7, 334, 986	7, 521, 21	8 0. 327345	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	4, 089, 469	4, 089, 46	9 1. 051809	0. 000000	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
200.00	Subtotal (see instructions)	96, 145, 321	363, 741, 180	459, 886, 50	1		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	96, 145, 321	363, 741, 180	459, 886, 50	1		202.00
				•	•	•	•

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104
Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 1:52 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31 00 31.00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04200 SUBPROVI DER 42.00 42.00 43 00 04300 NURSERY 43 00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.115830 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 205509 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 55.00 55.01 05501 ULTRA SOUND 0. 175839 55.01 57.00 05700 CT SCAN 0. 020235 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.078686 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.027052 59.00 06000 LABORATORY 0. 156864 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.117025 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 66.00 06600 PHYSI CAL THERAPY 0. 388987 66.00 06700 OCCUPATI ONAL THERAPY 0. 306328 67.00 67.00 06701 AUDI OLOGY 0. 365375 67.01 67.01 68.00 06800 SPEECH PATHOLOGY 0. 286928 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 06901 CARDI OLOGY 69.01 69.01 0.120982 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.341727 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0.460362 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 289950 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 90.01 90.02 09002 CLI NI C 0.000000 90.02 09003 DERMATOLOGY CLINIC 0.000000 90.03 90.03 09004 ENT CLINIC 90.04 0.000000 90.04 90.05 09005 SURGERY CLINIC 0.000000 90.05 09007 UROLOGY CLINIC 0.413787 90.07 90.07 09009 GASTROENTEROLOGY CLINIC 90.09 0.000000 90.09 90 11 09011 NEUROLOGY CLINIC 0.000000 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0.000000 90.12 90. 13 09013 ALLERGY CLINIC 0. 480040 90.13 90. 14 09014 WOUND CARE 0.143923 90.14 09100 EMERGENCY 91 00 91 00 0 183149 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 327345 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 1. 051809 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00

202.00

202.00

Total (see instructions)

Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm

					10 12/31/2023	5/30/2024 1: 5	2 pm
			Ti tl	e XIX	Hospi tal	Cost	· ·
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	.,				
		col. 26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	10, 868, 930		10, 868, 93	0 0	10, 868, 930	30.00
31. 00	03100 NTENSI VE CARE UNIT	3, 389, 162		3, 389, 16		.,	31.00
40. 00	04000 SUBPROVI DER – I PF	2, 959, 326		2, 959, 32			
41. 00	04100 SUBPROVI DER - I RF	2, 737, 320		2, 737, 32	0 0		41.00
42. 00	04200 SUBPROVI DER				0 0	0	42.00
43. 00	04300 NURSERY				0 0	_	43.00
44. 00		2 022 220		2 022 22	0	-	
44.00	04400 SKILLED NURSING FACILITY	2, 923, 239		2, 923, 23	9 0	2, 923, 239	44. 00
FO 00	ANCILLARY SERVICE COST CENTERS	/ 0/1 2/0		(0/1 0/	0	/ 0/1 2/0	F0 00
50.00	05000 OPERATING ROOM	6, 961, 260		6, 961, 26			
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 475, 414		7, 475, 41			
55.00	05500 RADI OLOGY-THERAPEUTI C	0		4 500 /	0		55.00
55. 01	05501 ULTRA SOUND	1, 538, 612		1, 538, 61		,	1
57. 00	05700 CT SCAN	1, 168, 448		1, 168, 44			
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	970, 394		970, 39		970, 394	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	459, 920		459, 92			
60.00	06000 LABORATORY	9, 907, 925		9, 907, 92			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	96, 598		96, 59			63.00
64.00	06400 I NTRAVENOUS THERAPY	0			0		64. 00
66.00	06600 PHYSI CAL THERAPY	3, 212, 498	0	3, 212, 49	8 0	3, 212, 498	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	747, 367	0	747, 36	7 0	747, 367	67.00
67. 01	06701 AUDI OLOGY	330, 523	0	330, 52	3 0		
68.00	06800 SPEECH PATHOLOGY	297, 178	0	297, 17	8 0	297, 178	68.00
69.00	06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
69. 01	06901 CARDI OLOGY	3, 127, 178		3, 127, 17	8 0	3, 127, 178	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 827, 868		3, 827, 86	8 0	3, 827, 868	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 219, 472		5, 219, 47		5, 219, 472	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 710, 942		14, 710, 94			
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0		77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o			0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	'			<u>'</u>		1
90.00	09000 CLI NI C	0			0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0			0 0		90. 01
90. 02	09002 CLI NI C	0			0		90.02
90. 03	09003 DERMATOLOGY CLINIC	0			0	0	90. 03
90. 04	09004 ENT CLINIC	0			0 0	Ō	90.04
90. 05	09005 SURGERY CLINIC	0			0 0		90.05
90. 07	09007 UROLOGY CLINIC	47, 348		47, 34			
90. 09	09009 GASTROENTEROLOGY CLINIC	17,010		17,0	0 0		90.09
90. 11	09011 NEUROLOGY CLINIC				0 0	0	90.11
90. 12	09012 OPTHAMOLOGY CLINIC				0 0		90. 12
90. 12	09013 ALLERGY CLINIC	195, 791		195, 79			90. 12
90. 13	09014 WOUND CARE	901, 977		901, 97			90. 13
90. 14	09100 EMERGENCY	8, 150, 445		8, 150, 44			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 462, 030		2, 462, 03			
92. UU		2, 402, 030		2, 402, 03	ΙV	2, 462, 030	72.00
05 00	OTHER REIMBURSABLE COST CENTERS	4 201 220		4 201 22		4 201 220	05 00
	09500 AMBULANCE SERVICES	4, 301, 339		4, 301, 33		.,	
	10200 OPI OI D TREATMENT PROGRAM	04 051 104	^	04 051 10	0		102.00
200.00	,	96, 251, 184	0				
201.00	I I	2, 462, 030	_	2, 462, 03		2, 462, 030	
202.00	Total (see instructions)	93, 789, 154	0	93, 789, 15	0	93, 789, 154	1202. UU

Provider CCN: 15-0104

						5/30/2024 1:5	2 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	oost ounter beserretten	Impatront	outputtont	+ col . 7)	Ratio	Inpati ent	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8.00	9. 00	10.00	
	INDATI ENT POLITIME CERVILOE COCT OFNITERS	6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				.1		
30.00	03000 ADULTS & PEDIATRICS	17, 880, 072		17, 880, 072			30.00
31.00	03100 INTENSIVE CARE UNIT	5, 228, 847		5, 228, 847	7		31.00
40.00	04000 SUBPROVI DER - I PF	3, 075, 004		3, 075, 004	1		40.00
41.00	04100 SUBPROVI DER – I RF	0					41.00
42.00	04200 SUBPROVI DER	l ol					42.00
43.00	04300 NURSERY	l ol					43.00
44. 00	04400 SKILLED NURSING FACILITY	2, 749, 597		2, 749, 59	7		44.00
11.00	ANCILLARY SERVICE COST CENTERS	2,717,077		2,717,07	1		11.00
50.00	05000 OPERATING ROOM	8, 758, 389	51, 340, 723	60, 099, 112	0. 115830	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 793, 939	34, 581, 161			0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0.000000	0. 000000	
55. 01	05501 ULTRA SOUND	664, 346	8, 085, 769			0. 000000	
57.00	05700 CT SCAN	7, 746, 725	49, 995, 767	57, 742, 492	0. 020235	0. 000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	816, 004	11, 516, 473	12, 332, 477	0. 078686	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 756, 472	12, 244, 987	17, 001, 459	0. 027052	0.000000	59.00
60.00	06000 LABORATORY	12, 070, 539	51, 092, 021			0. 000000	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	477, 796	347, 650			0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	1,,,,,,	017,000			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 857, 586	6, 401, 048			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	1, 757, 432	682, 330			0.000000	
67. 01	06701 AUDI OLOGY	0	904, 612			0. 000000	
68.00	06800 SPEECH PATHOLOGY	187, 561	848, 162	1		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	
69. 01	06901 CARDI OLOGY	6, 579, 550	19, 268, 764			0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 891, 827	8, 309, 705	11, 201, 532	0. 341727	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 152, 737	9, 185, 020	11, 337, 757	0. 460362	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 982, 110	41, 754, 060	50, 736, 170	0. 289950	0.000000	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	l ol	0	(0. 000000	0.000000	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	l ol	0	(0. 000000	
	OUTPATIENT SERVICE COST CENTERS	-1	-				1
90.00	09000 CLINIC	O	0	(0.000000	0.000000	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER		0	1		0. 000000	
90.01	09002 CLINIC		0			0. 000000	
		0	-	1			
90. 03	09003 DERMATOLOGY CLINIC	0	0	1		0. 000000	
90. 04	09004 ENT CLINIC	0	0	1		0. 000000	
90.05	09005 SURGERY CLINIC	0	0	(0. 000000	
90.07	09007 UROLOGY CLINIC	0	114, 426	114, 426	0. 413787	0.000000	90. 07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	(0.000000	0.000000	90.09
90. 11	09011 NEUROLOGY CLINIC	l ol	0		0.000000	0.000000	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0	0		0. 000000	0.000000	
90. 13	09013 ALLERGY CLINIC		407, 864	407, 864		0. 000000	
90. 14	09014 WOUND CARE	11, 900	6, 255, 199			0. 000000	
91. 00	09100 EMERGENCY	5, 520, 656	38, 980, 984			0. 000000	
92.00							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	186, 232	7, 334, 986	7, 521, 218	0. 327345	0. 000000	92.00
0= -:	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	4, 089, 469	4, 089, 469	1. 051809	0. 000000	
	10200 OPIOID TREATMENT PROGRAM	0	0	()		102.00
200.00	1 1	96, 145, 321	363, 741, 180	459, 886, 50°			200. 00
201.00	1 1			1			201.00
202.00	Total (see instructions)	96, 145, 321	363, 741, 180	459, 886, 50°			202. 00
		·			•		

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0104
Period: From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared:

5/30/2024 1:52 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31 00 31.00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04200 SUBPROVI DER 42.00 42.00 43 00 04300 NURSERY 43 00 04400 SKILLED NURSING FACILITY 44.00 44.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 55.00 55.01 05501 ULTRA SOUND 0.000000 55.01 57.00 05700 CT SCAN 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 06701 AUDI OLOGY 0.000000 67.01 67.01 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 06901 CARDI OLOGY 0. 000000 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 90.01 90.02 09002 CLI NI C 0.000000 90.02 09003 DERMATOLOGY CLINIC 0.000000 90.03 90.03 09004 ENT CLINIC 90.04 0.000000 90.04 90.05 09005 SURGERY CLINIC 0.000000 90.05 09007 UROLOGY CLINIC 90.07 0.000000 90.07 09009 GASTROENTEROLOGY CLINIC 90.09 0.000000 90.09 90 11 09011 NEUROLOGY CLINIC 0.000000 90.11 09012 OPTHAMOLOGY CLINIC 90.12 0.000000 90.12 90. 13 09013 ALLERGY CLINIC 0.000000 90.13 90. 14 09014 WOUND CARE 0.000000 90.14 09100 EMERGENCY 91 00 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 000000 95.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00

202.00

202.00

Total (see instructions)

Health Financial Systems	WITHAM MEMORI	AL HOSDITAL		In Lie	u of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2023 To 12/31/2023	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)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		•			
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF	859, 853 239, 226 270, 397		859, 85 239, 22 270, 39	6 1, 971	96. 95 121. 37 118. 60 0. 00	31.00 40.00
42. 00 SUBPROVI DER	0	0			0.00	
43. 00 NURSERY	0		Ì	731	0.00	
44.00 SKILLED NURSING FACILITY	232, 786		232, 78		53. 18	
200.00 Total (lines 30 through 199)	1, 602, 262		1, 602, 26		00.10	200.00
Cost Center Description	Inpatient	Inpati ent	., .,			
	Program days	Program Capital Cost (col. 5 x col. 6)				
	6, 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
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)	2, 010 484 1, 185 0 0 0 2, 195 5, 874	58, 743 140, 541 0 0 0 0 116, 730				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-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
			[rom 01/01/2023	Part II	
			-	Γo 12/31/2023	Date/Time Pre	pared:
			\0.01.1.		5/30/2024 1:5	2 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	749, 832	60, 099, 112			35, 515	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	713, 423	36, 375, 100		·	17, 845	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000	0	0	55.00
55. 01 05501 ULTRA SOUND	10, 421	8, 750, 115	0. 00119	83, 839	100	55. 01
57.00 05700 CT SCAN	10, 003	57, 742, 492	0. 000173	2, 881, 753	499	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	62, 768	12, 332, 477	0. 005090	231, 755	1, 180	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	49, 091	17, 001, 459	0. 00288	7 0	0	59.00
60. 00 06000 LABORATORY	378, 349	63, 162, 560	0. 005990	3, 848, 283	23, 051	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	427	825, 446	0. 000517	99, 483	51	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 000000	0	0	64.00
66. 00 06600 PHYSI CAL THERAPY	313, 279	8, 258, 634	0. 037934		11, 295	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	6, 410	2, 439, 762	0. 00262	·	671	67.00
67. 01 06701 AUDI OLOGY	31, 146	904, 612			0	67. 01
68. 00 06800 SPEECH PATHOLOGY	1, 770	1, 035, 723			105	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 7,0	1,033,723	0. 000000		0	69.00
69. 01 06901 CARDI OLOGY	52, 870	25, 848, 314	0. 00204		4, 674	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 943	11, 201, 532	0.002043		2, 747	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	23, 032	11, 201, 332	0. 00131.			71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	109, 460				1, 580 3, 785	73.00
		50, 736, 170			· ·	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		-	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000) 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	0	0	0.00000	0		00 00
	0	_			0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000			90. 01
90. 02 09002 CLI NI C	0	0	0.000000		Ŭ	90.02
90. 03 09003 DERMATOLOGY CLINIC	0	0	0. 000000		0	90. 03
90. 04 09004 ENT CLINIC	0	0	0. 000000		0	90.04
90. 05 09005 SURGERY CLINIC	0	0	0. 000000		0	90.05
90. 07 09007 UROLOGY CLINIC	249	114, 426	0. 002176		0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0	0. 000000		0	90. 09
90. 11 09011 NEUROLOGY CLI NI C	0	0	0. 000000		0	90. 11
90. 12 09012 OPTHAMOLOGY CLINIC	0	0	0. 000000		0	90. 12
90. 13 09013 ALLERGY CLINIC	29, 931	407, 864	0. 07338		0	90. 13
90. 14 09014 WOUND CARE	249, 218	6, 267, 099			0	90. 14
91. 00 09100 EMERGENCY	837, 081	44, 501, 640	0. 018810			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	194, 774	7, 521, 218	0. 02589	95, 908	2, 484	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	3, 840, 477	426, 863, 512		20, 003, 842	138, 644	200.00

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	STS Provider C		Peri od:	Worksheet D	
				From 01/01/2023	Part III	
				To 12/31/2023	Date/Time Pre 5/30/2024 1:5	epared: 2 nm
		Title	e XVIII	Hospi tal	PPS	/2 piii
Cost Center Description	Nursi ng	Nursi ng		n Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0)	0 0	0	
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0)	0	0	
42. 00 04200 SUBPROVI DER	0	0)	0	0	
43. 00 04300 NURSERY	0	0)	0	0	1 .0.00
44.00 04400 SKILLED NURSING FACILITY	0	0)	0		44.00
200.00 Total (lines 30 through 199)	0	0)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
LUDATI FUT DOUTLING OFFICE COOT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.00	0 00	0.010	1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	8, 86			
31. 00 03100 I NTENSI VE CARE UNI T		0	1, 97			
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0		2, 28			
	0		<u>'</u>	0.00		
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0		73	0.00		
		0				
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient	U	18, 22	8	5, 874	200.00
Cost Center Description	Program					
	Program Pass-Through					
	Cost (col. 7					
	x col. 8)					
	7. 001. 0)					

9. 00

30.00

31.00

40. 00 41. 00 42. 00 43. 00

44. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS
31. 00 03100 INTENSIVE CARE UNIT

44.00 04400 SKILLED NURSING FACILITY 200.00 Total (lines 30 through 199)

40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY

				10 12/31/2023	5/30/2024 1: 5	
		Title	Title XVIII		PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
, , , , , , , , , , , , , , , , , , ,	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments		,		
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	<u> </u>	•	•			
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		Ō		0	o o	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0		0	o o	
55. 01 05501 ULTRA SOUND		l ő		0 0	o o	55. 01
57. 00 05700 CT SCAN		l ő		0 0	o o	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0			o o	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
60. 00 06000 LABORATORY					j ,	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.				0 0		63.00
64. 00 06400 NTRAVENOUS THERAPY				0 0	1	64.00
66. 00 06600 PHYSI CAL THERAPY				0 0	1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY						67.00
67. 00 06700 0CC0PATTONAL THERAPT				0 0		1
		0				67. 01
	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
69. 01 06901 CARDI OLOGY	0	0		0	_	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	1 , 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	1	73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	1	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLI NI C	0	0		0 0		1
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0	_	1 ,0.0.
90. 02 09002 CLI NI C	0	0		0 0	1	90. 02
90. 03 09003 DERMATOLOGY CLINIC	0	0		0 0	0	90. 03
90. 04 09004 ENT CLINIC	0	0		0	0	90. 04
90. 05 09005 SURGERY CLINIC	0	0		0	0	90. 05
90. 07 09007 UROLOGY CLINIC	0	0		0	0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0	0	90.09
90. 11 09011 NEUROLOGY CLI NI C	0	0		0	0	90. 11
90. 12 09012 0PTHAMOLOGY CLINIC	0	0		0	0	90. 12
90. 13 09013 ALLERGY CLINIC	0	0		0 0	0	90. 13
90. 14 09014 WOUND CARE	0	0		0 0	0	90. 14
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 60, 099, 112 0.000000 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 36, 375, 100 54.00 0000000000000000000 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 0.000000 0 8, 750, 115 05501 ULTRA SOUND 0 55.01 0.000000 55.01 57.00 05700 CT SCAN 0 0 57, 742, 492 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 12, 332, 477 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 0 17, 001, 459 0.000000 59 00 0 60.00 06000 LABORATORY 0 63, 162, 560 0.000000 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 825, 446 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 64.00 0 8, 258, 634 06600 PHYSI CAL THERAPY 0 0.000000 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 2, 439, 762 0.000000 67.00 06701 AUDI OLOGY 0.000000 67.01 0 904, 612 67.01 06800 SPEECH PATHOLOGY 0 68 00 Ω 1, 035, 723 0 000000 68 00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 69.00 06901 CARDI OLOGY 0 0 25, 848, 314 0.000000 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 11, 201, 532 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 11, 337, 757 72 00 0 0.000000 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 50, 736, 170 0.000000 73.00 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 0.000000 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 0 0 90.01 90.01 09002 CLI NI C 0000000000 0 0 90.02 0 0.000000 90.02 0 09003 DERMATOLOGY CLINIC 0 0 0.000000 90.03 90.03 90.04 09004 ENT CLINIC 0 0 0 0.000000 90.04 90.05 09005 SURGERY CLINIC 0 0 0 0.000000 90.05 09007 UROLOGY CLINIC 0 90 07 0 114, 426 0.000000 90 07 90.09 09009 GASTROENTEROLOGY CLINIC 0 0 0 0.000000 90.09 09011 NEUROLOGY CLINIC 90.11 0 0.000000 90.11 90.12 09012 OPTHAMOLOGY CLINIC 0 0 0.000000 90.12 09013 ALLERGY CLINIC 0 407, 864 90.13 C 0.000000 90.13

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6, 267, 099

44, 501, 640

7, 521, 218

426, 863, 512

0.000000

0.000000

0.000000

90.14

91.00

92.00

95.00

200.00

90. 14

91.00

92.00

95.00

200.00

09014 WOUND CARE

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Н	eal th Financial	Systems		WITHAM MEMOR	RIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
Α	APPORTIONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SE	ERVICE OTHER PA	ASS	Provi der (Worksheet D
т	TUDOLICU COSTS						From 01/01/2023	Part IV

THROUGH COSTS 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm Title XVIII Hospi tal PPS I npati ent Outpati ent Cost Center Description Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 9, 341, 842 50 00 2, 846, 417 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 909, 852 12, 011, 388 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 55.00 0 05501 ULTRA SOUND 0.000000 83, 839 0 780, 440 55.01 55.01 0 0 05700 CT SCAN 57.00 0.000000 2, 881, 753 9, 557, 089 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 231, 755 0 2, 600, 821 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 413, 514 59.00 06000 LABORATORY 3, 848, 283 0 4, 343, 901 60.00 0.000000 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0.000000 99, 483 110, 362 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 66.00 06600 PHYSI CAL THERAPY 0.000000 297, 753 0 15, 604 0 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 255, 596 0 67.00 67.00 10, 743 0 67.01 06701 AUDI OLOGY 0.000000 0 67.01 06800 SPEECH PATHOLOGY 68.00 0.000000 61, 502 0 62, 941 0 68.00 0 69 00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 69.01 06901 CARDI OLOGY 0.000000 2, 285, 797 5, 955, 897 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 1, 815, 712 0 1, 400, 136 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 777, 755 0 1, 668, 798 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 14, 988, 638 73.00 0.000000 1, 754, 779 0 73.00 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 90.00 09000 CLI NI C 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 90.01 0.000000 0 0 90.01 0 90.02 09002 CLI NI C 0.000000 0 0 0 0 90.02 09003 DERMATOLOGY CLINIC 0 90 03 0.000000 0 0 90 03 90.04 09004 ENT CLINIC 0.000000 0 0 90.04 90.05 09005 SURGERY CLINIC 0.000000 0 0 90.05 0 0 09007 UROLOGY CLINIC 90.07 0.000000 0 0 0 90.07 0 90 09 09009 GASTROENTEROLOGY CLINIC 0.000000 90 09 Ω 0 0 o 90.11 09011 NEUROLOGY CLINIC 0.000000 0 0 90.11 09012 OPTHAMOLOGY CLINIC 0.000000 0 90.12 90.12 90.13 09013 ALLERGY CLINIC 0.000000 0 0 0 0 90.13 0 90.14 09014 WOUND CARE 0.000000 90.14 1, 163, 627 0 91.00 09100 EMERGENCY 0.000000 1, 757, 658 4, 504, 969 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 95, 908 1, 381, 793 0 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95 00 09500 AMBULANCE SERVICES

20, 003, 842

0

70, 312, 503

0 200.00

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0104 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 341, 842 50.00 0.115830 1, 082, 066 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0. 205509 54.00 12, 011, 388 54.00 2, 468, 448 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 Λ 55.00 55.01 05501 ULTRA SOUND 0.175839 780, 440 0 0 137, 232 55.01 0 57.00 05700 CT SCAN 0.020235 9, 557, 089 0 193, 388 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.078686 2, 600, 821 58 00 0 204, 648 58 00 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.027052 413, 514 11, 186 59.00 60.00 06000 LABORATORY 0.156864 4, 343, 901 0 0 0 681, 402 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.117025 12, 915 63.00 110, 362 63.00 0 06400 I NTRAVENOUS THERAPY 0.000000 64.00 Ω 64.00 66.00 06600 PHYSI CAL THERAPY 0.388987 15,604 6,070 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0.306328 10,743 0 0 3, 291 67.00 06701 AUDI OLOGY 0 67 01 0.365375 67 01 0 0 68.00 06800 SPEECH PATHOLOGY 0.286928 62, 941 18,060 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 0 0 69.01 06901 CARDI OLOGY 0.120982 5, 955, 897 0 720, 556 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 400, 136 0 o 478, 464 71 00 71 00 0 341727 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 0.460362 1,668,798 0 768, 251 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 289950 14, 988, 638 23, 043 4, 345, 956 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 C 0 77.00 0 07800 CAR T-CELL LMMUNOTHERAPY 0.000000 0 78.00 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 90.00 09000 CLI NI C 0 0 0 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 90.01 90.01 0 0 0 90.02 90.02 09002 CLI NI C 0.000000 0 0 90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 0 0 90.03 90.04 09004 ENT CLINIC 0.000000 0 0 0 0 0 90.04 0 09005 SURGERY CLINIC 90.05 0.000000 0 90.05 0 09007 UROLOGY CLINIC 0 90.07 0.413787 0 0 90.07 09009 GASTROENTEROLOGY CLINIC 0.000000 0 90.09 90.09 0 90.11 09011 NEUROLOGY CLINIC 0.000000 0 0 0 90.11 09012 OPTHAMOLOGY CLINIC 0 90.12 90.12 0 0.000000 C 0 0 90.13 09013 ALLERGY CLINIC 0.480040 0 0 90.13 90. 14 09014 WOUND CARE 0.143923 1, 163, 627 0 1, 779 167, 473 90.14 09100 EMERGENCY 0 0.183149 4.504.969 91.00 91.00 825, 081 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0. 327345 1, 381, 793 452, 323 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1. 051809 0 95.00 Subtotal (see instructions) Less PBP Clinic Lab. Services-Program 200.00 12, 576, 810 200. 00 0 70, 312, 503 24,822

0

0

24, 822

70, 312, 503

201.00

12, 576, 810 202. 00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm

						5/30/2024 1:5	2 pm
			Title	XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
1	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0				50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0				55.00
55. 01	05501 ULTRA SOUND	o	0				55. 01
57.00	05700 CT SCAN	o	0				57.00
58.00	O5800 MAGNETIC RESONANCE IMAGING (MRI)	o	0				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
1	06000 LABORATORY	0	0				60.00
1	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
1	06400 I NTRAVENOUS THERAPY	0	0				64.00
	06600 PHYSI CAL THERAPY	0	0				66.00
1	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	1			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
1	07300 DRUGS CHARGED TO PATIENTS	0	6, 681				73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78.00
	OUTPATIENT SERVICE COST CENTERS	-1	-	I.			
	09000 CLI NI C	0	0				90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	1			90. 01
- 1	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
1	09013 ALLERGY CLINIC	0	0	1			90. 13
	09014 WOUND CARE		256	1			90. 14
	09100 EMERGENCY		0				91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	1			92.00
<u> </u>	OTHER REIMBURSABLE COST CENTERS	<u>ا</u>					1
	09500 AMBULANCE SERVICES	0					95. 00
200.00	Subtotal (see instructions)		6, 937				200.00
201.00	Less PBP Clinic Lab. Services-Program		5, 707				201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	6, 937				202.00
- 1		1	•	•			•

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Period: From 01/01/2023	Worksheet D Part II		
		Component	CCN: 15-S104	To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm	
		Title	XVIII	Subprovi der - I PF	PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs		
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x		
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)		
	B, Part II, col. 26)	col. 8)	col. 2)				
	1.00	2. 00	3.00	4.00	5. 00		
ANCILLARY SERVICE COST CENTERS			0.00				
50.00 05000 OPERATING ROOM	749, 832	60, 099, 112			0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	713, 423	36, 375, 100			399		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000		0		
55. 01 05501 ULTRA SOUND	10, 421	8, 750, 115	0.00119		0		
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 003 62, 768	57, 742, 492 12, 332, 477	0. 00017 0. 00509		9 17	57. 00 58. 00	
59. 00 05900 CARDIAC CATHETERIZATION	49, 091	17, 001, 459	0. 00309		0		
60. 00 06000 LABORATORY	378, 349	63, 162, 560			1, 896		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	427	825, 446	0. 00051		0	63.00	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000	00	0	64.00	
66. 00 06600 PHYSI CAL THERAPY	313, 279	8, 258, 634	0. 03793		301	66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	6, 410	2, 439, 762	0. 00262		17	67.00	
67. 01 06701 AUDI OLOGY	31, 146	904, 612	0. 03443		0		
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	1, 770	1, 035, 723 0	0. 00170 0. 00000		7 0	68. 00 69. 00	
69. 01 06900 ELECTROCARDI OLOGY	52, 870	25, 848, 314	0. 00000		18		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 943	11, 201, 532	0. 0020		56		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	23, 032	11, 337, 757	0. 00203		0		
73.00 07300 DRUGS CHARGED TO PATIENTS	109, 460	50, 736, 170	0. 00215		270	73.00	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0		
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	00	0	78. 00	
OUTPATIENT SERVICE COST CENTERS		0	0.0000			00.00	
90. 00 09000 CLINIC 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0. 00000 0. 00000		0		
90. 02 09002 CLINI C	0	0	0.00000		0		
90. 03 09003 DERMATOLOGY CLINIC	0	0	0. 00000		0	90.03	
90. 04 09004 ENT CLINIC	o	0	0. 00000		Ö		
90. 05 09005 SURGERY CLINIC	0	0	0. 00000		0	90. 05	
90. 07 09007 UROLOGY CLINIC	249	114, 426	0. 00217		0		
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0	0. 00000		0		
90. 11 09011 NEUROLOGY CLINIC	0	0	0.00000		0		
90. 12 09012 0PTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC	0 29, 931	0 407, 864	0. 00000 0. 07338		0	90. 12 90. 13	
90. 14 09013 ALLERGY CLINIC 90. 14 09014 WOUND CARE	249, 218	6, 267, 099			0		
91. 00 09100 EMERGENCY	837, 081	44, 501, 640	0. 01881		468	1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7, 521, 218			0		
OTHER REIMBURSABLE COST CENTERS							
95. 00 09500 AMBULANCE SERVICES						95.00	
200.00 Total (lines 50 through 199)	3, 645, 703	426, 863, 512		606, 639	3, 458	200. 00	

APPORT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PAS		CN: 15-0104 CCN: 15-S104	Peri From To		u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/30/2024 1:5	pared:
			Title	XVIII	Sub	provi der – I PF	PPS	
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program	Po		Allied Health	
		1. 00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			I				
50.00	05000 OPERATI NG ROOM	0	0		0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55. 01	05501 ULTRA SOUND	0	0		0	0	0	55. 01
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	•	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
67. 01	06701 AUDI OLOGY	0	0		0	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
69. 01	06901 CARDI OLOGY	0	0		0	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL I MMUNOTHERAPY	0	0		0	0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			I	0	O	0	00 00
90. 00 90. 01	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		-	0	-	90.00
90.01	09001 OTHER OUTPATTENT SERVICE COST CENTER	0	0		0	0	0	90. 01
90. 02	09003 DERMATOLOGY CLINIC	0	0		0	0	0	90. 02 90. 03
90.03	09004 ENT CLINIC		0		0	0	0	90.03
90.04	09005 SURGERY CLINIC		0		0	0	0	90.04
90.05	09007 UROLOGY CLINIC		0		0	0	0	90.05
90. 07	09007 DROLOGY CLINIC		0		0	0	0	90.07
90. 09	09011 NEUROLOGY CLINIC		0		0	0	0	90.09
90. 11	1 1		0	•	0	0	0	90.11
90. 12	09013 ALLERGY CLINIC		0		0	0	0	90. 12
90. 13	09014 WOUND CARE		0		0	٥	0	90. 13
91. 00	09100 EMERGENCY	0	0		0	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ü		0	ď	0	92.00
12.00	OTHER RELIMBURGARIE COST CENTERS	<u> </u>		l .	U		U	1 /2.00

0

0

0

0

95. 00 0 200. 00

200.00

92. 00 09200| 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500| AMBULANCE SERVICES

Total (lines 50 through 199)

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA CH COSTS	RVICE OTHER PAS	S Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			Title	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
				and 4)		(see instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	C)	0 60, 099, 112	0.000000	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	c		0 36, 375, 100		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0. 000000	55.00
55. 01	05501 ULTRA SOUND	0			0 8, 750, 115		
57.00	05700 CT SCAN	0	1		0 57, 742, 492	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-	•	0 12, 332, 477	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 17, 001, 459		
60.00	06000 LABORATORY	0	C	l	0 63, 162, 560		
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		1	0 825, 446	0. 000000 0. 000000	1
66.00	06600 PHYSI CAL THERAPY	0		1	0 8, 258, 634	0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0			0 2, 439, 762		
67. 01	06701 AUDI OLOGY	Ö		1	0 904, 612		
68. 00	06800 SPEECH PATHOLOGY	Ö		1	0 1, 035, 723		
69.00	06900 ELECTROCARDI OLOGY	0	c		0 0	0.000000	
69. 01	06901 CARDI OLOGY	0	C		0 25, 848, 314	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 11, 201, 532	0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	C		0 11, 337, 757	0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 50, 736, 170		
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		1	0		
78. 00	O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	<u> </u>)	0 0	0.000000	78. 00
90.00	09000 CLINIC	0		1	0 0	0.000000	90.00
90. 00	09001 OTHER OUTPATIENT SERVICE COST CENTER			l	0 0		
90. 02	09002 CLINIC	0		l .	0 0		1
90. 03	09003 DERMATOLOGY CLINIC	0		•	0 0	0. 000000	1
90.04	09004 ENT CLINIC	0	C		0 0	0.000000	90. 04
90.05	09005 SURGERY CLINIC	0	C		0 0	0. 000000	90. 05
90. 07	09007 UROLOGY CLINIC	0	C	l .	0 114, 426		
90. 09	09009 GASTROENTEROLOGY CLINIC	0	C		0	0. 000000	1
90. 11	09011 NEUROLOGY CLINIC	0	C		0		1
90. 12	O9012 OPTHAMOLOGY CLINIC O9013 ALLERGY CLINIC	0			0 407, 864	0.000000	
90. 13	09014 WOUND CARE	0	1		0 407, 864 0 6, 267, 099		
90. 14	09100 EMERGENCY		-	•	0 44, 501, 640		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0 7, 521, 218		
00	OTHER REIMBURSABLE COST CENTERS			1	-, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	()	0 426, 863, 512		200. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10
			Provider CCN: 15-0104 Component CCN: 15-S104		Worksheet D Part IV Date/Time Prepared: 5/30/2024 1:52 pm	
		Title	: XVIII	Subprovi der -	PPS	<u> </u>
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Throug Costs (col. x col. 10)	Outpatient Program h Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
ANCILLIADY SERVICE COST CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 55. 00 55. 00 55. 00 55. 01 55. 01 55. 01 55. 00 55. 01 57. 00 58. 00 58. 00 58. 00 58. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 60. 00	0. 000000 0. 000000	20, 342 0 0 52, 096 3, 396 0 316, 531 0 7, 943 6, 371 0 4, 037 0 8, 730 37, 339 0 124, 963		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 00 55. 00 55. 01 57. 00 58. 00 59. 00 60. 00 63. 00 64. 00 67. 01 68. 00 69. 01 71. 00 72. 00 73. 00 77. 00
OUTPATIENT SERVICE COST CENTERS	0. 000000 0. 000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 07 90. 09 90. 11 90. 12 90. 13 90. 14 91. 00 92. 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50 through 199)		606, 639		0 894	0	95. 00 200. 00

					IPF		
	·			Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	, , , , , , , , , , , , , , , , , , ,	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	,	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 115830	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 205509	0	0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55.00
55. 01	05501 ULTRA SOUND	0. 175839	0	0	0	0	55. 01
57. 00	05700 CT SCAN	0. 020235	0	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 078686	0	0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 027052	l o	0	0	0	59.00
	06000 LABORATORY	0. 156864	0	0	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 117025	0	0		0	63.00
	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
	06600 PHYSI CAL THERAPY	0. 388987	0	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 306328	0	1	_	0	67. 00
	06701 AUDI OLOGY	0. 365375	0	1	_	Ö	67. 01
	06800 SPEECH PATHOLOGY	0. 286928	0	1		Ö	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000	0	1	_	0	69.00
	06901 CARDI OLOGY	0. 120982	0	0		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 120702			0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 460362	0	0		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 400302	0	1	_	0	73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0. 287730	ı	1	· ·	0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				0	78.00
	OUTPATIENT SERVICE COST CENTERS	0.00000		1 0	0	U	78.00
	09000 CLINIC	0. 000000	0	0	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000				0	90.00
	09002 CLINIC	0. 000000	0	1		0	90.01
	09003 DERMATOLOGY CLINIC	0. 000000	0		_	0	90.02
	09004 ENT CLINIC	0. 000000		1	_	_	90.03
			0			0	90.04
	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0.000000	0		_	_	90.05
		0. 413787	0	1	_	0	
	09009 GASTROENTEROLOGY CLINIC	0. 000000	0	0		0	90.09
	09011 NEUROLOGY CLINIC	0. 000000	0	0	_	0	90. 11
	09012 OPTHAMOLOGY CLINIC	0.000000	0	1	_	0	90. 12
	09013 ALLERGY CLINIC	0. 480040	0	_	_	0	90. 13
	09014 WOUND CARE	0. 143923	894			129	90. 14
	09100 EMERGENCY	0. 183149	0			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 327345	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1. 051809	ł	0			95. 00
200.00	Subtotal (see instructions)		894			129	200. 00
201. 00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		894	0	3, 892	129	202. 00

Health Financial Systems		I AL HOSPI TAL			u of Form CMS-	<u> 2552-10</u>
APPORTIONMENT OF MEDICAL, OTHER HEALTH SI	ERVICES AND VACCINE COST	Provi der (CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D Part V	
		Component	CCN: 15-S104	To 12/31/2023	Date/Time Pre	epared:
		T: +1	e XVIII	Subprovi der -	5/30/2024 1: 5 PPS	52 pm
		11 (1	e Aviii	I PF	PPS	
		osts				
Cost Center Description	Cost	Cost				
	Reimbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM		0	0			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		-1	0			55.00
55.01 05501 ULTRA SOUND		0	0			55. 01
57.00 05700 CT SCAN		-	0			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (1	MRI)	-	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		-1	0			59.00
60. 00 06000 LABORATORY		-	0			60.00
63. 00 06300 BLOOD STORING, PROCESSING &	1	-1	0			63.00
64. 00 06400 I NTRAVENOUS THERAPY		- 1	0			64.00
66. 00 06600 PHYSI CAL THERAPY		~	0			66.00
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY		-1	0			67.00
67. 01 06701 AUDI OLOGY 68. 00 06800 SPEECH PATHOLOGY		٩	0			
69. 00 06900 ELECTROCARDI OLOGY		-	0			68. 00 69. 00
69. 01 06900 ELECTROCARDI OLOGY		-1	0			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO	DATI ENTS	٩	0			71.00
72.00 07200 MEDICAL SUPPLIES CHARGED TO PATIEN		- 1	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4	0 1, 12	-1			73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		- 1	o o			77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		-	ol			78.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		-,			1
90. 00 09000 CLI NI C		0	0			90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST	T CENTER	o	o			90. 01
90. 02 09002 CLI NI C		0	0			90.02
90.03 09003 DERMATOLOGY CLINIC		0	0			90. 03
90. 04 09004 ENT CLINIC		-1	0			90.04
90. 05 09005 SURGERY CLINIC		-1	0			90.05
90. 07 09007 UROLOGY CLINIC		-	0			90. 07
90.09 09009 GASTROENTEROLOGY CLINIC		-1	0			90.09
90. 11 09011 NEUROLOGY CLINIC		٧	0			90. 11
90. 12 09012 0PTHAMOLOGY CLINIC			0			90. 12
90 13 09013 ALLERGY CLINIC		OI.	ol			90 13

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90.13

90. 14

91.00 92.00 95.00

200.00

201.00

202.00

90. 13 09013 ALLERGY CLINIC

90. 14 | 09014 | WOUND CARE
91. 00 | 09100 | EMERGENCY
92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

95. 00 | 09500 | AMBULANCE SERVICES

200. 00 | Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

90. 14 09014 WOUND CARE

202.00

- 1	Heal th Financial	Systems		WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	APPORTI ONMENT OF	I NPATI ENT/OUTPATI ENT	ANCI LLARY SI	ERVICE OTHER PAS	S Provi der C	CN: 15-0104	Peri od:	Worksheet D	
	THROUGH COSTS						From 01/01/2023		
					Component	CCN: 15-5832	To 12/31/2023		pared:
								5/30/2024 1:5	2 pm
					Title	XVIII	Skilled Nursing	PPS	
							Facility		
	Cost	Center Description		Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
				Anestheti st	Program	Program	Post-Stepdown		
				Cost	Post-Stepdown		Adjustments		
					Adjustments				

	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	'	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_					
50.00	05000 OPERATING ROOM	C	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	1	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55.00
55. 01	05501 ULTRA SOUND	C	0	(0	0	
57. 00	05700 CT SCAN	C	0	(0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	
60.00	06000 LABORATORY	0	0	(0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	0	64.00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	C	0	(0	0	67.00
67. 01	06701 AUDI OLOGY	0	0	(0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	C	0	(0	0	69.00
69. 01	06901 CARDI OLOGY	C	0	(0	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	C	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0	(0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	C	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	C	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS				_		
90. 00	09000 CLI NI C	0	0	(0	1	
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	(0	0	
90. 02	09002 CLI NI C	0	0	(0	0	
90. 03	09003 DERMATOLOGY CLINIC	C	0	(0	0	90.03
90.04	09004 ENT CLINIC	0	0	(0	0	90.04
90. 05	09005 SURGERY CLINIC	C	0	(0	0	90.05
90. 07	09007 UROLOGY CLINIC	C	0	(0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	C	0	(0	0	90.09
90. 11	09011 NEUROLOGY CLINIC	C	0	(0	0	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	C	0	(0	0	90. 12
90. 13	09013 ALLERGY CLINIC	C	0	(0	0	90. 13
90. 14	09014 WOUND CARE	C	0	(0	0	90. 14
91.00	09100 EMERGENCY	0	0	1	0	1	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C				0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00							95.00
200.00	Total (lines 50 through 199)	0	0	(0	· 0	200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	WITHAM MEMORIA		CN: 15_0104	Period:	eu of Form CMS-: Worksheet D	2552-10
	H COSTS	WICE OTHER PASS		CCN: 15-5832	From 01/01/2023 To 12/31/2023	Part IV	epared:
			Title	XVIII	Skilled Nursing	5/30/2024 1:5 PPS	o2 pm
					Facility		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
			(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	cols. 2, 3,	col . 8)	col. 7)	
				and 4)		(see	
		4. 00	5. 00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50. 00	05000 OPERATING ROOM	O	0		0 60, 099, 112	0.000000	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0 36, 375, 100		
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		0 30, 373, 100		
55. 01	05501 ULTRA SOUND		0		0 8, 750, 115		
57. 00	05700 CT SCAN		0		0 57, 742, 492		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0 12, 332, 477		1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0 17, 001, 459		
60. 00	06000 LABORATORY		0		0 63, 162, 560		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0 825, 446	l .	
64. 00	06400 I NTRAVENOUS THERAPY		0		0 020, 110		
66. 00	06600 PHYSI CAL THERAPY		0		0 8, 258, 634		
67. 00	06700 OCCUPATI ONAL THERAPY		0		0 2, 439, 762		
67. 01	06701 AUDI OLOGY	l ol	0		0 904, 612	l .	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 035, 723		1
69. 00	06900 ELECTROCARDI OLOGY	l ol	0		0 0	l	
69. 01	06901 CARDI OLOGY	O	0		0 25, 848, 314	l .	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0 11, 201, 532		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	o	0		0 11, 337, 757		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 50, 736, 170	0.000000	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	O	0		0	0.000000	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0		
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0		
90. 02	09002 CLI NI C	0	0		0		
90. 03	09003 DERMATOLOGY CLINIC	0	0		0		
90. 04	09004 ENT CLINIC	0	0		0		1
90. 05	09005 SURGERY CLINIC	0	0		0 0		
90.07	09007 UROLOGY CLINIC	0	0		0 114, 426		
90.09	09009 GASTROENTEROLOGY CLINIC	0	0		0	0.00000	
90. 11	09011 NEUROLOGY CLINIC	0	0	•	0		
	09012 OPTHAMOLOGY CLINIC	0	0		0 0		
90. 13 90. 14	09013 ALLERGY CLINIC		0		0 407, 864 0 6, 267, 099		
90. 14	09014 WOUND CARE		0		-,,		
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0 44, 501, 640 0 7, 521, 218		
72. UU	OTHER DEIMPHRADIE COST CENTERS	<u> </u>	0	l	0 1,321,218	J. 0.000000	72.00

0

0

92.00 95.00

200.00

426, 863, 512

0

200.00

92. 00 09200 | OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 | AMBULANCE SERVICES

Total (lines 50 through 199)

Heal th	Financial Systems	WITHAM MEMORIAL	L HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE OTHER PASS	Component	CCN: 15-5832	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
			Title	XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9	
		col. 7) 9.00	10. 00	x col . 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	7, 00	10.00	111.00	12.00	10.00	
50.00	05000 OPERATING ROOM	0. 000000	2, 644		0 0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	28, 691		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0		55.00
55. 01	05501 ULTRA SOUND	0. 000000	0		0		55. 01
57. 00	05700 CT SCAN	0. 000000	0		0 0	_	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	_	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	_	59.00
60.00	06000 LABORATORY	0. 000000	188, 618		0 0	_	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0.000000	0 E40 07E		0 0	_	64.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 000000 0. 000000	569, 075 618, 690	•	0 0		66. 00 67. 00
67. 00	06701 AUDI OLOGY	0. 000000	010, 090		0 0	_	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	10, 444		0 0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	10, 444		0 0	_	69.00
69. 01	06901 CARDI OLOGY	0. 000000	13, 072		0 0		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	68, 639		0 0	_	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	00, 037	1	0 0	_	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	542, 198		0 0	1	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0		78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	90. 01
90. 02	09002 CLI NI C	0. 000000	0		0 0	0	90. 02
90. 03	09003 DERMATOLOGY CLINIC	0. 000000	0		0	0	90. 03
90. 04	09004 ENT CLINIC	0. 000000	0		0	0	90. 04
90. 05	09005 SURGERY CLINIC	0. 000000	0		0 0	0	90. 05
90. 07	09007 UROLOGY CLINIC	0. 000000	0		0	1	90. 07
90. 09	09009 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0		90.09
90. 11	09011 NEUROLOGY CLINIC	0. 000000	0		0 0	1	90. 11
90. 12	09012 OPTHAMOLOGY CLINIC	0. 000000	0		0 0	1	90. 12
90. 13	09013 ALLERGY CLINIC	0.000000	0		0 0	_	90. 13
	09014 WOUND CARE	0. 000000	0		0 0		90.14
タェ いし	IV 7 IV VII I IVII IN TENTE IN C. I		()		CII ()	· ()	. 7 . (//)

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0. 000000

2, 042, 071

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0 92.00 95.00

91.00

0 200.00

91. 00 09100 EMERGENCY

92. 00 | 09200 | 09SERVATION BEDS (NON-DISTINCT PART) | 0THER REIMBURSABLE COST CENTERS | 95. 00 | 09500 | AMBULANCE SERVICES | 200. 00 | Total (lines 50 through 199)

Title XVIII Skilled Nursing PPS Facility Charges Costs PPS Cost Center Description Cost to Cost Cost PPS Services Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.115830 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 0. 205509 0 0 0 54 00 54 00 0 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 55.00 0 55.01 05501 ULTRA SOUND 0.175839 0 55.01 57.00 05700 CT SCAN 0.020235 0 0 0 0 0 0 0 0 0 0 0 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0.078686 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.027052 0 59.00 06000 LABORATORY 0 60.00 0.156864 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 117025 0 0 63.00 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06600 PHYSI CAL THERAPY 0.388987 0 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.306328 0 67.00 67.00 0 06701 AUDI OLOGY 0 67.01 0.365375 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 0. 286928 0 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.00 06901 CARDI OLOGY 0. 120982 0 0 0 0 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71 00 0.341727 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.460362 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0.289950 8,872 0 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 0 0 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 Ω 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 О 0 90.00 0 0 90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0.000000 0 90.01 0 0.000000 90.02 90.02 09002 CLI NI C 0 0 90.03 09003 DERMATOLOGY CLINIC 0.000000 0 0 0 90.03 0 0 0 90.04 09004 ENT CLINIC 0.000000 0 90.04 09005 SURGERY CLINIC 0 90.05 0.000000 0 90.05 0 90.07 09007 UROLOGY CLINIC 0.413787 0 0 90.07 09009 GASTROENTEROLOGY CLINIC 0 90.09 90.09 0.000000 0 0 0 0 09011 NEUROLOGY CLINIC 0 0.000000 90.11 90.11 0 0 09012 OPTHAMOLOGY CLINIC 90.12 0.000000 0 0 90.12 0 90.13 09013 ALLERGY CLINIC 0.480040 0 0 90.13 90.14 09014 WOUND CARE 0.143923 0 0 90.14 0 0 91.00 09100 EMERGENCY 0.183149 C 0 Λ 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.327345 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1. 051809 0 95.00 0 0 0 200.00 Subtotal (see instructions) 200.00 8,872

201.00

0 202.00

0

8, 872

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C	CN: 15-0104	Peri od: From 01/01/2023	Worksheet D Part V	
		Component	CCN: 15-5832	To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		Title	e XVIII	Skilled Nursing Facility	PPS	
·	Co	sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOULL ADV. CEDW OF COCT. OFNITEDS	6. 00	7.00				

Rei mbursed Servi ces Servi ces Servi ces Servi ces Subject To Ded. & Coi ns. (see i nst.) Ded. & Coi ns. Ded. & Co
Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)
Ded. & Coi ns. (see i nst.) Ded. & Coi ns. (see i nst.)
See inst. (see inst.
ANCILLARY SERVICE COST CENTERS
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0 0 50. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 00 55. 01 05501 ULTRA SOUND 0 0 55. 01 57. 00 05700 CT SCAN 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 00
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 0 55. 01 05501 ULTRA SOUND 0 0 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55. 01 05501 ULTRA SOUND 0 0 55. 01 57. 00 05700 CT SCAN 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 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 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00
55. 01 05501 ULTRA SOUND
57. 00 05700 CT SCAN 0 0 57. 00 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 59. 00 05900 CARDIAC CATHETERIZATION 0 0 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 59. 00
(0.00 0,000 LABORATORY
60. 00 06000 LABORATORY 0 0 60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0
64. 00 06400 I NTRAVENOUS THERAPY 0 0 64. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 67. 0C
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 69. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 2, 572 73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77. 00
77. 00 07700 REEGGENET C 113CT ACQUITATION 0 0 0 77. 00 0 78. 00 0 78. 00 0 78. 00 0 0 0 0 0 0 0 0 0
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0 0 90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0 0 90. 01
90. 02 09002 CLINI C 0 0 90. 02
90. 03 09003 DERMATOLOGY CLINIC 0 90. 03
90. 04 09004 ENT CLINIC 0 90. 04
90. 05 09005 SURGERY CLINI C
90. 07 09007 UROLOGY CLINI C 0 90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC 0 90. 09
90. 11 09011 NEUROLOGY CLI NI C
90. 12 09012 0PTHAMOLOGY CLINI C
90. 13 09013 ALLERGY CLINIC 0 90. 13
91. 00 09100 EMERGENCY 0 0 91. 00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00
OTHER RELABILICADE COST CENTERS
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES 0 95. 00
95. 00 09500 AMBULANCE SERVICES 0 95. 00 200. 00 Subtotal (see instructions) 0 2,572 200. 00
95. 00 O9500 AMBULANCE SERVICES O 95. 00 200. 00 Subtotal (see instructions) O 2,572 200. 00 201. 00 Less PBP Clinic Lab. Services-Program O 201. 00 Control of the control o
95. 00 09500 AMBULANCE SERVICES 0 95. 00 200. 00 Subtotal (see instructions) 0 2,572 200. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/30/2024 1:5	
		Title XVIII	Hospi tal	PPS	_ p
Cost Center Description					
·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Inpatient days (including private room	days and swing-hed day	vs excluding newborn)		8 869	1 00

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8, 869	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8, 869	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
4 00	do not complete this line.		4 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	6, 860 0	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	U	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room 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 days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 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 Program (excluding swing-bed and	2, 010	9. 00
7. 00	newborn days) (see instructions)	2,010	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room 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 only (including private room days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12. 00	through December 31 of the cost reporting period	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services 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 the cost	0.00	20. 00
	reporting period	2.22	
21. 00	Total general inpatient routine service cost (see instructions)	10, 868, 930	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting 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 reporting period (line 6	0	23. 00
23.00	Swing-bed cost appropriate to swintype services after becember 51 of the cost reporting period (The visit Reportin	O	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	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, 868, 930	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	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 and private room cost differential (line	10, 868, 930	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 225. 50	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 463, 255	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 463, 255	41.00

COMPUTATION OF INPATIENT OPERATING COS	Γ	Provi der C		Peri od:	Worksheet D-1	2552-10
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
		Title	e XVIII	Hospi tal	PPS	2 piii
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col . 2)	4.00	col . 4)	
42 00 NUDCEDY (+; +1 a V 8 VIV and v)	1. 00	2.00	3.00	4. 00 0 0	5. 00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient H		0	ı <u>j</u> 0. 0	<u>U</u>	U	42.00
43. 00 INTENSIVE CARE UNIT	3, 389, 162	1, 971	1, 719. 5	1 484	832, 243	43.00
44. 00 CORONARY CARE UNIT	0,007,102	1,,,,	1,71713		002,210	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	
40.00 Program i marti ant ancillam and	diana and Allina D. 2. and	2 11 200)			1. 00	40.00
48.00 Program inpatient ancillary ser 48.01 Program inpatient cellular ther			III lino 10	column 1)	3, 552, 210 0	48. 00 48. 01
49.00 Total Program inpatient costs (corumir 1)	6, 847, 708	
PASS THROUGH COST ADJUSTMENTS	diii 01 1111es 41 tili odgii 40.	or) (see riistru	Cti (iis)		0, 047, 700	47.00
50.00 Pass through costs applicable t	Program inpatient routine	services (fro	m Wkst. D. sur	n of Parts I and	253, 613	50.00
III)	13 1 11 1 1 1 1 1 1 1		,			
51.00 Pass through costs applicable t	Program inpatient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	138, 644	51.00
and IV)						
52.00 Total Program excludable cost (olotod	vol ol · · · · ·	notiot!	392, 257	1
53.00 Total Program inpatient operati medical education costs (line 4		erated, non-ph	ysician anesti	netist, and	6, 455, 451	53.00
TARGET AMOUNT AND LIMIT COMPUTA						-
54.00 Program discharges	1 014				0	54.00
55.00 Target amount per discharge					0.00	
55.01 Permanent adjustment amount per	di scharge				0.00	
55.02 Adjustment amount per discharge						
6.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
market basket)						00.00
61.00 Continuous improvement bonus pa	ment (if line 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.00
55.01, or line 59, or line 60,						
53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						
enter zero. (see instructions)						,,,,,,
62.00 Relief payment (see instruction					0	
63.00 Allowable Inpatient cost plus i		uctions)			0	63.00
64.00 Medicare swing-bed SNF inpatien		ombor 31 of th	a cost ranorti	ng period (See	0	64.00
instructions)(title XVIII only)	Toutine costs through bec	CIIIDCI 31 01 tii	c cost reporti	ng perrou (see		04.00
65.00 Medicare swing-bed SNF inpatien	routine costs after Decem	ber 31 of the	cost reporting	period (See	0	65.00
instructions)(title XVIII only)						
66.00 Total Medicare swing-bed SNF in	atient routine costs (line	64 plus line	65)(title XVII	I only); for	0	66.00
CAH, see instructions	tiont mouties as to the	b Doo 05	of the	montle	_	47.00
67.00 Title V or XIX swing-bed NF inp (line 12 x line 19)	THERE FOULTHE COSTS THROUG	n becember 31	oi the cost re	eporting period	0	67.00
68.00 Title V or XIX swing-bed NF inp	tient routine costs after	December 31 of	the cost ren	orting period	0	68. 00
(line 13 x line 20)	in the costs are		000 t 1 opt			-5.00
PART III - SKILLED NURSING FACI						
70.00 Skilled nursing facility/other	3		•)		70.00
71.00 Adjusted general inpatient rout		ııne 70 ÷ line	2)			71.00
72.00 Program routine service cost (I 73.00 Medically necessary private room		m (lina 14 v l	ino 2E)			72.00
73.00 Medically necessary private roo 74.00 Total Program general inpatient	11	•	,			73. 00 74. 00
75. 00 Capi tal -related cost allocated				Part II. column		75.00
26, line 45)	, , , , , , , , , , , , , , , , , , , ,	(,		
76.00 Per diem capital -related costs	line 75 ÷ line 2)					76. 00
77.00 Program capital-related costs (77. 00
78.00 Inpatient routine service cost						78.00
79.00 Aggregate charges to beneficiar		•		70		79.00
80.00 Total Program routine service of	•	cost IImitatio	n (line 78 mir	nus line 79)		80.00
81.00 Inpatient routine service cost		1)				81.00
82.00 Inpatient routine service cost 83.00 Reasonable inpatient routine se						82. 00 83. 00
84.00 Program inpatient ancillary ser)				84.00
85.00 Utilization review - physician	,	ons)				85.00
86.00 Total Program inpatient operati						86.00
PART IV - COMPUTATION OF OBSERV						
87.00 Total observation bed days (see	•				2, 009	
88.00 Adjusted general inpatient rout						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 CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)			2, 462, 030	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	859, 853	10, 868, 930	0. 07911	1 2, 462, 030	194, 774	90.00
91.00 Nursing Program cost	0	10, 868, 930	0. 00000	2, 462, 030	0	91.00
92.00 Allied health cost	0	10, 868, 930	0.00000	00 2, 462, 030	0	92.00
93.00 All other Medical Education	0	10, 868, 930	0. 00000	2, 462, 030	0	93.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-S104		
	Title XVIII	Subprovi der -	PPS
		IPF	

Cost Center Description PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 0
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS I npatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 0
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 0
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0 0
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	
 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 	~~ l
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	80
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0
reporting period (if calendar year, enter 0 on this line)	0
	"
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0
reporting period	
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,	85
newborn days) (see instructions)	03
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0 1
through December 31 of the cost reporting period (see instructions)	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0 1
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0 1
through December 31 of the cost reporting period	~ '
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0 1
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0 1
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)	0 1
SWING BED ADJUSTMENT	
	00 1
reporting period	
	00 1
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.	00 1
reporting period	00 1
	00 2
reporting period	
21.00 Total general inpatient routine service cost (see instructions) 2, 959, 3	
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0 2
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0 2
x line 18)	
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0 2
7 x line 19)	0 2
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0 2
26.00 Total swing-bed cost (see instructions)	0 2
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2,959,	26 2
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	0 2
29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges)	0 2
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	
, , , , , , , , , , , , , , , , , , ,	00 3
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)	00 3
	00 3
	00 3
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,959,3	0 3
27 minus line 36)	20 3
PART II - HOSPITAL AND SUBPROVIDERS ONLY	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,297.	
39.00 Program general inpatient routine service cost (line 9 x line 38) 1,538,0	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,538,0	71 4
1,300,0	

	I Systems INPATIENT OPERATING COST	WITHAM MEMORI		CN: 15-0104	Peri od:	u of Form CMS-2 Worksheet D-1	
COMM CTATTON CT	THE ATT OF ELECTRIC COST			CCN: 15-S104	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Title	e XVIII	Subprovi der -	5/30/2024 1: 5 PPS	2 pm
					. I PF		
Cos	st Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	5	Program Cost (col. 3 x col. 4)	
42 00 NUDCEDY	(title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00	42.00
	e Care Type Inpatient Hospital Units			0. (0	0	42.00
	E CARE UNIT	0	C	0.0	00 0	0	43.00
•	CARE UNIT						44.00
	ENSIVE CARE UNIT INTENSIVE CARE UNIT						45. 00 46. 00
	ECIAL CARE (SPECIFY)						47.00
	st Center Description						
48.00 Program	inpatient ancillary service cost (W	lkst D_3 col '	3 line 200)			1. 00 115, 961	48.00
48.01 Program	inpatient cellular therapy acquisit	ion cost (Works	heet D-6, Part	III, line 10	, column 1)	0	
49.00 Total Pr	ogram inpatient costs (sum of lines					1, 654, 032	49.00
	OUGH COST ADJUSTMENTS		(6	140	C David Land	140 544	
50.00 Pass thr	ough costs applicable to Program in	patient routine	services (Tro	m wkst. D, su	m of Parts I and	140, 541	50.00
	ough costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	3, 458	51.00
52.00 Total Pr	ogram excludable cost (sum of lines					143, 999	
	ogram inpatient operating cost excleducation costs (line 49 minus line		eLated, non-ph	ysician anest	hetist, and	1, 510, 033	53.00
	MOUNT AND LIMIT COMPUTATION	: 52)					
54.00 Program	di scharges					0	
	mount per discharge					0.00	
	t adjustment amount per discharge nt amount per discharge (contractor	use only)				0. 00 0. 00	
	mount (line 54 x sum of lines 55, 5)			0.00	1
	ce between adjusted inpatient opera			line 56 minus	line 53)	0	57.00
	yment (see instructions)					0	
	costs (lesser of line 53 ÷ line 54, and compounded by the market basket		m the cost rep	orting period	ending 1996,	0.00	59.00
	costs (lesser of line 53 ÷ line 54		om prior year	cost report,	updated by the	0.00	60.00
61.00 Continuo 55.01, o 53) are	us improvement bonus payment (ifli r line 59, or line 60, enter the le less than expected costs (lines 54	sser of 50% of	the amount by	which operati	ng costs (line	0	61.00
	ro. (see instructions) ayment (see instructions)					0	62.00
63.00 Allowabl	e Inpatient cost plus incentive pay	ment (see instr	uctions)			0	
64.00 Medi care	INPATIENT ROUTINE SWING BED COST swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost report	ing period (See	0	64.00
	ions)(title XVIII only) swing-bed SNF inpatient routine co	sts after Decemb	her 31 of the	cost renortin	a neriod (See	0	65.00
	ions)(title XVIII only)	StS dittel Decem	oci oi oi tiic	cost reportin	g period (see	Ĭ	00.00
CAH, see	dicare swing-bed SNF inpatient rout instructions		·	, ,	3,	0	
	or XIX swing-bed NF inpatient routi x line 19)	ne costs through	n December 31	of the cost r	eporting period	0	67.00
68.00 Title V	or XIX swing-bed NF inpatient routi x line 20)	ne costs after I	December 31 of	the cost rep	orting period	0	68.00
69.00 Total ti	tle V or XIX swing-bed NF inpatient - SKILLED NURSING FACILITY, OTHER I					0	69.00
70.00 Skilled	nursing facility/other nursing faci	lity/ICF/IID row	utine service	cost (line 37)		70.00
	general inpatient routine service routine service cost (line 9 x line		line 70 ÷ line	2)			71.00
9	y necessary private room cost appli	,	m (line 14 x l	ine 35)			73.00
74.00 Total Pr	ogram general inpatient routine ser	vice costs (line	e 72 + line 73)			74.00
26, line	,		e costs (from	Worksheet B,	Part II, column		75.00
	capital-related costs (line 75 ÷ l capital-related costs (line 9 x lin	,					76.00
	t routine service cost (line 74 min						78.00
79.00 Aggregat	e charges to beneficiaries for exce	ss costs (from p					79.00
	ogram routine service costs for com	•	cost limitatio	n (line 78 mi	nus line 79)		80.00
	t routine service cost per diem lim t routine service cost limitation (1)				81.00
	le inpatient routine service costs						83.00
84.00 Program	inpatient ancillary services (see i	nstructions)	•				84.00
	ion review - physician compensation						85.00
	ogram inpatient operating costs (sw - COMPUTATION OF OBSERVATION BED PA:		nrougn 85)				86.00
I AIRT I V	servation bed days (see instruction						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 CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S104	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description						
					1.00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	270, 397	2, 959, 326	0. 09137	1 0	0	90.00
91.00 Nursing Program cost	0	2, 959, 326	0. 00000	0 0	ol	91.00
92.00 Allied health cost	0	2, 959, 326	0. 00000	0 0	ol	92.00
93.00 All other Medical Education	0	2, 959, 326	0. 00000	0 0	o l	93.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-5832		
	Title XVIII	Skilled Nursing	PPS
		Facility	

		Facility		
	Cost Center Description	-	1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4, 377	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4, 377	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3. 00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		4, 377	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 3	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	1 of the cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December	31 of the cost	0	7. 00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding	swing-bed and	2, 195	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	om dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	Ulli days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	om days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private	room days)	0	12.00
	through December 31 of the cost reporting period			
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line Medically necessary private room days applicable to the Program (excluding swing-bed d		0	14. 00
15. 00		ays)	0	15.00
	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of reporting period	the cost	0.00	19.00
20. 00	1	e cost	0. 00	20.00
	reporting period			
21.00	Total general inpatient routine service cost (see instructions)		2, 923, 239	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting x line 18)	period (iine 6	0	23. 00
24. 00		a period (line	0	24. 00
	7 x line 19)	9	_	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			
26. 00	, , ,		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		2, 923, 239	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed cha	rnes)	0	28. 00
	Private room charges (excluding swing-bed charges)	i ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instruct	i ons)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost dif	forential (line	2 923 239	36. 00 37. 00
37.00	27 minus line 36)	rerential (IINe	2, 923, 239	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM I NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)			38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)			39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	I		41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	WITHAM MEMORI			Peri od:	u of Form CMS-2 Worksheet D-1	
			Component		From 01/01/2023 To 12/31/2023		
			Title	e XVIII	Skilled Nursing	5/30/2024 1: 5 PPS	52 pm
	Cost Center Description	Total	Total	Average Per	Facility Program Days	Program Cost	
	cost center bescription	Inpatient Cost 1.00	Inpatient Days 2.00	Di em (col. 1 ÷ col. 2) 3.00		(col. 3 x col. 4) 5.00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	11.00	3. 33	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						 43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
40.00	Donation to the control of the contr	-+ D 21	2 11 200)			1. 00	40.00
	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III line 10	column 1)		48. 00 48. 01
	Total Program inpatient costs (sum of lines				corumii 1)		49. 00
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and		50.00
51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II		51.00
	and IV)						
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non sh	vsician anosth	netist and		52.00 53.00
55.00	medical education costs (line 49 minus line		erateu, non-pri	ysi ci aii aliesti	ietist, and		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program discharges Target amount per discharge						54.00 55.00
	Permanent adjustment amount per discharge						55. 00
	Adjustment amount per discharge (contractor	use only)					55. 02
	Target amount (line 54 x sum of lines 55, 55				50)		56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and to	arget amount (line 56 minus	line 53)		57. 00 58. 00
59.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	m the cost rep	ortina period	endi na 1996.		59.00
	updated and compounded by the market basket)		·	0 .			
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)			•			60.00
61. 00	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	the amount by	which operatir	ng costs (İine		61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)						62.00
	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)				63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See		64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	ber 31 of the	cost reportino	g period (See		65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	I only); for		66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost re	eporting period		67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	orting period		68.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI	URSING FACILIT	Y, AND ICF/IID	ONLY		2 022 222	69.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		, ,		2, 923, 239 667. 86	1
	Program routine service cost (line 9 x line		75 . 11116	-/		1, 465, 953	
	Medically necessary private room cost applic					0	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II column	1, 465, 953 0	
	26, line 45)		5 55515 (TIOIII	or Roncet D, F	a. c ii, coruilli		
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line					0. 00 0	
	Inpatient routine service cost (line 74 minu					0	
	Aggregate charges to beneficiaries for exces	·	•		70	0	
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatio	n (line 78 mir	nus line 79)	0 0. 00	
	Inpatient routine service cost per diem imm Inpatient routine service cost limitation (I		1)			0.00	
83. 00	Reasonable inpatient routine service costs (see instruction				1, 465, 953	83.00
	Program inpatient ancillary services (see in		one)			631, 918	1
	Utilization review - physician compensation Total Program inpatient operating costs (sum					0 2, 097, 871	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00	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 CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-5832	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per					0. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0. 00000	00	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	0 0	0	93.00

Health Financial Systems	WITHAM MEMORIAL	HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Inputiont days (including private room days	and cui na had day	(c. oveludina nowborn)		0 040	1 1 00

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		8, 869	1.00
2.00	Inpatient days (including private room days, excluding swing-			8, 869	2.00
3. 00	Private room days (excluding swing-bed and observation bed days	ays). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation by	and days)		6, 860	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0, 000	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	oom 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 roo	d	21 -6 -1	0	7.00
7. 00	reporting period	om days) through becember	31 Of the Cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	swi ng-bed and	199	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)	· ·	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e			0	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only)			731 0	
10.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces 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 reporting period	ces after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0. 00	19. 00
	reporting period	3			
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	ns)		10, 868, 930	21 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) 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, 868, 930	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-be	ed 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	
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 mi		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 10, 868, 930	36. 00 37. 00
37.00	27 minus Line 36)	and private 100m Cost Of	irerential (IIIIe	10, 606, 930	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		<u>'</u>		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 225. 50	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			243, 875 0	39. 00 40. 00
41. 00	Total Program general inpatient routine service cost (line 39	,		243, 875	

	cial Systems OF INPATIENT OPERATING COST	WITHAM MEMORIA	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	I npati ent	I npati ent	Diem (col. 1	11 ogi am bays	(col. 3 x	
		Cost	Days	÷ col . 2)	1.00	col . 4)	
2. 00 NURSE	RY (title V & XIX only)	1.00	2. 00 731	3.00	4.00	5. 00	42
	sive Care Type Inpatient Hospital Units		731	0.0	<u> </u>	<u> </u>	72
B. OO INTEN	SIVE CARE UNIT	3, 389, 162	1, 971	1, 719. 5	1 32	55, 024	
	ARY CARE UNIT INTENSIVE CARE UNIT						44
	CAL INTENSIVE CARE UNIT						45
1	SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1. 00	
. 00 Progr	am inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00	48
. 01 Progr	am inpatient cellular therapy acquisiti	on cost (Workshe	et D-6, Part		column 1)	0	
	Program inpatient costs (sum of lines	41 through 48.01	l)(see instru	ctions)		467, 125	49
	THROUGH COST ADJUSTMENTS through costs applicable to Program inp	atient routine s	ervices (fro	m Wkst D sun	of Parts I and	0	50
111)	through costs approcable to rrogram rnp	attent routine s	SCI VICCS (IIO	ii wkst. D, suii	or raits i and		
	through costs applicable to Program inp	atient ancillary	, services (f	rom Wkst. D, s	sum of Parts II	0	51
and I . 00 Total	V) Program excludable cost (sum of lines	50 and 51)				0	52
	Program inpatient operating cost exclu		ated, non-ph	ysician anesth	etist, and	0	
medi c	al education costs (line 49 minus line		, p.,,		· · · ·]
	T AMOUNT AND LIMIT COMPUTATION					0	۱.,
	am discharges t amount per discharge					0.00	54
, ,	nent adjustment amount per discharge					0.00	
	tment amount per discharge (contractor					0. 00	
	t amount (line 54 x sum of lines 55, 55			E/	1: 52)	0	
	rence between adjusted inpatient operat payment (see instructions)	ing cost and tar	get amount (iine 56 minus	11ne 53)	0	
	ed costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	
	ed and compounded by the market basket)						
	ted costs (lesser of line 53 ÷ line 54, t basket)	or line 55 from	n prior year	cost report, ι	ipdated by the	0. 00	60
. 00 Conti 55. 01 53) a	nuous improvement bonus payment (if lin , or line 59, or line 60, enter the les re less than expected costs (lines 54 x	ser of 50% of th	ne amount by w	which operatir	ng costs (İine	0	61
	zero. (see instructions) f payment (see instructions)					0	62
	able Inpatient cost plus incentive paym	ent (see instrud	ctions)			_	63
	AM INPATIENT ROUTINE SWING BED COST						
	are swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	e cost reporti	ng period (See	0	64
	uctions)(title XVIII only) are swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the (cost reporting	period (See	0	65
instr	uctions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line (65)(title XVII	l only); for	0	66
	see instructions ·V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	portina period	0	67
(Line	12 x line 19)	-					
	 V or XIX swing-bed NF inpatient routing 13 x line 20) 	e costs after De	ecember 31 of	the cost repo	orting period	0	68
	title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69
	III - SKILLED NURSING FACILITY, OTHER N						
	ed nursing facility/other nursing facil ted general inpatient routine service c						70
-	am routine service cost (line 9 x line		ne 70 - Tine	2)			72
1 5	ally necessary private room cost applic		(line 14 x li	ine 35)			73
	Program general inpatient routine serv				loot III		74
	al-related cost allocated to inpatient ine 45)	routine service	COSIS (From)	worksneet B, F	art II, COIUMN		75
00 Per d	iem capital-related costs (line 75 ÷ li	ne 2)					76
	am capital-related costs (line 9 x line						77
	ient routine service cost (line 74 minu gate charges to beneficiaries for exces		rovi den rocch	46)			78
00	Program routine service costs for comp				nus line 79)		80
1	ient routine service cost per diem limi		242.01	, 10 mm			81
1 .	ient routine service cost limitation (I						82
	nable inpatient routine service costs (am inpatient ancillary services (see in		S)				83
	zation review - physician compensation		ns)				85
. 00 Total	Program inpatient operating costs (sum	of lines 83 thr					86
	IV - COMPUTATION OF OBSERVATION BED PASS					2.000	ļ <u>,</u> -
	observation bed days (see instructions ted general inpatient routine cost per	•				2, 009 1, 225. 50	

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0104 Period:			Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)			2, 462, 030	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	859, 853	10, 868, 930	0. 07911	2, 462, 030	194, 774	90.00
91.00 Nursing Program cost	0	10, 868, 930	0. 00000	2, 462, 030	0	91.00
92.00 Allied health cost	0	10, 868, 930	0. 00000	2, 462, 030	0	92.00
93.00 All other Medical Education	0	10, 868, 930	0. 00000	2, 462, 030	0	93.00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	st Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS				2, 260, 476		30.00
			1		1	1

	II LIE AVIII	поѕрі таі	PP3	
Cost Center Description	Ratio of Cost	I npati ent	Inpatient	
·	To Charges	Program	Program Costs	
	10 charges	0		
		Charges	(col. 1 x	
			col . 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u>.</u>			
30. 00 03000 ADULTS & PEDI ATRI CS		2, 260, 476		30.00
31. 00 03100 I NTENSI VE CARE UNI T		1, 304, 112		31. 00
		1, 304, 112		
40. 00 04000 SUBPROVI DER - I PF		0		40. 00
41. 00 04100 SUBPROVI DER - I RF		이		41.00
42. 00 04200 SUBPROVI DER		0		42.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	·	•		
50. 00 05000 OPERATI NG ROOM	0. 115830	2, 846, 417	329, 700	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 205509	909, 852	186, 983	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	707, 032		
			0	55.00
55. 01 05501 ULTRA SOUND	0. 175839	83, 839	14, 742	55. 01
57. 00 05700 CT SCAN	0. 020235	2, 881, 753	58, 312	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 078686	231, 755	18, 236	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 027052	0	0	59.00
60. 00 06000 LABORATORY	0. 156864	3, 848, 283	603, 657	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		99, 483	11, 642	63.00
	0. 117025	99, 483		
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	O	0	64.00
66. 00 06600 PHYSI CAL THERAPY	0. 388987	297, 753	115, 822	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 306328	255, 596	78, 296	67.00
67. 01 06701 AUDI OLOGY	0. 365375	ol	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 286928	61, 502	17, 647	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	01,002	0	69. 00
		2 205 707		
69. 01 06901 CARDI OLOGY	0. 120982	2, 285, 797	276, 540	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 341727	1, 815, 712	620, 478	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 460362	777, 755	358, 049	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 289950	1, 754, 779	508, 798	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000	ol	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	ol	0	78.00
OUTPATIENT SERVICE COST CENTERS	0.00000	٥,	<u></u>	70.00
90. 00 09000 CLI NI C	0.000000	O	0	90. 00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	ő	0	90. 01
		_		
90. 02 09002 CLI NI C	0.000000	0	0	90. 02
90. 03 O9003 DERMATOLOGY CLINIC	0. 000000	0	0	90. 03
90. 04 09004 ENT CLINIC	0.000000	0	0	90.04
90. 05 09005 SURGERY CLI NI C	0.000000	0	0	90.05
90. 07 09007 UROLOGY CLI NI C	0. 413787	ol	0	90. 07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000	ol	0	90. 09
90. 11 09011 NEUROLOGY CLINI C		ol Ol	0	90. 11
	0.000000	~ 		
90. 12 09012 0PTHAMOLOGY CLINIC	0. 000000	0	0	90. 12
90. 13 09013 ALLERGY CLINIC	0. 480040	0	0	90. 13
90. 14 09014 WOUND CARE	0. 143923	o	0	90. 14
91. 00 09100 EMERGENCY	0. 183149	1, 757, 658	321, 913	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 327345	95, 908	31, 395	92.00
OTHER REIMBURSABLE COST CENTERS	0. 327343	73, 700	31, 373	72.00
				95. 00
95. 00 09500 AMBULANCE SERVI CES		00 000 0:-	0 550 0:-	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		20, 003, 842	3, 552, 210	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		20, 003, 842		202. 00

Health Financial Systems WITHAM MEMORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider C	CN: 15-0104 CCN: 15-S104	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre	pared:
Title	e XVIII	Subprovi der - I PF	5/30/2024 1: 5 PPS	2 pm
Cost Center Description	Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY		1, 581, 198		30. 00 31. 00 40. 00 41. 00 42. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 55. 00 05500 RADIOLOGY-THERAPEUTIC 55. 01 05501 ULTRA SOUND 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 01 06701 AUDIOLOGY 68. 00 06800 SPEECH PATHOLOGY 69. 01 06901 CARDIOLOGY 69. 01 06901 CARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07300 DRUGS CHARGED TO PATIENTS 77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 11583 0. 20550 0. 00000 0. 17583 0. 02023 0. 07868 0. 02705 0. 15686 0. 11702 0. 00000 0. 38898 0. 36537 0. 28692 0. 00000 0. 12098 0. 34172 0. 46038 0. 28995 0. 00000	20, 342 00 00 09 09 00 09 00 00 00 00 00 00 00	0 4, 180 0 0 1, 054 267 0 49, 652 0 3, 090 1, 952 0 1, 158 0 1, 056 12, 760 0 36, 233	55. 00 55. 01 57. 00 58. 00 59. 00 60. 00 63. 00 64. 00 67. 01 68. 00 69. 01 71. 00 72. 00 73. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 00000 0. 41378 0. 00000 0. 00000 0. 48004 0. 14392 0. 18314 0. 32734	00 0 0 00 0 00 0 00 0 00 0 00 0 00 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 07 90. 09 90. 11 90. 12 90. 13 90. 14 91. 00
95.00 O9500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 202.00 Net charges (line 200 minus line 201)		606, 639 0 606, 639		95. 00 200. 00 201. 00 202. 00

alth Financial Systems IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	VITHAM MEMORIAL HOSPITAL Provider C	CN: 15-0104	Peri od:	wof Form CMS-3 Worksheet D-3	
	Component	CCN: 15-5832	From 01/01/2023 To 12/31/2023		
	Ti tl e	e XVIII	Skilled Nursing Facility	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	
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>	Г
0.00 03000 ADULTS & PEDIATRICS					30
. 00 03100 INTENSIVE CARE UNIT					3
0. 00 04000 SUBPROVI DER - I PF					40
. 00 04100 SUBPROVI DER - RF					4
2. 00 04200 SUBPROVI DER					42
B. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43
0. 00 05000 OPERATING ROOM		0. 11583	30 2, 644	306	50
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20550		5, 896	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	1
5. 01 05501 ULTRA SOUND		0. 17583		0	
7.00 05700 CT SCAN		0. 02023		0	5
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 07868	86 0	0	58
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0270	52 0	0	5
0. 00 06000 LABORATORY		0. 15686	64 188, 618	29, 587	60
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 11702		0	
1. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
5. 00 06600 PHYSI CAL THERAPY		0. 38898			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 30632	· ·		
7. 01 06701 AUDI 0L0GY 3. 00 06800 SPEECH PATHOLOGY		0. 3653 0. 28692		0 2, 997	
9. 00 06900 SPEECIT PATHOLOGY		0. 00000		2, 797	1
9. 01 06901 CARDI OLOGY		0. 12098		1, 581	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 34172		23, 456	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 46036		0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 2899!	50 542, 198	157, 210	7:
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	7
3.00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00 0	0	78
OUTPATIENT SERVICE COST CENTERS				_	4.
0.00 09000 CLINIC		0.00000			
D. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER D. 02 09002 CLINIC		0.00000			
0. 03 09003 DERMATOLOGY CLI NI C		0.00000		0	
0. 04 09004 ENT CLINIC		0. 00000		0	
0. 05 09005 SURGERY CLINIC		0. 00000			1
0. 07 09007 UROLOGY CLINIC		0. 41378			
0.09 09009 GASTROENTEROLOGY CLINIC		0. 00000		0	90
). 11 09011 NEUROLOGY CLINIC		0.00000	00 0	0	91
0. 12 09012 OPTHAMOLOGY CLINIC		0.00000			
0. 13 09013 ALLERGY CLINIC		0. 48004		0	1
0. 14 09014 WOUND CARE		0. 14392		0	
I. 00 09100 EMERGENCY		0. 18314			
2.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 3273	45 0	0	9.
5. 00 09500 AMBULANCE SERVICES					9
00.00 Total (sum of lines 50 through 94 and 96	through 98)		2, 042, 071	631, 918	
11.00 Less PBP Clinic Laboratory Services-Prod			2, 042, 071	031, 910	20
Net charges (line 200 minus line 201)	a only onarges (iffic of)		2, 042, 071		20

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-0104	Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		Ti t	le 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 . 2)	
			1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						

	litle :		Hospital .	Cost	
Cost Center Description	Ra	atio of Cost	I npati ent	Inpatient	
	-	To Charges	Program	Program Costs	
		3	Charges	(col. 1 x	
			onal goo	col . 2)	
	_	1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
			021 004		20.00
30. 00 03000 ADULTS & PEDI ATRI CS			821, 994		30.00
31.00 03100 INTENSIVE CARE UNIT			99, 664		31.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			o		43.00
ANCILLARY SERVICE COST CENTERS	·		,		
50. 00 05000 OPERATI NG ROOM		0. 115830	185, 029	21, 432	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 205509	24, 715	5, 079	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 000000	21,710	0	55. 00
55. 01 05501 ULTRA SOUND		0. 175839	10, 986	1, 932	55. 01
57. 00 05700 CT SCAN		0. 020235	115, 330	2, 334	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 078686	10, 943	861	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 027052	37, 747	1, 021	59.00
60. 00 06000 LABORATORY		0. 156864	217, 222	34, 074	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 117025	12, 364	1, 447	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.000000	o	0	64.00
66. 00 06600 PHYSI CAL THERAPY		0. 388987	6, 556	2, 550	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 306328	4, 899	1, 501	67. 00
67. 01 06701 AUDI OLOGY		0. 365375	٠, ٥/١	0	67. 01
			1 520		
68. 00 06800 SPEECH PATHOLOGY		0. 286928	1, 529	439	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000	0	0	69.00
69. 01 06901 CARDI OLOGY		0. 120982	80, 825	9, 778	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 341727	74, 069	25, 311	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 460362	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 289950	151, 437	43, 909	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.000000	o	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.000000	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		-,	_	
90. 00 09000 CLI NI C		0. 000000	0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0. 000000	o	0	90. 01
90. 02 09002 CLI NI C		0. 000000	0	0	90.01
			- 1	0	
90. 03 09003 DERMATOLOGY CLI NI C		0.000000	0		90.03
90. 04 09004 ENT CLINIC		0. 000000	0	0	90. 04
90. 05 09005 SURGERY CLINIC		0. 000000	0	0	90. 05
90. 07 09007 UROLOGY CLINIC		0. 413787	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 OPTHAMOLOGY CLINIC		0.000000	o	0	90.12
90. 13 09013 ALLERGY CLINIC		0. 480040	ol	0	90. 13
90. 14 09014 WOUND CARE		0. 143923	n	0	90. 14
91. 00 09100 EMERGENCY		0. 183149	90, 408	16, 558	91.00
			70, 400	10, 330	92.00
		0. 327345	υ	U	72. UU
OTHER REIMBURSABLE COST CENTERS					05.00
95. 00 09500 AMBULANCE SERVI CES			4 604 6==	a.o. o:	95.00
200.00 Total (sum of lines 50 through 94 and 96 through 9			1, 024, 059	168, 226	
201.00 Less PBP Clinic Laboratory Services-Program only of	narges (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			1, 024, 059		202.00

Health Financial Systems	WITHAM MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Peri od: From 01/01/2023 To 12/31/2023

MMILE_INDIVIDUAL_RISER_IA_SERVICES_BUINER_EPPS		Title XVIII	Hospi tal	5/30/2024 1: 5 PPS	2 pm
APART A. IPARTIPH INSPITAL SPRINCES MORTE IPPS 1.00 BIRK Associate Softer than outline repyments for discharges occurring prior to October 1 (see 4, 034, 26 1.01) 1.01 BIRK Cancents other than outline repyments for discharges occurring on or after October 1 (see 1, 482, 718 1.02) 1.02 BIRK Cancents send for operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1, 482, 718 1.02) 1.03 BIRK Cancents specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1, 482, 718 1.02) 1.04 BIRK Cancents specific operating payment for Model 4 BPCI for discharges occurring on or after 0 clother 1 (see instructions) 2.05 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.06 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.07 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.08 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.09 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.00 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.01 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.02 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.03 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.04 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.05 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.06 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.07 Outline for Instruction All Statems 1 (see instructions) 2.08 Outline repyment for discharges occurring prior to October 1 (see instructions) 2.09 Outline for Instruction All Statems 1 (see instructions) 2.00 Outline for All Opath 1 and 1 (see instructions) 2.01 Outline for All Opath 1 and 1 (see instructions) 2.02 Outline f				1 00	
1.01 Nick amounts other than outlier payments for discharges occurring on or after October 1 (see 1,482,718 1.02 1.03 1.03 1.03 1.04 1.05		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1.02 Dist amounts other than outlier payments for discharges occurring on or after October 1 (see 1,482,78 1.02 1.03 Dist for Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 0.05 1.05 Dist for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 0.05 1.06 Dist for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 0.00 1.07 Dist for Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 0.00 1.08 Dist for payments for discharges (see Instructions) 2.00 1.09 Differ payments for discharges occurring prior to October 1 (see Instructions) 4.06 1.09 Differ payments for discharges occurring prior to October 1 (see Instructions) 4.06 1.00 Differ payments for discharges occurring prior to October 1 (see Instructions) 4.06 1.00 Differ payments for discharges occurring prior to October 1 (see Instructions) 4.06 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.06 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ payments for discharges occurring on or after October 1 (see Instructions) 4.00 1.00 Differ Diffe		DRG amounts other than outlier payments for discharges occurring prior to October 1 (see			1. 00 1. 01
1,000 1867 for Federial specific operating payment for Model 4 BPCI for discharges occurring prior to Dctocher 1,000 1	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (s	ee	1, 482, 718	1. 02
October 1 (see instructions) 2.00 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01 2.00 2.01	1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring price	r to October	0	1. 03
2.01 Outlier reconciliation amount 0 2.01		October 1 (see instructions)	r after	0	1. 04
2.03 Dutil ter payments for discharges occurring prior to October 1 (see Instructions) 42,699 2.04	2. 01	Outlier reconciliation amount		-	2. 01
Managed Carle Simulated Payments 0 3.00	2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)		42, 699	2. 03
Indirect Medical Education Adjustment	3.00	Managed Care Simulated Payments	one)	0	3.00
or before 12/3/17/96, (see instructions) 1.0 OF FIE count for quali fing hospitals under \$131 of the CAA 2021 (see instructions) 2.0 OF 5.01 FIE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 43.79(e) 2.0 CRUTAL Track program FIE cap I imitation adjustment after the cap-building window closed under \$127 or no. 00. 00. 00. 00. 00. 00. 00. 00. 00. 0	4.00	Indirect Medical Education Adjustment			4.00
FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) after the cap-building window closed under \$127 of the CAA 2021 (see instructions)		or before 12/31/1996. (see instructions)	od ending or		5.00
Rural track program FTE cap I limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 0.00 0.20		FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to	the cap for		5. 01 6. 00
2.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) if the cost report straddle solly 1, 2011 then see instructions. 4.22 Adjustment (Increase or decrease) to the hospital's rural track programs ITE limitation(s) for rural track programs with a rural track for Medicare (BME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 412.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddle suly 1, 2011, see instructions. 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) 8.03 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions) 8.04 Under § 5506 of ACA. (see instructions) 8.05 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus lines 8.01 through 8.27 (see instructions) 8.01 TEC count for allopathic and osteopathic programs in the current year from your records 8.02 Current year all owable FTE (see instructions) 8.03 Of Total allowable FTE count for the prior year in the program (see instructions) 8.04 District through 14 divided by 3 and 3 divided by 3 and 3 divided by 3 and 3 divident for residents in initial years of the program (see instructions) 8.04 District for year resident to bed ratio (line 18 divided by 1 ine 4). 8.05 Office of through 14 divided by 1 ine 18 divided by 1 ine 14 divident program and years of the program of the program and years and years and years and years and years and years and years and years and years and years and years and years and years and years and years and yea	6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed ur	der §127 of	0. 00	6. 26
Adjustment (increase or decrease) to the hospital's rural track programs if ilinitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8. 00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 60069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report stradide sluly 1, 2011, see instructions. 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) 8. 21 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. 2021 (see instructions) 9. 00 Sun of Times 3 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus lines 7 should be programs in the current year from your records 10. 00 FTE count for allopathic and osteopathic programs in the current year from your records 11. 00 FTE count for allopathic and osteopathic programs in the current year from your records 12. 00 Current year all owable FTE (see instructions) 13. 00 Total and owable FTE count for the prior year of the program (see instructions) 14. 00 Total and owable FTE count for the prior year if that year ended on or after September 30, 1997, concentral year of the program (see instructions) 15. 00 Sun of lines 12 through 14 divided by 3 16. 00 Adjustment for residents in initial years of the program (see instructions) 16. 00 Total year resident to be dratio (line 18 divided by line 4). 17. 00 Adjustment for residents in initial years of the program (see instructions) 18. 00 Over the year resident to be fratio (see instructions) 18. 00 Over year resident to be dratio (see instructions) 19. 00 Over year resident to obed ratio (divide lin		ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(E			7. 00 7. 01
Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CPR 413.75(c)(2)(iv), 6 HR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 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) 8.11 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions) 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 or minus line 7.02, plus/minus line 8, plus lines 8.20 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 10.00 Total allowable FTE count for the prior year. 10.00 Line of the prior year of the your sear. 10.00 Sum of lines 12 through 14 divided by 3. 10.00 Total allowable FTE count for the penior year if that year ended on or after September 30, 1997, otherwise enter zero. 10.00 Adjustment for residents in initial years of the program (see instructions) 10.00 Adjustment for residents in initial years of the program (see instructions) 10.00 Adjustment for residents in initial years of the program (see instructions) 10.00 Adjustment for residents of year and year	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) track programs with a rural track for Medicare GME affiliated programs in accordance with		0. 00	7. 02
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddle sully 1, 2011, see instructions: 1.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions) 1.02 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.03 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.04 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.05 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.05 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.06 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.06 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.07 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.08 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 1.09 The count for all plantile index of step shall be face and the count for plantile interventions 1.00 The count for increase if the prior year. 1.01 The count for resident slots and observations 1.00 The count for resident slots and step shall be program (see instructions) 1.00 The plantile of the prior year slots and	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic program affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (N		0. 00	8. 00
B.02	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA.	If the cost	0.00	8. 01
1.	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching h	ospi tal	0. 00	8. 02
minus line 7.02, plus/minus line 8, plus line 8. plus line 8. 27 (see instructions)	8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 20	21 (see	0. 00	8. 21
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 10.00 12.00 10.00 1		minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	1, plus or		9. 00
13.00 Total all owable FTE count for the prior year. 0.00 13.00 14.00 15.00 15.00 16.0	11.00	FTE count for residents in dental and podiatric programs.		0. 00	11.00
14.00					
15.00 Sum of lines 12 through 14 divided by 3. 0.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 19.00 0.000 0.000 0.000 0.000 0.000 0.000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.00000 0.00000 0.00000 0.000000 0.00000 0.0000000 0.00000000		Total allowable FTE count for the penultimate year if that year ended on or after Septemb	er 30, 1997,		
17.00		Sum of lines 12 through 14 divided by 3.			
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00	17.00	Adjustment for residents displaced by program or hospital closure		0. 00	17. 00
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 22.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 1ME payment adjustment (see instructions) 0.22.00 1ME payment adjustment - Managed Care (see instructions) 0.22.01 1ME payment adjustment - Managed Care (see instructions) 0.22.01 1ME payment adjustment - Managed Care (see instructions) 0.22.01 1ME payment adjustment for the Add-on for § 422 of the MMA 23.00 1ME FTE Resident Count Over Cap (see instructions) 0.00 24.00 1ME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 1F the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 1ME payments adjustment factor. (see instructions) 0.000000 26.00 27.00 1ME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 1ME add-on adjustment amount (see instructions) 0.000000 28.00 1ME add-on adjustment amount (see instructions) 0.000000 28.00 29.00 1041 1ME payment (sum of lines 22 and 28) 0.029.00 1041 1ME payment (sum of lines 22 and 28) 0.029.00 1041 1ME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.00 0.000000 20.000000 20.0000000000			ļ		
22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 10.00 IME payments adjustment factor. (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31		· · · · · · · · · · · · · · · · · · ·	ļ		
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 29. 00 IME add-on adjustment amount (see instructions) 29. 01 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21. 42 31. 00 32. 00 Sum of lines 30 and 31			ļ		
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 (f)(1)(iv)(C). 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25.00 (f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(f)(ļ		
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21.42 31.00 32.00 Sum of lines 30 and 31		Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	12 105		
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 21.42 31.00 32.00 Sum of lines 30 and 31		(f)(1)(iv)(C).	12. 105		
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 9.01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2. 04 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 21. 42 31. 00 32. 00 Sum of lines 30 and 31 23. 46 32. 00		If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24	(see		
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20.00 Sum of lines 30 and 31 20.00 Sum of lines 30 and 31		Resident to bed ratio (divide line 25 by line 4)			
29.00 Total IME payment (sum of lines 22 and 28) 0 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.04 30.00 Percentage of Medicaid patient days (see instructions) 21.42 31.00 Sum of lines 30 and 31 23.46 32.00			ļ		28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20. 00 Percentage of Medicaid patient days (see instructions) 21. 42 31. 00 32. 00 Sum of lines 30 and 31	28. 01	IME add-on adjustment amount - Managed Care (see instructions)	ļ	0	28. 01
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.04 30.00 31.00 Percentage of Medicaid patient days (see instructions) 21.42 31.00 32.00 Sum of lines 30 and 31 23.46		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		_	29. 00 29. 01
31.00 Percentage of Medicaid patient days (see instructions) 21.42 31.00 32.00 Sum of lines 30 and 31 23.46 32.00	30 00		15)	2 04	30 00
32.00 Sum of lines 30 and 31 23.46 32.00			<i>-</i> ,		
33.00 Allowable disproportionate share percentage (see instructions) 10.00 33.00	32.00	Sum of lines 30 and 31	l	23. 46	32.00
	33. 00	Allowable disproportionate share percentage (see instructions)	l	10. 00	33.00

	· · · · · · · · · · · · · · · · · · ·	RIAL HOSPITAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0104	Period: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	5/30/2024 1: 5 PPS	2 pm
34 00	Disproportionate share adjustment (see instructions)			1. 00 137, 925	34 00
34.00	proportionate share adjustment (see thisti detrons)		Prior to 10/1		34.00
	To		1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		0	0	35.00
35. 00	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital UCP, including supplemental UCP (see instruction	,	851, 785	744, 154	
35. 03	Pro rata share of the hospital UCP, including supplementa		637, 088	187, 055	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiar	v discharges (Lines 40 thro	824, 143 ough 46)		36.00
40.00	Total Medicare discharges (see instructions)	, geo (*	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see inst Divide line 41 by line 40 (if less than 10%, you do not q		0.00		41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	darry for day detilient)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 dividays)	ded by line 41 divided by	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instruct		0.00		45.00
46. 00 47. 00	Total additional payment (line 45 times line 44 times lin Subtotal (see instructions)	e 41.01)	6, 521, 750		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MD	H, small rural hospitals	0, 321, 730		48.00
	only. (see instructions)			A	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruct	i ons)		6, 521, 750	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt.	• •		420, 319	1
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4			0	
53. 00	Nursing and Allied Health Managed Care payment	, Title 47 See Thistructions	<i>)</i> .	0	
54.00	Special add-on payments for new technologies			9, 751	54.00
54. 01	Islet isolation add-on payment	(0)		0	54.01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li Cellular therapy acquisition cost (see instructions)	ne 69)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see	intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, P	*	through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			6, 951, 820 7, 404	
61.00	Total amount payable for program beneficiaries (line 59 m	inus line 60)		6, 944, 416	
62.00	Deductibles billed to program beneficiaries			813, 960	
63.00	Coinsurance billed to program beneficiaries			0	63.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			64, 483 41, 914	
66.00		instructions)		3, 200	1
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			6, 172, 370	
68.00	Credits received from manufacturers for replaced devices			0	68.00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	96). (FOR SCH See INSTRUCTION	ons)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Dem	onstration) adjustment (se	e instructions)	0	70.50
70. 75	N95 respirator payment adjustment amount (see instruction			0	70. 75
70.87	Demonstration payment adjustment amount before sequestrat			0	70.87
70. 88 70. 89	SCH or MDH volume decrease adjustment (contractor use onl Pioneer ACO demonstration payment adjustment amount (see			0	70.88
70. 89	HSP bonus payment HVBP adjustment amount (see instruction			0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			0	
70. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			4, 587 -16, 190	70. 93 70. 94
70. 94					

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	W THE WEIGHT / LE	Provi der Co	CN: 15-0104	Peri od:	Worksheet E	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/30/2024 1:5	
		Title	x XVIII	Hospi tal	PPS	12 piii
	-	11 11 0		(yyyy)	Amount	
				0	1.00	
70.96 Low volume adjustment for federal	fiscal year (yyyy) (Enter i	n column 0		022	660, 751	70. 96
the corresponding federal year for	the period prior to 10/1)					
70.97 Low volume adjustment for federal	fiscal year (yyyy) (Enter i	n column 0	20	023	229, 730	70. 97
the corresponding federal year for	the period ending on or af	ter 10/1)				
70.98 Low Volume Payment-3				0	0	
70.99 HAC adjustment amount (see instruc					20, 540	
71.00 Amount due provider (line 67 minus		69 & 70)			7, 030, 708	
71.01 Sequestration adjustment (see inst					140, 614	
71.02 Demonstration payment adjustment a					0	
71.03 Sequestration adjustment-PARHM pass	s-throughs				, 770 , 70	71.03
72.00 Interim payments					6, 778, 678	
72.01 Interim payments-PARHM					0	72. 01
73.00 Tentative settlement (for contractor 73.01 Tentative settlement-PARHM (for contractor 73.01 Tentative settlement-PARHM (for contractor 73.01 Tentative settlement-PARHM (for contractor 73.00 Tentative settlement)	3,				0	73.00
73.01 Tentative settlement-PARHM (for con 74.00 Balance due provider/program (line		12 72 and			111, 416	
74. 00 Barance due provider/program (11 ne	/I minus imes /i.ui, /i.u	12, 72, and			111, 410	74.00
74.01 Balance due provider/program-PARHM	(see instructions)					74. 01
75. 00 Protested amounts (nonal lowable co		nce with			430, 441	
CMS Pub. 15-2, chapter 1, §115.2	st report rtells) in accorde	ince with			430, 441	75.00
TO BE COMPLETED BY CONTRACTOR (Line	es 90 through 96)					1
90.00 Operating outlier amount from Wkst		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 a	djustment amount (see instr	uctions)			0	92.00
93.00 Capital outlier reconciliation adj	ustment amount (see instruc	tions)			0	93.00
94.00 The rate used to calculate the time					0.00	
95.00 Time value of money for operating					0	95.00
96.00 Time value of money for capital re	lated expenses (see instruc	tions)			0	96.00
					On/After 10/1	
LIOD D. D. L. A. L.				1. 00	2. 00	
HSP Bonus Payment Amount						100 00
100.00 HSP bonus amount (see instructions				0	0	100.00
HVBP Adjustment for HSP Bonus Payme				0. 0000000000	0. 0000000000	101 00
101.00 HVBP adjustment factor (see instru- 102.00 HVBP adjustment amount for HSP bon-		·c)		0. 0000000000		101.00
HRR Adjustment for HSP Bonus Paymer		15)		U U	U	102.00
103.00 HRR adjustment factor (see instruc				0.0000	0.0000	102 00
104.00 HRR adjustment amount for HSP bonus		.)		0.0000		104.00
Rural Community Hospital Demonstra			ıstment	<u> </u>	0	1104.00
200.00 Is this the first year of the curre						200.00
Century Cures Act? Enter "Y" for ye	,	Ja anaoi	2131			
Cost Reimbursement						1
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir	e 49)				201.00
202.00 Medicare discharges (see instruction		•				202.00
203.00 Case-mix adjustment factor (see in:	•					203.00
Computation of Demonstration Target		first year	of the curren	nt 5-year demons	tration	1

HSP Bonus Payment Amount		
100.00 HSP bonus amount (see instructions)	0	0 100.00
HVBP Adjustment for HSP Bonus Payment		
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000 101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0 102.00
HRR Adjustment for HSP Bonus Payment		
103.00 HRR adjustment factor (see instructions)	0. 0000	0. 0000 103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0 104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		
200.00 Is this the first year of the current 5-year demonstration period under the 21st		200.00
Century Cures Act? Enter "Y" for yes or "N" for no.		
Cost Reimbursement		
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		201. 00
202.00 Medicare discharges (see instructions)		202. 00
203.00 Case-mix adjustment factor (see instructions)		203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curren	t 5-year demonst	tration
peri od)		
204.00 Medicare target amount		204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)		205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)		206. 00
Adjustment to Medicare Part A Inpatient Reimbursement		
207.00 Program reimbursement under the §410A Demonstration (see instructions)		207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)		209. 00
210.00 Reserved for future use		210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)		211. 00
Comparision of PPS versus Cost Reimbursement	Г	
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)		212. 00
213.00 Low-volume adjustment (see instructions)		213. 00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		218. 00
(line 212 minus line 213) (see instructions)		

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: 5/30/2024 1: 52 pm Provider CCN: 15-0104

					10	12/31/2023	5/30/2024 1: 5	
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
		0	1. 00	2.00	3.00	10/01 4.00	5. 00	
1. 00	DRG amounts other than outlier		1.00	2.00		4.00	0.00	1. 00
	payments						-	
1. 01	DRG amounts other than outlier payments for discharges	1. 01	4, 034, 265	0	4, 034, 265		4, 034, 265	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 482, 718	0		1, 482, 718	1, 482, 718	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00						2.00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	42, 699	0	42, 699		42, 699	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	О	0		0	0	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments							
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 instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj	ustment for the	e Add-on for Se	ection 422 of	the MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.000000		0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8.01) Disproportionate Share Adjustm	ont						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1000	0. 1000	0. 1000	0. 1000		10.00
11. 00	i nstructi ons) Di sproporti onate share	34. 00	137, 925	0	100, 857	37, 068	137, 925	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	824, 143	0	637, 088	187, 055	824, 143	11. 01
12 00	Additional payment for high pe Total ESRD additional payment	rcentage of ESI 46.00	עט beneficiary	di scharges 0	O	ol		12.00
12. 00 13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	6, 521, 750 0	0		1, 706, 841 0	6, 521, 750 0	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)			O			0	
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	6, 521, 750	0	4, 814, 909	1, 706, 841	6, 521, 750	15. 00

						From 01/01/2023 To 12/31/2023		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	On/After	Total (Col 2 through 4)	
			1.00		0.00	10/01	5.00	
4 / 00		0	1. 00	2. 00	3.00	4.00	5. 00	11.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	420, 319	0	305, 87	4 114, 445	420, 319	16. 00
17. 00	Special add-on payments for new technologies	54. 00	9, 751	0	9, 75	1 0	9, 751	17.00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.00
10 00	instructions) SUBTOTAL			0	5, 130, 53	4 1, 821, 286	6, 951, 820	10 00
17.00	JOBIOTAL	W/S L, line	(Amounts from L)		3, 130, 33	1,021,200	0, 731, 020	17.00
		0	1.00	2. 00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	417, 419	0	302, 97	4 114, 445	417, 419	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	2, 900	0	2, 90	0	2, 900	ł
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. 0000	0.000			22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	420, 319	0	305, 87	4 114, 445	420, 319	26. 00
		W/S E, Part A	(Amounts to					
		l i ne	E, Part A)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 12878 660, 75		660, 751	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				229, 730	229, 730	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0104 Worksheet E From 01/01/2023 Part A Exhibit 5 Date/Time Prepared: 12/31/2023 5/30/2024 1:52 pm Title XVIII Hospi tal PPS Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 4.034.265 4,034,265 4, 034, 265 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 1, 482, 718 1, 482, 718 1, 482, 718 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 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 0 2.01 **BPCI** 2.02 42, 699 42, 699 42, 699 2.02 Outlier payments for discharges occurring 2.03 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 C 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 0.000000 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 0 6.00 0 0 6.01 IME payment adjustment for managed care (see 22.01 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 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 r 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.1000 0.1000 0.1000 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 137, 925 100, 857 37, 068 137, 925 11.00 instructions) Uncompensa<u>ted care payments</u> 187, 055 11.01 36 00 824, 143 637, 088 824, 143 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 12.00 instructions) 47.00 6, 521, 750 4, 814, 909 13.00 Subtotal (see instructions) 1, 706, 841 6, 521, 750 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 1, 706, 841 15 00 49 00 6, 521, 750 4 814 909 6, 521, 750 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 420, 319 305, 874 114, 445 420, 319 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 9, 751 9, 751 9, 751 17.00 0 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 Λ Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions)

5, 130, 534

1, 821, 286

6, 951, 820 19.00

19.00 SUBTOTAL

Health Financial Systems	WITHAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider C		Period: From 01/01/2023 To 12/31/2023		pared:
		Title	: XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1. 00	417, 419	302, 97	4 114, 445	417, 419	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2. 00	2, 900	2, 90	0	2, 900	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	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	6, 00	0		ol o	l 0	23.00

20. 00	Capital DRG other than outlier	1. 00	417, 419	302, 974	114, 445	417, 419	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, 900	2, 900	0	2, 900	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	5. 00	0.0000	0.0000	0. 0000		22.00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	0	0	0	0	23.00
	instructions)						
24.00	Allowable disproportionate share percentage	10. 00	0.0000	0.0000	0.0000		24.00
	(see instructions)						
25. 00	Disproportionate share adjustment (see	11. 00	0	0	0	0	25.00
	instructions)						
26. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	12. 00	420, 319	305, 874	114, 445	420, 319	26. 00
	instructions)		(1)				
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	A) 1.00	2.00	2.00	4.00	
27. 00		U	1.00	2.00	3. 00	4. 00	27. 00
	Low volume adjustment prior to October 1	70. 96	660, 751	660, 751		660, 751	28.00
28.00	Low volume adjustment on or after October 1	70. 96	229, 730		229, 730	•	29.00
30. 00	HVBP payment adjustment (see instructions)	70. 97	4, 587		4, 587	•	30.00
30. 00	HVBP payment adjustment for HSP bonus	70. 93	4, 367	0	4, 367	4, 367	30.00
30. 01	payment (see instructions)	70. 90	0	0	U		30.01
31. 00	HRR adjustment (see instructions)	70. 94	-16, 190	-14, 559	-1, 631	-16, 190	31.00
	HRR adjustment for HSP bonus payment (see	70. 94	-10, 190	-14, 339	-1,031	-10, 190	31.00
31.01	instructions)	70. 71	0	0	U	į o	31.01
	That detronay					(Amt. to	
						Wkst. E, Pt.	
						A)	
		0	1.00	2. 00	3. 00	4. 00	
32.00	HAC Reduction Program adjustment (see	70. 99		0	20, 540	20, 540	32.00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		Y				100.00
	Wkst. E, Pt. A.						

Health Financial Systems	WITHAM MEMORIAL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0104		Worksheet E Part B Date/Time Prepared: 5/30/2024 1:52 pm

PART R - MEDICAL Mot OTHER HEALTH SERVICES 1.00 Medical and their services (seen instructions) 1.50 5.6331 1.00 1.			Title XVIII	Hospi tal	5/30/2024 1: 5 PPS	2 piii
Mexit B - Metical and other services reliabured under OPPS (see Instructions)					1 00	
Medical and other services reliabursed under (PMP (see Instructions) 12,5%, 810 () 0.006 of 3.00 () 0.007 (or REH payment (see Instructions) 12,777 ± 0.00 () 0.007 (or Inter payment (see Instructions) 12,777 ± 0.00 () 0.007 (or Inter payment (see Instructions) 12,777 ± 0.00 (or Inter payment (see Instructions) 10,000 6.00 (or Inter 2 Times I Inter 5 0.00 (or Inter 5 Times I Inter 5 0.00 (or Inter 5 Times I Inter 5 0.00 (or Inter 5 Times I Inter 5 Times I Inter 5 0.00 (or Inter 5 Times I Int		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 Description payment (see Instructions) 1.00 0		1				
0.00 Control representation 12,777 4.00 4.00 Control representation 1.2,777 4.00 Control representation 1.2,777 4.00 5.00 Entrol the hospital specific payment for cost ratio (see instructions) 0.00 5.00						
Enter the hospital specific payment to cost ratio (see instructions)						
Lino 2 times in 5					-	
2.00 Sum of Times 3			tions)			
0.00 Ancil lary service other pass through costs including REH direct graduate medical advantion costs from 0.00					-	
Wast. 0, Pt. IV, col. 13, line 200					-	
10.00 Organ acquisitions 6,937 11.00 Organ acquisition 6,937 Organ	9. 00		t graduate medical educ	cation costs from	0	9.00
COMPUTATION OF ITSSER OF COST OR CHARGES Reusemble charges 24,822 12,00 Ancillary service charges 24,822 12,00 Ancillary service charges 24,822 12,00 Ancillary service charges (sum of lines 12 and 13) 3,00 Organical and acquisition charges (sum of lines 12 and 13) 4,80 3,00 Ancillary sharpes 4,80 4,80 13,00 Ancillary sharpes 4,80 4,80 13,00 Ancillary sharpes 4,80 13,00 Ancillary sharpes 4,80 13,00 Ancillary sharpes 4,80 13,00 Ancillary sharpes 15,00 Ancillary	10.00				0	10.00
Reasonable charges 24, 822 12.00 20 13.00 07gan acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 24, 822 13.00 07gan acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 0.13.00 13.00	11. 00				6, 937	11. 00
12.00						
14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 Country Charges 14.00 Country Charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0.15.00 15.00 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0.15.00 17.00	12. 00				24, 822	12.00
Customary charges			ne 69)		-	
15.00 Aggregate amount actually collected from patients Liable for payment for services on a charge basis 0 15.00	14.00				24, 822	14.00
had such payment been made in accordance with 42 CPR \$413.13(e)	15. 00		ayment for services on	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 17.00 24.82 18.00 17.80 17	16. 00			on a chargebasis	0	16. 00
18.00 Total customary charges (see instructions) 24, 822 18.00 10.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 17,885 19.00 10.00 1	17. 00	' '	?)		0. 000000	17.00
Instructions						
20.00 Excess of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see instructions) 0, 937 21.00	19. 00		y if line 18 exceeds li	ne 11) (see	17, 885	19. 00
instructions	20. 00		v if line 11 exceeds Li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00 23.00 23.00 70 70 70 70 70 70 70		instructions)	,	(555		
23.00 Cost of physicians' services in a teaching hospital (see instructions) 12,033,741						
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 12,033,741 24.00		1	ructions)		-	
25.00 Deductible sand Coinsurance amounts (For CAH, see instructions) 0 25.00		Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			12, 033, 741	
26. 00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 137, 009 26. 00	25 00		.\		0	25 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 9,903,669 27.00			•	ructions)	-	
28. 00 Direct graduate medical education payments (From Wkst. E-4, line 50) 28. 00 28. 50 28. 50 28. 50 28. 50 28. 50 29. 00 28. 50 28. 50 29. 00 28. 50 29. 00 28. 50 29. 00 29	27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p				
28. 50 REH Facility payment amount (see instructions) 28. 50 REH facility payment amount (see instructions) 29. 00 29	28 00		ne 50)		0	28 00
30. 00 Subtotal (sum of lines 27, 28, 28, 28, 50 and 29) 9, 903, 669 30, 00 21, 100 21, 142 31, 100 32, 100 32, 100 32, 100 33, 100 34, 100			ne 30)		O	
31.00 Primary payer payments 2.142 31.00 32.00 20.00 32.00 20.00 33.00 20.	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			-	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0.00 0						1
33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 197, 200 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 128, 180 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37, 211 36.00 37.00 Subtotal (see instructions) 37, 211 36.00 39.00 MSP-LCC reconciliation amount from PS&R 10, 029, 707 37.00 38.00 MSP-LCC reconciliation amount from PS&R 17 39.00 39.50 Floneer ACO demonstration payment adjustment (see instructions) 17 39.00 39.75 39						
34. 00			ES)			
35. 00 Adjusted reimbursable bad debts (see instructions) 328, 180 35. 00 310 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 37, 211 36. 00 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 10,029,707 37. 00 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -43 38. 00 39. 00 OTHER ADJUSTMENT PER PS&R 17 39. 00 39. 50 39. 75 39. 50 70 Poincer ACO demonstration payment adjustment (see instructions) 39. 50 39. 75 39. 97 Demonstration payment adjustment amount (see instructions) 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 200, 595 40. 01 40. 02 Demonstration adjustment (see instructions) 200, 595 40. 01 40. 02 Demonstration adjustment amount after sequestration 40. 03 30. 04. 00 30. 04. 00 30. 05 30.					-	
37.00 Subtotal (see instructions) 10,029,707 37.00 38.00 MSP-LCC reconciliation amount from PS&R -43 38.00 MSP-LCC reconciliation amount from PS&R 17 39.00 39.50 OTHER ADJUSTMENT PER PS&R 19 39.00 39.50 39.75 39.75 39.75 39.97 MSP respirator payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 10,029,767 40.00 40.01 Sequestration adjustment (see instructions) 200,595 40.01 40.02 40.03 40.00						
38.00 MSP-LCC reconciliation amount from PS&R -43 38.00 39.00 THER ADJUSTMENT PER PS&R 17 39.00 39.05 39.55 39.55 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 10,029,767 40.00 40.01 Sequestration adjustment (see instructions) 10,029,767 40.00 40.01 Sequestration adjustment amount after sequestration 200,595 40.01 40.02 40.03 41.00 Interim payments 41.01 Interim payments 41.01 Interim payments -PARHM pass-throughs 41.01 Interim payments-PARHM (for contractors use only) 42.00 42.00 42.01 43.00 8al ance due provider/program-PARHM (see instructions) 42.01 43.00 8al ance due provider/program (see instructions) 43.01 8al ance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 70 8E COMPLETED BY CONTRACTOR 49.00 49.0			ructions)			
39.00 OTHER ADJUSTMENT PER PS&R 17 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.97 39.98 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 39.90 39.						
39.75 39.75 39.97 39.97 39.98 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 50.00 Sequestration adjustment amount after sequestration 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment sequestration 40.03 Sequestration adjustment (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Interim payments 40.03 Interim payments 41.00 Interim payments-PARHM 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 Tentative settlement-PARHM (see instructions) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program (see instructions) 43.01 Balance due provider/program (see instructions) 43.01 Original outlier amount (see instructions) 90.00 Original outlier original outlier amount (see instructions)						
39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments 41.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 (s115.2) 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.99 As 39.99 As 39.99 Acceleration adjustment amount payments for replaced devices (see instructions) 93.98 Acceleration adjustment amount payment payment amount payment amount payment amount payment			5)			
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 50.029,767 40.02 Demonstration adjustment-PARHM pass-throughs 41.00 Interim payments 41.00 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Si15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 0 39.98 39.99 10,029,767 40.00 39.90 39.99 10,029,767 40.01 200,595 40.01 40.02 40.03 41.01 41.01 41.01 42.01 43.00 44.00 43.00 43.00 43.00 44.00 44.00 44.00 44.00 45.01 46.00 47.01 48.00 48.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00 49.00						
40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 92. 00 The rate used to calculate the Time Value of Money 93. 00 Sequestration adjustment amount after sequestration 94. 00 Quality and Qual		, , , , , , , , , , , , , , , , , , , ,	ed devices (see instruc	ctions)	-	
40. 01 Sequestration adj ustment (see instructions) 40. 02 Demonstration payment adj ustment amount after sequestration 40. 03 Sequestration adj ustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 90. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 92. 00 Training adjustment amount (see instructions) 940. 01 Outlier amount (see instructions) 950. 02 Outlier amount (see instructions) 960. 00 Outlier reconciliation adjustment amount (see instructions) 970. 00 Outlier amount (see instructions) 980. 00 Outlier amount (see instructions) 990. 00 Outlier amount (see instructions)					-	
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement -PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.00 40.00 40.00 40.00 40.00 40.00 40.00 40.00 41.00 41.00 41.00 42.01 43.00 43.01 43.01 44.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00		1				
40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90. 00 Original outlier amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 The rate used to calculate the Time Value of Money 92. 00 The rate used to calculate the Time Value of Money 93. 00 Value of Money 94. 00 Value of Money 95. 778, 368 96. 778, 368 97. 778,						
41. 01 Interim payments-PARHM		Sequestration adjustment-PARHM pass-throughs				
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 42.00 42.01 42.01 42.01 42.01 43.00 42.00 42.01 43.00 43.01 44.00 91.00 90.00 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 90.00 91.00 92.00		1			9, 778, 368	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 50,804 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 42.01 43.00 43.00 43.00 43.01 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 91.00 92.00		1			0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 43.01 44.00 44.00 44.00 47.00 47.00 47.00 47.00 47.00 47.00 47.00 97.	42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f					50, 804	
\$115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Outlier reconciliation adjustment amount (see instructions) 94. 00 Outlier reconciliation adjustment amount (see instructions) 95. 00 Outlier reconciliation adjustment amount (see instructions) 96. 00 Outlier reconciliation adjustment amount (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions)			ice with CMS Pub. 15-2	chapter 1.	n	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 92.00	20	§115. 2		11.55		
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 91.00 92.00	00 00				0	00.00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00					-	
UR (N) llime Value of Money (see instructions)	92.00	The rate used to calculate the Time Value of Money			0. 00	92.00
75. 00 Time variae of money (see Histractions)	93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od: From 01/01/2023	Worksheet E	
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				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	Provi der CCN: 15-0104	Peri od: From 01/01/2023	Worksheet E Part B
	Component CCN: 15-S104		
	Title XVIII	Subprovi der -	PPS

	little XVIII Subprovider - IPF	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
00	Medical and other services (see instructions)	1, 128	
00	Medical and other services reimbursed under OPPS (see instructions)	129	
00	OPPS or REH payments Outlier payment (see instructions)	250 0	
01	Outlier reconciliation amount (see instructions)	0	1 .
00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
00	Line 2 times line 5	0	1
00 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct graduate medical education costs from	_	1
00	Wkst. D, Pt. IV, col. 13, line 200	i	1
. 00	Organ acqui si ti ons	0	10
00	Total cost (sum of lines 1 and 10) (see instructions)	1, 128	11
	COMPUTATION OF LESSER OF COST OR CHARGES		-
. 00	Reasonable charges Ancillary service charges	3, 892	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0,072	1
. 00	Total reasonable charges (sum of lines 12 and 13)	3, 892	
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17
	Total customary charges (see instructions)	3, 892	
00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	2, 764	19
00	instructions)		1 ,,
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20
00	Lesser of cost or charges (see instructions)	1, 128	2
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions)	0	1 -
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	250	24
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	0	25
	Deductibles and Coinsurance amounts (for CAH, see instructions)	0	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 378	
	instructions)	I	
	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	1 -
	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28
	Subtotal (sum of lines 27, 28, 28.50 and 29)	1, 378	
	Primary payer payments	0	
00	Subtotal (line 30 minus line 31)	1, 378	3:
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0	
. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)		١ ,
		_	
00		0	3
00 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	_	34
00 00 00 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	0 0 0 1, 378	3:
00 00 00 00	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	0 0 0 1, 378 0	34 35 36 37 38
00 00 00 00 00 00	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)	0 0 0 1, 378	34 35 36 37 38 38
00 00 00 00 00 00 50	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)	0 0 0 1, 378 0 0	34 35 36 37 38 38 39
00 00 00 00 00 00 50 75	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) N95 respirator payment adjustment amount (see instructions)	0 0 0 1, 378 0	34 35 36 36 37 37 37 37
00 00 00 00 00 00 50 75	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)	0 0 0 1,378 0 0	34 35 36 37 36 37 37 37 37 37 37
00 00 00 00 00 00 50 75 97 98 99	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) 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	0 0 1, 378 0 0 0 0	34 35 35 36 36 36 36 36 36 36 36 36 36 36 36 36
00 00 00 00 00 50 75 97 98 99 00	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) 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)	0 0 1, 378 0 0 0 0 0 0 1, 378	30 30 30 30 30 30 30 30 30 30 30 30 30 3
00 00 00 00 00 50 75 97 98 99 00 01	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) 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)	0 0 1,378 0 0 0 0 0 1,378 28	34 35 36 36 36 36 36 36 36 36 36 46 46
00 00 00 00 00 50 75 97 98 99 00 01 02	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) 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) Demonstration payment adjustment amount after sequestration	0 0 1, 378 0 0 0 0 0 0 1, 378	34 35 36 36 37 37 38 39 39 39 39 39 40 40 40 40
00 00 00 00 00 50 75 97 98 99 00 01 02 03	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) 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)	0 0 1,378 0 0 0 0 0 1,378 28	34 35 36 36 37 38 38 38 38 38 38 38 38 38 38 40 40 40 40 40 40 40 40 40 40 40 40 40
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-	0 0 1,378 0 0 0 0 0 1,378 28 0	34 35 36 37 38 39 39 39 39 39 40 40 40 41 41 41
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only)	0 0 1,378 0 0 0 0 0 1,378 28	343 353 363 373 373 373 373 374 474 474 474 474
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 75 . 97 . 98 . 00 . 01 . 02 . 03 . 00 . 00	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0 0 1,378 0 0 0 0 1,378 28 0	343 353 363 373 373 373 373 373 374 404 404 4144 4144 4144 4144
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 75 . 97 . 98 . 99 . 00 . 01 . 02 . 03 . 00 . 01 . 00	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	0 0 1,378 0 0 0 0 0 1,378 28 0	34 35 36 37 38 38 39 39 39 39 39 40 40 40 41 41 41 42 42 43
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	0 0 1,378 0 0 0 0 1,378 28 0	34 35 36 36 37 38 38 39 39 39 39 39 40 40 40 41 41 41 42 43 44 44 44 44 44 44 44 44 44 44 44 44
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	0 0 1, 378 0 0 0 0 0 1, 378 28 0 1, 782	34 35 36 36 37 38 38 39 39 39 39 39 40 40 40 41 41 41 42 43 44 44 44 44 44 44 44 44 44 44 44 44
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01 00	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Bal ance due provider/program (see instructions) Bal ance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR	0 0 1, 378 0 0 0 0 0 1, 378 28 0 1, 782 0 -432	34 35 36 37 38 39 39 39 39 39 40 40 40 41 41 42 42 42 42 44
00 00 00 00 00 00 50 75 97 98 99 00 01 02 03 00 01 00 01 00	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) 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) Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Bal ance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2	0 0 1, 378 0 0 0 0 0 1, 378 28 0 1, 782	34 35 36 37 38 39 39 39 39 39 40 40 40 41 41 42 42 42 42 42 43 44 44

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0104	Peri od: From 01/01/2023	Worksheet E	
		Component CCN: 15-S104	To 12/31/2023		pared: 2 pm
		Title XVIII	Subprovi der -	PPS	
			IPF		
				1. 00	
93.00 Time Value of Money (see instructions)				0	93.00
94.00 Total (sum of lines 91 and 93)				0	94.00
				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		Worksheet E
		From 01/01/2023	
	Component CCN: 15-5832	To 12/31/2023	
			5/30/2024 1:52 pm
	Title XVIII	Skilled Nursing	PPS

	litle XVIII Skilled Nursing Facility	PPS
		1. 00
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00
00	Medical and other services (see instructions)	2, 572
00	Medical and other services reimbursed under OPPS (see instructions)	0
00	OPPS or REH payments	
00	Outlier payment (see instructions)	
)1)0	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	
00	Line 2 times line 5	0
00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00
00	Transitional corridor payment (see instructions)	0
00	Ancillary service other pass through costs including REH direct graduate medical education costs from	0
	Wkst. D, Pt. IV, col. 13, line 200	
00	Organ acqui si ti ons	0
00	Total cost (sum of lines 1 and 10) (see instructions)	2, 572
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges	
00	Ancillary service charges	8, 872
00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0, 0, 2
00	Total reasonable charges (sum of lines 12 and 13)	8, 872
	Customary charges	
.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0
00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0
00	had such payment been made in accordance with 42 CFR §413.13(e)	0.000000
00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)	0. 000000 8, 872
00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	6, 300
00	instructions)	0,000
00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0
	instructions)	
00	Lesser of cost or charges (see instructions)	2, 572
	Interns and residents (see instructions)	0
00	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0
00	Deductibles and coinsurance amounts (for CAH, see instructions)	0
00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	
00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 572
	instructions)	
00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0
	REH facility payment amount (see instructions)	0
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)	0 2, 572
	Primary payer payments	2, 372
	Subtotal (line 30 minus line 31)	2, 572
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	,
00	Composite rate ESRD (from Wkst. I-5, line 11)	0
	Allowable bad debts (see instructions)	0
	Adjusted reimbursable bad debts (see instructions)	0
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	0 2, 572
	MSP-LCC reconciliation amount from PS&R	2, 372
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0
50	Pioneer ACO demonstration payment adjustment (see instructions)	O
	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
	Subtotal (see instructions)	2, 572
01	Sequestration adjustment (see instructions)	51
	Demonstration payment adjustment amount after sequestration	0
02	' ' '	
02 03	Sequestration adjustment-PARHM pass-throughs	2, 680
02 03 00	' ' '	2, 680
02 03 00 01	Sequestration adjustment-PARHM pass-throughs Interim payments	2, 680
02 03 00 01 00	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM	
02 03 00 01 00 01 00	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	
02 03 00 01 00 01 00	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	0 -159
02 03 00 01 00 01 00 01	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0
02 03 00 01 00 01 00 01	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2	0 -159
02 03 00 01 00 01 00 01	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 TO BE COMPLETED BY CONTRACTOR	0 -159
02 03 00 01 00 01 00 01 00	Sequestration adjustment-PARHM pass-throughs Interim payments Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2	0 -159

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od:	Worksheet E	
		Component CCN: 15-5832	From 01/01/2023 To 12/31/2023		narod:
		Component Con. 15-3832	10 12/31/2023	5/30/2024 1: 5	
		Title XVIII	Skilled Nursing	PPS	
			Facility		
				1. 00	
93.00 Time Value of Money (see instructions)					93.00
94.00 Total (sum of lines 91 and 93)					94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/30/2024 1:52 pm Provi der CCN: 15-0104

					5/30/2024 1: 5	2 pm
		Title XVIII		Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
	Total interim payments paid to provider		6, 778, 678		9, 705, 070	
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2.00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
	List separately each retroactive lump sum adjustment					3.00
3.00	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					
	ADJUSTMENTS TO PROVIDER		0	12/31/2023	73, 298	
3. 02			0		0	
3. 03			0		0	
3. 04			0		0	
3. 05			0		0	3.05
	Provider to Program				0	1 2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	
3. 51					0	
3. 53			0		0	
3. 54			0		0	1
	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		73, 298	
	3. 50-3. 98)		_			
	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		6, 778, 678		9, 778, 368	4.00
	appropriate)					-
	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		Γ			- 00
5.00	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		0		0	5. 01
5. 02			0		0	
5. 03			0		o	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	
5. 52			0		0	0.02
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		111, 416		50, 804	6. 01
	SETTLEMENT TO PROGRAM		0		0	1
7. 00	Total Medicare program liability (see instructions)		6, 890, 094		9, 829, 172	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor	`	9	1.00	2:00	8.00

Health Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	ERVI CES RENDERED		 From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/30/2024 1:52 pm

		Title	XVIII	Subprovi der -	PPS	2 pm
	· -	I npati en	t Part A	I PF 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		1, 169, 192	2	1, 782	1. 00
2.00	Interim payments payable on individual bills, either		(0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	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					
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02 3. 03			(0 0	3. 02 3. 03
3. 03						3. 03
3. 05					l ől	3.05
0.00	Provi der to Program			1	J	0.00
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			(0	3. 51
3. 52			(0	3. 52
3. 53			(0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0 0	3. 54 3. 99
3. 99	3. 50-3. 98)			,	ا	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 169, 192	2	1, 782	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR	I	I	T		F 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		(0	5. 01
5. 02			(0	5. 02
5. 03			()	0	5. 03
F F0	Provi der to Program	l		\	0	
5. 50 5. 51	TENTATIVE TO PROGRAM		(5. 50 5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				ő	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)				_	
6. 01	SETTLEMENT TO PROVIDER		10, 032		0	6. 01
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 179, 22 ⁴		432 1, 350	6. 02 7. 00
7.00	Trotal medicare program trability (see Instructions)		1, 1/7, 224	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor		·			8. 00

Health Financial Systems WITH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WITHAM MEMORIAL HOSPITAL Provider CCN: 15-0104 Component CCN: 15-5832

8.00

		Title	XVIII	Skilled Nursing	PPS	<u> 2 piii </u>
		Innation	t Part A	Facility	t B	
		Tilpati en	it rait A	Fai	l 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, 166, 416	5	2, 680	1. 00
2.00	Interim payments payable on individual bills, either		(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 PROVI DER		(0	3. 01
3.02			(o	3. 02
3. 03			(0	3. 03
3.04			(0	3.04
3.05			(0	3. 05
	Provi der to Program					
3. 50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51					0	3. 51
3. 52 3. 53			(0	3. 52 3. 53
3. 53 3. 54				1	0	3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 77	3. 50-3. 98)		`		Ĭ	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 166, 416	5	2, 680	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			T		
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	5. 01
5. 02	TENTATI VE TO TROVIDER				o o	5. 02
5. 03					o l	5. 03
	Provi der to Program			<u> </u>		
5.50	TENTATI VE TO PROGRAM		()	0	5.50
5. 51			(0	5. 51
5. 52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		372		o	6. 01
6. 02	SETTLEMENT TO PROVIDER		3/2		159	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 166, 788	3	2, 521	7. 00
7.00	1.2.2. m.2 22 p. og. am 1. ab. 1. cy (000 1.100 ab. 1010)		.,, ,	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

8.00 Name of Contractor

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0104	Peri od:	Worksheet E-1	
				From 01/01/2023		narad.
	To 12/31/2023 Date/Time P					
			Title XVIII	Hospi tal	PPS	, <u> </u>
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD	COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					1.00
2.00	Medicare days (see instructions)					2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col.	6. line 2				3.00
4.00	Total inpatient days (see instructions)					4.00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst	. S-10, col. 3 l	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for t	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8.00	Calculation of the HIT incentive payment (see	e instructions)				8.00
9.00	Sequestration adjustment amount (see instruct	i ons)				9. 00
10.00	Calculation of the HIT incentive payment after		(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &	CAH				
30.00	Initial/interim HIT payment adjustment (see i	nstructions)				30.00
31.00	Other Adjustment (specify)					31.00
32.00	Balance due provider (line 8 (or line 10) min	nus line 30 and l	ine 31) (see instruction	ns)		32.00

Heal th	Financial Systems	WITHAM MEMORIAL	HOSPI TAL		1	n Lie	u of Form CMS-2	552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0104	Period: From 01/01	/2023	Worksheet E-3 Part II	
			Component	CCN: 15-S104				oared: 2 pm
			Ti tl	e XVIII	Subprovi d	er -	PPS	
					I PF			
							1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS							
1.00	Net Federal IPF PPS Payments (excluding outli	ier, ECT, and med	li cal educa	tion payments))		1, 306, 616	1.00
2.00	Net IPF PPS Outlier Payments						o	2.00
3.00	Net IPF PPS ECT Payments						o	3.00
	1							

		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 306, 616	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0. 00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0. 00	4. 01
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		l
5.00	New Teaching program adjustment. (see instructions)	0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0. 00	6. 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0. 00	7. 00
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	8. 00
9. 00	Average Daily Census (see instructions)	6. 246575	1
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).	o	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 306, 616	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	o	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	l	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	1, 306, 616	16. 00
17.00	Primary payer payments	0	17. 00
	Subtotal (line 16 less line 17).	1, 306, 616	1
	Deducti bl es	113, 556	
	Subtotal (line 18 minus line 19)	1, 193, 060	
	Coi nsurance	0	
	Subtotal (line 20 minus line 21)	1, 193, 060	1
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15, 738	
24. 00	Adjusted reimbursable bad debts (see instructions)	10, 230	1
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
	Subtotal (sum of lines 22 and 24)	1, 203, 290	
	Direct graduate medical education payments (see instructions)	0	
	Other pass through costs (see instructions)	0	
	Outlier payments reconciliation	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
	Pioneer ACO demonstration payment adjustment (see instructions)	0	
	Recovery of accelerated depreciation.	0	
	Demonstration payment adjustment amount before sequestration	1 202 200	
31. 00 31. 01	Total amount payable to the provider (see instructions)	1, 203, 290	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	24, 066 0	1
	Interim payments	1, 169, 192	1
	Tentative settlement (for contractor use only)	1, 109, 192	1
	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	10, 032	1
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
33.00	\$115. 2		33.00
EO 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
		0	
	Outlier reconciliation adjustment amount (see instructions) The rate weed to calculate the Time Value of Menov	0. 00	1
52.00	The rate used to calculate the Time Value of Money	0.00	
აა. 00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (TH		55.00
00.00	COVID-19 PHE)	0.000000	00.00
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	•
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	99.01

Heal th	Financial Systems	WITHAM MEMORIAL		In Lie	u of Form CMS-2	<u> 2552-10</u>	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0104	Peri od:	Worksheet E-3		
			Component CCN: 15-5832	From 01/01/2023 To 12/31/2023		nared:	
			Component Con. 13-3032	10 12/31/2023	5/30/2024 1:5	2 pm	
			Title XVIII	Skilled Nursing	PPS		
	Facility						
					1 00		
	PART VI - CALCULATION OF REIMBURSEMENT SETTLI	EMEMENT - ALL OTH	ED HEALTH SERVICES FOR	TITIE YVIII DADT	1. 00 A DDS SNE		
	SERVICES	LIVILIVILIVI - ALL OTTI	LK HEALTH SERVICES FOR	IIILL AVIII FARI	A FF3 SINI		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS))				1	
1.00	Resource Utilization Group Payment (RUGS)	,			1, 310, 021	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, 310, 021	4.00	
	COMPUTATION OF NET COST OF COVERED SERVICES						
5.00	Medical and other services (Do not use this	line as vaccine c	osts are included in li	ne 1 of W/S E,		5.00	
	Part B. This line is now shaded.)				0		
6. 00						6. 00	
7. 00	Coinsurance				119, 800		
8.00	Allowable bad debts (see instructions)				583		
9.00	Reimbursable bad debts for dual eligible ben		nstructions)		0 379	9.00	
10. 00 11. 00	Adjusted reimbursable bad debts (see instruc Utilization review	tions)					
12.00	Subtotal (sum of lines 4, 5 minus lines 6 an	d 7 plus lines 1	0 and 11) (see instructi	one)	0 1, 190, 600		
13. 00	Inpatient primary payer payments	u 7, prus rines i	o and ii) (see iiisti ucti	0115)	1, 190, 600	13.00	
14. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	V)			0	14.00	
14. 50	Pioneer ACO demonstration payment adjustment		s)		0		
	Recovery of accelerated depreciation.	(See That detroit	3)		0		
14. 99	Demonstration payment adjustment amount befo	re seguestration			0	14. 99	
15. 00	Subtotal (see instructions	. o ooquooti ati oii			1, 190, 600		
15. 01	Sequestration adjustment (see instructions)				23, 804		
15. 02	Demonstration payment adjustment amount afte	r seguestration			0	ı	
15. 75	Sequestration for non-claims based amounts (8	15. 75	
16.00	Interim payments	,			1, 166, 416	16.00	
	Tentative settlement (for contractor use onl	y)			0	17.00	
18.00	Balance due provider/program (line 15 minus	lines 15.01, 15.0	2, 15.75, 16, and 17)		372	18. 00	
19.00	Protested amounts (nonallowable cost report	items) in accorda	nce with CMS 19 Pub. 15	-2, chapter 1,	0	19. 00	
	§115. 2						

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 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 1:52 pm

		1	0 12/31/2023	Date/lime Pre 5/30/2024 1:5	
		Title XIX	Hospi tal	Cost	2 p
			Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CVI CES I CIC II I LES V CIC XI	X JERVI CES		
1. 00	Inpatient hospital/SNF/NF services		467, 125		1.00
2. 00	Medical and other services		407, 123	0	2.00
3. 00	Organ acquisition (certified transplant programs only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		467, 125	0	4.00
5. 00	Inpatient primary payer payments		407, 123	U	5.00
6. 00	Outpatient primary payer payments		U	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		467, 125	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		407, 123	U	7.00
	Reasonable Charges				
0.00			007 105		0 00
8. 00	Routine service charges		887, 195	0	8.00
9.00	Ancillary service charges		1, 024, 059	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 911, 254	0	12.00
	CUSTOMARY CHARGES	 			
13. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		1, 911, 254	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	1, 444, 129	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	ly if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see insti		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		467, 125	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		467, 125	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	467, 125	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00			467, 125	0	36.00
37. 00			0	0	37.00
38. 00			467, 125	0	38.00
39. 00			0		39.00
40. 00			467, 125	0	40.00
41. 00	Interim payments		809, 513	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		-342, 388	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	43.00
.5. 55	chapter 1, §115.2	1 45 10 2,		O	.5. 55
	1 · · · · · · · · · · · · · · · · · · ·		1		•

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu				u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCM			Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 1:52	oared: 2 pm
		Title XVIII		PPS	
	·	· · ·			
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03 plus 2.04 (see	instructions)	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	instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see in	structions)		O	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 instruct	ions)		o	6.00
7.00	Time value of money for capital related expenses (see in	structions)		0	7.00

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

Provider CCN: 15-0104

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 1:52 pm

37		General Fund	Speci fi c	Endowment	5/30/2024 1:5 Plant Fund	2 pm
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1. 00 2. 00	Cash on hand in banks Temporary investments	44, 104, 038 38, 688, 696		0 0	0	1. 00 2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4. 00	Accounts receivable	18, 933, 188		0	0	4.00
5. 00	Other receivable	1, 708, 489	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	4, 848, 793	0	0	0	6. 00 7. 00
8. 00	Prepai d expenses	4, 040, 773	0	0	0	8.00
9. 00	Other current assets	2, 042, 449	Ö	o	0	9. 00
10.00	Due from other funds	0	0	o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	110, 325, 653	0	0	0	11. 00
	FI XED ASSETS	T		_1		
12.00	Land	2, 895, 261	0	0	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	3, 301, 660	0	0	0	13. 00 14. 00
15. 00	Buildings	129, 709, 202	-	0	0	15.00
16. 00	Accumulated depreciation	-45, 300, 226		Ö	0	16.00
17. 00	Leasehold improvements	0	0	Ö	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 23. 00	Accumulated depreciation Major movable equipment	90, 931, 056	0	0	0	22. 00 23. 00
24. 00	Accumul ated depreciation	-72, 742, 817	0	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	72, 742, 017	0	Ö	0	25. 00
26. 00	Accumulated depreciation	0	0	Ö	0	26. 00
27.00	HIT designated Assets	0	0	o	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	108, 794, 136	0	0	0	30.00
31. 00	OTHER ASSETS Investments	1 0	0	ol	0	31.00
32. 00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	0	Ö	ol	0	33.00
34. 00	Other assets	36, 103, 218	0	ō	0	34.00
35.00	Total other assets (sum of lines 31-34)	36, 103, 218	0	o	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	255, 223, 007	0	0	0	36.00
07.00	CURRENT LI ABI LI TI ES	0.0/4.505	1 0	ما		1 07 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	8, 861, 595 11, 064, 656		0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	11,004,030	0	0	0	39.00
40. 00	Notes and Loans payable (short term)	0	0	Ö	0	40.00
41. 00	Deferred income	0	0	Ö	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	11, 001, 382		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	30, 927, 633	0	0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1	0	ol	0	46. 00
47. 00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	Ö	ő	0	48. 00
49. 00	Other long term liabilities	22, 751, 818	0	o	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	22, 751, 818	0	o	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	53, 679, 451	0	0	0	51.00
F0 00	CAPI TAL ACCOUNTS	004 540 554				
52. 00 53. 00	General fund balance Specific purpose fund	201, 543, 556	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		l o	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		55.00
56. 00	Governing body created - endowment fund balance			Ö		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
FO 00	replacement, and expansion	201 542 551			-	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	201, 543, 556		0 0	0	59. 00 60. 00
00.00	Total Trabilities and rund barances (sum of Tines 51 and 159)	255, 223, 007		٩	Ü	00.00
	1. /	1	1	1		1

Period: Worksheet G-1 From 01/01/2023 Provider CCN: 15-0104

					To 12/31/2023	Date/Time Pre 5/30/2024 1:5	pared: 2 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	200, 741, 507 802, 049 201, 543, 556		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 201, 543, 556 0 201, 543, 556		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

Health Financial Systems WASTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0104

			0 12/31/2023	5/30/2024 1:5		
	Cost Center Description	I npati ent	Outpati ent	Total	_ p	
	'	1.00	2. 00	3. 00		
	PART I - PATIENT REVENUES	•				
	General Inpatient Routine Services					
1.00	Hospi tal	21, 213, 229		21, 213, 229	1.00	
2.00	SUBPROVI DER - I PF	3, 071, 896		3, 071, 896	2.00	
3.00	SUBPROVI DER - I RF			0	3.00	
4.00	SUBPROVI DER			0	4. 00	
5.00	Swing bed - SNF			0	5.00	
6.00	Swing bed - NF			0	6. 00	
7.00	SKILLED NURSING FACILITY	2, 725, 043		2, 725, 043	7. 00	
8.00	NURSING FACILITY				8. 00	
9.00	OTHER LONG TERM CARE				9. 00	
10.00	Total general inpatient care services (sum of lines 1-9)	27, 010, 168	3	27, 010, 168	10.00	
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	6, 130, 001		6, 130, 001	11.00	
12.00	CORONARY CARE UNIT				12.00	
13.00	BURN INTENSIVE CARE UNIT				13.00	
	SURGI CAL INTENSI VE 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, 130, 001		6, 130, 001	16. 00	
	[11-15]					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	33, 140, 169		33, 140, 169		
18. 00	Ancillary services	63, 495, 663		379, 610, 920		
	Outpati ent servi ces	5, 619, 857		52, 596, 082		
20. 00	RURAL HEALTH CLINIC			0	20.00	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00	
22. 00	HOME HEALTH AGENCY				22. 00	
23. 00	AMBULANCE SERVICES		4, 107, 696	4, 107, 696		
24. 00	CMHC				24.00	
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)				25.00	
26. 00	HOSPI CE				26. 00	
27. 00	DIETARY, A&G, PHYSICIAN PRACTICES	(54, 945, 047	54, 945, 047	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 102, 255, 689	422, 144, 225	524, 399, 914	28. 00	
	G-3, line 1)					
00.00	PART II - OPERATING EXPENSES		100 704 040		00.00	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		180, 736, 242		29.00	
30.00	ADD (SPECIFY)	(30.00	
31.00					31.00	
32.00		1			32.00	
33.00					33.00	
34. 00 35. 00					34. 00 35. 00	
36. 00	Total additions (sum of lines 20.25)		, ol		36.00	
37. 00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)		_		37.00	
38. 00	DEDUCT (SPECIFT)				38.00	
39. 00					39.00	
40. 00					40.00	
41. 00					41.00	
41.00	Total deductions (sum of lines 37-41)		<u></u>		41.00	
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	180, 736, 242		43.00	
43.00	to Wkst. G-3, line 4)		100, 730, 242		73.00	
	10 m/sc. 6 6, 11116 4)	ı	1		ı	

Health Financial Systems WITHAM MEMORIAL HOSPITAL In Lieu of				
STATEM	ENT OF REVENUES AND EXPENSES Provider CCN: 15-0104 Period:	Worksheet G-3		
	From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·	
	10 12/01/2020	5/30/2024 1: 5		
		1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	524, 399, 914 359, 097, 120	1.00	
2.00				
3.00			3.00	
4.00			4.00	
5. 00	Net income from service to patients (line 3 minus line 4)	-15, 433, 448	5.00	
,	OTHER I NCOME		,	
6. 00	Contributions, donations, bequests, etc	0		
7.00	Income from investments	0	,	
8.00	Revenues from telephone and other miscellaneous communication services	0		
9.00	Revenue from tel evision and radio service	0		
	Purchase di scounts	0		
	Rebates and refunds of expenses	0		
	Parking lot receipts	0	1	
	Revenue from laundry and linen service Revenue from meals sold to employees and quests			
	Revenue from rental of living quarters			
	Revenue from sale of medical and surgical supplies to other than patients		•	
	Revenue from sale of drugs to other than patients		•	
	Revenue from sale of medical records and abstracts			
	Tuition (fees, sale of textbooks, uniforms, etc.)		19.00	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen		20.00	
21. 00	Rental of vending machines		•	
	Rental of hospital space	0	ı	
23. 00	Governmental appropriations			
24. 00	OTHER OPERATI NG I NCOME	7, 345, 072	1	
24. 01	NON-OPERATING INCOME	8, 890, 425	1	
	COVID-19 PHE Funding	0	24.50	
25. 00	Total other income (sum of lines 6-24)	16, 235, 497		
	Total (line 5 plus line 25)	802, 049	ı	
	OTHER EXPENSES (SPECIFY)	0		
	Total other expenses (sum of line 27 and subscripts)	Ö	28. 00	
	Net income (or loss) for the period (line 26 minus line 28)	802, 049		

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	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III	
Title XVIII Hospital					
	DART I FULLY PROCEEDING HETHOR			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1 00	CAPITAL FEDERAL AMOUNT				1 00
1. 00 1. 01	Capital DRG other than outlier			417, 419 0	1. 00 1. 01
2.00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			2, 900	2.00
2. 00	Model 4 BPCI Capital DRG outlier payments			2, 400	2.00
3. 00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			24. 84	3.00
4. 00	Number of interns & residents (see instructions)			0.00	4.00
5. 00	Indirect medical education percentage (see instructions)			0.00	5.00
6. 00	Indirect medical education percentage (see Histructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0.00	6.00
0.00	1.01) (see instructions)	5 5 a 51 111155 1 and 11 5	i, coramic rana	· ·	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instructions)			0. 00	8.00
9. 00	Sum of lines 7 and 8	,		0. 00	9.00
10.00	Allowable disproportionate share percentage (see instructions	s)		0. 00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			420, 319	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00	
3. 00	Total inpatient program capital cost (line 1 plus line 2)		0	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
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	2.00
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	3. 00 4. 00
	Applicable exception percentage (see instructions)			0.00	5.00
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see in	netrueti one)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary	,	v lino 4)	0.00	7.00
8. 00	Capital minimum payment level (line 5 plus line 7)	y Circuiistances (iiile 2	x iiile o)	0	8.00
9. 00	Current year capital payments (from Part I, line 12, as appli	i cabl o)		0	9.00
10.00	Current year comparison of capital minimum payment level to		less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)		,	0	11.00
12. 00	Net comparison of capital minimum payment level to capital page 1	avments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)			0	
15. 00				0	15.00
16. 00		•		0	16.00
17.00	Current year exception offset amount (see instructions)			0	17.00
					•