WI THAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND F AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION T SUMMARY	Provider CCN: 15-0104	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/26/2017 10:50 am
PART I - COST	REPORT STATUS			
Provi der use only	 [X] Electronically filed cost report [Manually submitted cost report [0] If this is an amended report enter the number [F] Medicare Utilization. Enter "F" for full or " 	of times the provider L" for low.	Date: 5/26/20 resubmitted this c	
Contractor use only	 5. [1] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended (5) Amended (6) Date Received: (6) Date Received: (7) Contractor No. (7) Contractor No. (8) Date Received: (9) Date Received: (10) Date Received:	11. or this Provider CCN12.		or Code: 4 olumn 1 is 4: Enter nes reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WITHAM MEMORIAL HOSPITAL (15-0104) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(Si gned)

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	43, 014	82, 288	0	26, 686	1.00
2.00	Subprovider - IPF	0	2	-203		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-26		0	7.00
200.00	Total	0	43, 016	82, 059	0	26, 686	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI CARE.

	Financial Systems		MEMORI AL					In Lieu	u of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ΛTΑ	Provio	ler CCN:	15-0104	Period: From 01/0		Part I	eet S-2	
							To 12/3		Date/T 5/26/2	ime Pre <u>017 10:</u>	
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			
1.00	Street: 2605 N. LEBANON STREET	P0 Box:									1.00
2.00	City: LEBANON	State: I		Zip Cod			nty: BOONE	D		(D	2.00
		Component Na	ime	CCN Number	CBSA Numbei		er Date Certifie		ent Syst , 0, or		
								V	XVIII	XIX	
	Uponital and Uponital Decod Componen	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital and Hospital-Based Componer Hospital	WITHAM MEMORIAL		150104	26900) 1	07/01/196	6 N	Р	0	3.00
4.00	Subprovider - IPF	HOSPI TAL WI THAM HOSPI TAL		15S104	26900) 4	01/01/200	O N	P	N	4.00
5.00 6.00 7.00 8.00	Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF	GEROPSYCH	5011	155000	24000		05 (07 (201			N	5.00 6.00 7.00 8.00
13.00 14.00 15.00 16.00 17.00 18.00	Hospital-Based SNF Hospital-Based NF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other	WITHAM HOSPITAL E	ECU	155832	26900)	05/07/201	5 N	Ρ	N	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
			I		1		Fro		Тс		
20,00	Cast Departing Deried (mm (dd (unu))						1.0	-	2.		20,00
20.00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information						01/01/ 9		12/31	/2016	20.00 21.00
22.00	Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil	ance with 42 CFR ity subject to 42	§412.106 2 CFR Sec	5? In c ction §4	olumn ¹	, enter "	Y''		١	1	22.00
22.01	amendment hospital?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	compensated care res or "N" for no October 1. Enter	payments for the in colum	s for th portion nn 2, "Y	of the " for y	cost es or "N"	g Y		Ň	1	22.01
22.02	Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ons) Ente period p	er in co prior to	lumn 1, Octobe	"Y" for y r 1. Enter	yes r		1	J	22.02
22.03	Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no	statistical area no for the portic 2, "Y" for yes or r after October 1 t more than 499 b	as adopte on of the ~ "N" for 1. (see i peds (as	ed by CM e cost r no for nstruct counted	S in FY eportin the po ions) D	2015? Ente g period rtion of oes this	er the		1	1	22.03
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	dicaid days on li f census days, or is cost reporting	nes 24 a r 3 if da g period	and/or 2 ate of d differe <u>"Y" for</u>	ischarg nt from <u>yes or</u>	e. Is the the method	bd	3 Medi ca	1 I d	l Ither	23.00
		-	Medicai paid day	d Medi /s elig unp da	caid ible M aid p ys	State Medicaid aid days	State Medi cai d el i gi bl e unpai d	HMO da	iys Med	di cai d days	
24,00	If this provider is an IPPS hospital	, enter the	1.00	2. 76	737	3.00	4.00	<u>5.00</u>) (128	5.00 0	24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state	1	0	0	0	0	1,	0	U	25. 00
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	3, out-of-state umn 4, Medicaid									

OSPI T.	Financial Systems WITHAM I AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider CC	N: 15-0104	Period: From 01/01 To 12/31	/2016	Date/Tir	et S-2 me Pre	pared:
					Urban/Ru	ral S	5/26/20		
					1.00		2.0		-
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	rural ge) sta	atus at the en	d of the co		1 1			26.00 27.00
	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	cati on	in column 2.		n	0			35.00
	effect in the cost reporting period.				Begi nni	na:	Endi r	na:	
					1.00		2.0		
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for num	per				36.00
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the n			us N	0			37.00
	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)	or yes o	or "N" for no.	(see	N				37.01
	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N		Y/N		-
9.00	Does this facility qualify for the inpatient hospital	pavme	nt adjustment	for low vol	1.00 ume Y)	2.0 Y	0	39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente uireme	er in column 1 nts in accorda	"Y" for ye nce with 42	5				
). 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. I	Enter "Y" for g				N		40.00
	Prospective Payment System (PPS)-Capital					V 1.00	XVIII 2.00	XI X 3. 00	
5.00	Does this facility qualify and receive Capital paymen	t for (di sproporti ona	te share in	accordance	N	N	Ν	45.00
6.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	Ν	46.00
7.00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
. 00	Is this a hospital involved in training residents in	approv	ed GME program	s? Enter "	Y" for yes	N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes o h of tl ", com	r "N" for no in his cost repor plete Workshee	n column 1. ting period	If column 1 ? Enter "Y"				57.00
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb			ans' servic	es as				58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,								50.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				the	N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"	for yes	<u>s or "N" for n</u>	o. (see ins	tructions)				
		Y/N	IME	Direct GM	E IME		Di rect	GME	
		1.00	2.00	3.00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	61.00
	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	C	. 00				61.0
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	C	. 00				61.02
1.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. 00	C	. 00				61.03
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	C	. 00				61.04
1. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	C	. 00				61.05

USFITAL I	AND HOSPITAL HEALTH CARE COMP	_EX IDENTIFICATION DA	ATA	Provider CC		eriod:	Worksheet S-2	
					Fr	com 01/01/2016 0 12/31/2016	Part I Date/Time Pre 5/26/2017 10:	
			Y/N	I ME	Direct GME	I ME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
use	er the amount of ACA §5503 aw of for cap relief and/or FTEs re or general surgery. (see in	that are nonprimary		0.00	0.00			61.(
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
spe for col pro unw FTE 1.20 Of pro	the FTEs in line 61.05, speci ecialty, if any, and the number each new program. (see instr umn 1, the program name, ente ogram code, enter in column 3, weighted count and enter in co unweighted count. the FTEs in line 61.05, speci ogram specialty, if any, and t	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE				0.00		61.
i ns ent 3,	sidents for each expanded prog structions) Enter in column 1, er in column 2, the program c the IME FTE unweighted count direct GME FTE unweighted cou	the program name, ode, enter in column and enter in column						
							1.00	
	<u>A Provisions Affecting the Hea</u> er the number of FTE resident					od for which	0.00	62.0
2.01 Ent dur	ir hospital received HRSA PCRE er the number of FTE resident ing in this cost reporting pe	s that rotated from a riod of HRSA THC pro	a Teach gram. (:	<u>see instructio</u>		your hospital	0.00	62.0
3.00 Has	aching Hospitals that Claim Re s your facility trained reside ' for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		period? Enter	N	63.
· ·		a			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Sec	ction 5504 of the ACA Base Yea	r FTF Residents in N	onprovi	der Settings	1.00	2.00 is your cost	3.00 reporting	
4.00 Ent in res set res	tiod that begins on or after J ter in column 1, if line 63 is the base year period, the num sident FTEs attributable to ro tings. Enter in column 2 the sident FTEs that trained in yo (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighted ur hospital. Enter in	ty train n-prima all nom d non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0. 00	0. 000000	64.
		Program Name		ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
is tra yea ass FTE pro res the col unw res rot non	ter in column 1, if line 63 yes, or your facility ained residents in the base ar period, the program name sociated with primary care Es for each primary care ogram in which you trained sidents. Enter in column 2, e program code, enter in umn 3, the number of weighted primary care FTE sidents attributable to cations occurring in all n-provider settings. Enter in umn 4, the number of weighted primary care				0.00	0.00	0. 000000	

	nancial Systems		MEMORIAL HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Pr	ovider CC	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	ction 5504 of the ACA Current		n Nonprovi dei	- Setting	1.00 sEffective	2.00 for cost report	3.00 ing periods	
66.00 En FT En FT	ginning on or after July 1, 20 ter in column 1 the number of Es attributable to rotations c ter in column 2 the number of Es that trained in your hospit column 1 divided by (column 1 +	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	rovider setti ry care resid 3 the ratio d	ngs. lent	0.00	0.00	0.000000	66.00
		Program Name	Program		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
nai yo wh En co nu ca to no co un re yo 5, di	iter in column 1, the program me associated with each of our primary care programs in ich you trained residents. Iter in column 2, the program ide. Enter in column 3, the mber of unweighted primary ore FTE residents attributable o rotations occurring in all on-provider settings. Enter in olumn 4, the number of weighted primary care isident FTEs that trained in our hospital. Enter in column the ratio of (column 3 vided by (column 3 + column). (see instructions)	1.00	2.00		<u>3.00</u> 0.00	4.00 D 0.00	5.00 0.000000	67.00
						1.0	0 2.00 3.00	-
70.00 Is En 71.00 If re 42 pr Co (s	patient Psychiatric Facility F this facility an Inpatient Ps ter "Y" for yes or "N" for no fine 70 yes: Column 1: Did th ecent cost report filed on or b CFR 412.424(d)(1)(iii)(c)) Co ogram in accordance with 42 CF folumn 3: If column 2 is Y, indi ee instructions)	ychiatric Facility (). le facility have an a lefore November 15, 2 Jumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	pproved GME 1 004? Enter ' ility train r)(D)? Enter '	eaching Y" for ye esidents Y" for ye	program in the es or "N" for in a new teac es or "N" for	e most N no. (see ching no.	0	70.00
75.00 Is	patient Rehabilitation Facilit this facility an Inpatient Re	habilitation Facilit	y (IRF), or a	loes it c	ontain an IRF	N		75.00
76.00 If renno CF	bprovider? Enter "Y" for yes fline 75 yes: Column 1: Did th cent cost reporting period enc 0. Column 2: Did this facility R 412.424 (d)(1)(iii)(D)? Ente dicate which program year bega	e facility have an a ling on or before Nov train residents in a er "Y" for yes or "N"	ember 15, 200 new teaching for no. Colu)4? Enter program umn 3: If	"Y" for yes of in accordance column 2 is N	or "N" for e with 42 /,	0	76.00
							1.00	-
80.00 Is 81.00 Is "Y	ng Term Care Hospital PPS this a long term care hospita this a LTCH co-located within for yes and "N" for no.					g period? Enter	N N	80.00 81.00
85.00 Is 86.00 Di §4	FRA Providers this a new hospital under 42 d this facility establish a ne 13.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider or yes and "N" for no	(excl uded uni	t) under	42 CFR Sectio	n	N	85.00 86.00
	s this hospital a "subclause (l or yes or "N" for no.	I)" LICH CLASSIFIEd	under sectior	1886(d)	(I)(B)(IV)(II)		N	87.00
						V 1.00	XI X 2.00	-
90.00 Do	tle V and XIX Services les this facility have title V		hospital ser	vi ces? E	nter "Y" for	N	Y	90.00
91.00 Ís	s or "N" for no in the applica this hospital reimbursed for	title V and/or XIX t				Ν	Y	91.00
92.00 Ar	Il or in part? Enter "Y" for y e title XIX NF patients occupy	ing title XVIII SNF	beds (dual ce	erti fi cati			N	92.00
93.00 Do	structions) Enter "Y" for yes les this facility operate an IC	F/IID facility for p			d XIX? Enter	Ν	N	93.00
94.00 Do	" for yes or "N" for no in the pes title V or XIX reduce capit plicable column.		or yes, and '	N" for n	o in the	Ν	N	94.00

Health Financial Systems WITHAM MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-0104	Peri od:	. 2. 00	Workshe	et S-2	2552-10 2
			From 01/01/ To 12/31/		Part I	me Pre	epared:
			V		XI 2		
			1.00		2.0		
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0.00 N		0. C N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		in.	0.00		0. C	00	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of payme	ent N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) If					107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
-	Physi cal 1.00	Occupationa 2.00	al Speec 3.00		Respir 4.0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109.00
				ł	1. C	00	-
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"	l Demonstrati for no.	on project (410A Demo)fo	or	N		110.00
Miscellaneous Cost Reporting Information				1.00	2.00	3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or				N		0	115.00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	t for long te s) based on t	erm care (inc he definitic	ludes				
I16.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insura- no.			or "N" for	N Y			116.00 117.00
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the polic	vis	2			118.00
jorarini mado, Entor z in the porrey is deduration.			., 13	-			
process made. Enter 2 th the portey is occurrence.		Premi ums	Losse	L	Insura	ance	
prena indeo. Entor 2 tr the portey is occurrence.				S	I nsura 3. 0		_
		Premiums	Losse	S		00	
		Premi ums	Losse 2.00	s 0	3. C)0	
118.01 List amounts of malpractice premiums and paid losses:		Premi ums 1.00 149,5 than the	Losse	s 0)0	
 118.01 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment 	ule listing c Harmless pro column 1, "Y alifies for t	Than the cost centers of the outpatier	Losse 2.00 584 1.00 N	s 0	3. C)0 (0 0 118.0 118.0 119.00
 118.01 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device	Premi ums 1.00 149,5 than the cost centers wision in AC "for yes or he Outpatien ructions) es charged to	Losse 2. 00 584 1. 00 N SA N SA N SA N SA N SA N	s 0	3. 0)0 (0118.07 118.02 119.00 120.00
 118.01 List amounts of malpractice premiums and paid losses: 118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualHold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implationation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 	ule listing c Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for	Premiums 1.00 149,5 than the than the total the than the than the than the total the than the total the than the total the than the total the than the total the than the total the to	Losse 2.00 384 1.00 N 34 N 34 N 34 N 4 N 5 N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S S S S S S S S S S S S S	s 0	3. 0)0 (0118.07 118.02 119.00 120.00
 118. 01 List amounts of malpractice premiums and paid losses: 118. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendments? 121. 00 Did this facility incur and report costs for high cost implain patients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state heal th or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for 	ule listing c Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A	Premiums 1.00 149,5 than the bost centers wision in AC "for yes or he Outpatier ructions) es charged to yes or "N" line number	Losse 2.00 384 1.00 N 34 N 34 N 34 N 4 N 5 N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S N S S S S S S S S S S S S S	s 0	3. 0)0 (118.02 118.02 119.00 120.00 121.00
 118. 01 List amounts of malpractice premiums and paid losses: 118. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119. 00 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no. 121. 00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Des this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A r yes and "N" ter the certi	Premiums 1.00 149,5 than the cost centers wision in AC wision in AC that ien ructions) es charged to yes or "N" line number for no. If fication dat	Losse 2.00 584 1.00 N 54 N 54 N 54 N 54 N 54 N 54 N 55 N 55 N 55 N	s 0	3. 0)0 (118.01 118.02 119.00 120.00 121.00 122.00 125.00 126.00
 118. 01 List amounts of malpractice premiums and paid losses: 118. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendments. 121. 00 Did this facility incur and report costs for high cost implain patients? Enter "Y" for yes or "N" for no. 121. 00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 123. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified heart transplant center, entification date, if applicable, in column 2 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certif	Premiums 1.00 149,5 than the bost centers wision in AC "for yes or he Outpatier ructions) es charged to yes or "N" line number for no. If fication date ication date	A N A N A N A N A N A N A N A N	s 0	3. 0)0 (118. 01 118. 02 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00
 118. 01 List amounts of malpractice premiums and paid losses: 118. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below. 126. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 127. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certif er the certif	Premiums 1.00 149,5 than the cost centers vision in AC "for yes or he Outpatien ructions) es charged to yes or "N" for no. If fication date fication date	Losse 2.00 384 1.00 N A N A N Y N e P N	s 0	3. 0)0 (118. 01 118. 02 118. 02 120. 00 121. 00 122. 00 125. 00 126. 00 127. 00 128. 00
 118. 01 List amounts of mal practice premiums and paid losses: 118. 02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122. 00 Does the cost report contain state health or similar taxes? If for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 127. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A worksh	Premiums 1.00 149,5 than the cost centers wision in AC wision in AC wision in AC than the cost centers wision in AC tractions the outpatien for no. If fication date fication date cation date cation date	Losse 2.00 384 1.00 N A N A N Y N e P N	s 0	3. 0)0 (118.01 118.02 119.00 120.00 121.00 122.00 125.00 126.00 127.00 128.00 129.00
 118. 01 List amounts of mal practice premiums and paid losses: 118. 02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quathold Harmless provision in ACA §3121 and applicable amendments. 121. 00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. 121. 00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	Harmless pro column 1, "Y alifies for t ts? (see inst ntable device Enter "Y" for e Worksheet A worksheet A r yes and "N" ter the certif er the certif r the certifi enter the certifi enter the certifi enter the certifi anter the certifi	Premiums 1.00 149,5 than the cost centers vision in AC "for yes or he Outpatier ructions) es charged tc yes or "N" line number for no. If fication date cation date tification	Losse 2. 00 584 1. 00 N A N A N A N N N P N N P N N	s 0	3. 0)0 (118.00 118.01 118.02 119.00 120.00 121.00 122.00 125.00 126.00 127.00 128.00 129.00 130.00 131.00

Health Financial Systems	WI THAM MEMORI A				u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC		Period: From 01/01/2016	Worksheet S-2 Part I	
				o 12/31/2016	Date/Time Pre	
					5/26/2017 10:	44 am
				1.00	2.00	
133.00 If this is a Medicare certified of			ication date			133.00
in column 1 and termination date, 134.00 If this is an organ procurement or	11		in column 1			134.00
and termination date, if applicabl						
All Providers 140.00 Are there any related organization	a ar home office costs as	dofined in CMS	Dub 15 1	N		140.00
chapter 10? Enter "Y" for yes or '				IN IN		140.00
are claimed, enter in column 2 the			tions)			
<u> </u>	2.00		uah 143 the n	<u>3.00</u>	of the home	
office and enter the home office of					of the home	
141.00Name:	Contractor's Name:		Contracto	r's Number:		141.00
142. 00 Street: 143. 00 Ci ty:	PO Box: State:		Zip Code:			142.00 143.00
143. 00 01 t.y.	plate.					143.00
					1.00	1.1.1.00
144.00 Are provider based physicians' cos	sts included in Worksheet A	A?			Y	144.00
				1.00	2.00	+
145.00 If costs for renal services are cl				N	N	145.00
inpatient services only? Enter "Y						
no, does the dialysis facility ind period? Enter "Y" for yes or "N"		FOR THIS COST	reporting			
146.00 Has the cost allocation methodolog		usly filed cos	t report?	N		146.00
Enter "Y" for yes or "N" for no ir		15-2, chapter	40, §4020) lf			
yes, enter the approval date (mm/o	da/yyyy) in column 2.					
					1.00	1
147.00 Was there a change in the statisti					N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				20	N N	148.00 149.00
149. Oolwas there a change to the simplifi	ed cost finding method? E	Part A	Part B	Title V	Title XIX	149.00
		1.00	2.00	3.00	4.00	
Does this facility contain a provi						
or charges? Enter "Y" for yes or ' 155.00Hospital	N TOT NO TOT Each comport	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		Ν	N	N	N	158.00 159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1.00	-
165.00 Is this hospital part of a Multica	ampus hospital that has on	e or more camp	uses in differ	ent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Namo	County	State 7in	Codo CBSA	FTE/Campus	
	Name 0	County 1.00		Code CBSA . 00 4. 00	5.00	-
166.00 fline 165 is yes, for each						166.00
campus enter the name in column						
0, county in column 1, state in column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HI				t Act	1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "	Y" for yes or	"N" for no.		Y	167.00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			e 167 is "Y"),	enter the	0	168.00
168.01 If this provider is a CAH and is r			r qualify for	a hardshi p		168.01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see	instructions)			
169.00 If this provider is a meaningful utransition factor. (see instruction		ıs not a CAH	(IINE 105 is '	N [°]), enter the	9.99	169.00
	,				1	1

Health Financial Systems	WI THAM MEMORI AL	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA	Provider CCN: 15-0104	Period:	Worksheet S-2	2
			From 01/01/2016 To 12/31/2016		epared: 44 am
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginnin period respectively (mm/dd/yyyy)	g date and ending da	te for the reporting	10/01/2014	09/30/2015	170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider ha	ve any days for indi	viduals enrolled in	N	(0171.00
section 1876 Medicare cost plans reported					
"Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see inst		nter the number of secti	on		

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	AL HOSPITAL Provider C	CN: 15-0104	Peri od:	Worksheet S	-2552- ⁻ -2
				From 01/01/2016 To 12/31/2016	Part II Date/Time Pi	
				Y/N	<u>5/26/2017 10</u> Date	<u>J:44 am</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
I. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	o bogi ppi pg of	the cost	N		1.0
1.00	reporting period? If yes, enter the date of the change in a					1.0
	······································		Y/N	Date	V/I	
	r		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	offices, drug der or its of the board	Y			3. 0
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
5.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
5.00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider i	s N		6.0
7.00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in			N		7.0
3.00 9.00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		0			9.0
10.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	ns.		Ν		10. (
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	Ν		11. (
					Y/N 1.00	
	Bad Debts					
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	s, see instruc policy change	tions. during this (cost reporting	Y N	12. (13. (
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see i	nstructions.	N	14.0
5.00	Did total beds available change from the prior cost report		yes, see in: t A	structions. Par	N t B	15. (
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/07/2017	Y	03/07/2017	17.0
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

	AL HOSPITAL			u of Form CM	
SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-0104	Period: From 01/01/2016 To 12/31/2016		- repare
	Descri	ption	Y/N	Y/N	
	C)	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			
Capital Related Cost					_
2.00 Have assets been relifed for Medicare purposes? If yes, see					22.
8.00 Have changes occurred in the Medicare depreciation expense	due to apprais	sals made du	iring the cost		23.
Reporting period? If yes, see instructions. 1.00 Were new leases and/or amendments to existing leases entero	ed into during	this cost r	eporting period?		24.
If yes, see instructions 0.00 Have there been new capitalized leases entered into during	the cost repor	ting period	12 If yes see		25.
instructions.	the cost repor	ting period	i: i yes, see		20.
5.00 Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period?	If yes, see		26.
instructions.					
7.00 Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? I	fyes, submit		27
Interest Expense					
8.00 Were new Loans, mortgage agreements or letters of credit en	ntered into dur	ing the cos	st reporting		28
period? If yes, see instructions. 00 Did the provider have a funded depreciation account and/or	bond funds (D	bt Sorvico	Decorate Fund)		29
treated as a funded depreciation account? If yes, see insti		ebt Service	Reserve Fund)		29
0. 00 Has existing debt been replaced prior to its scheduled mate		debt? If ve	es, see		30
instructions.			-,		
1.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	es, see		31.
Purchased Servi ces					
2.00 Have changes or new agreements occurred in patient care set		ed through c	contractual		32
arrangements with suppliers of services? If yes, see instru					
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainir	ng to compet	itive bidding? If		33
no, see instructions. Provider-Based Physicians					
00 Are services furnished at the provider facility under an a	rrangement with	nrovi der-h	ased physicians?		34
If yes, see instructions.	indigenerit with				54
5.00 If line 34 is yes, were there new agreements or amended exi	isting agreemer	nts with the	e provider-based		35
physicians during the cost reporting period? If yes, see in	nstructions.		· .		
			Y/N	Date	
			1.00	2.00	_
Home Office Costs b. 00 Were home office costs claimed on the cost report?					36
7.00 If line 36 is yes, has a home office cost statement been p	renared by the	home office	2		37
If yes, see instructions.	i opar ou by tile	TONG OTTICE	··		37
8.00 If line 36 is yes, was the fiscal year end of the home of	fice different	from that c	of		38
the provider? If yes, enter in column 2 the fiscal year end					
2.00 If line 36 is yes, did the provider render services to othe			es,		39
see instructions.					
0.00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40
Cast Depart Droparar Contact Information	1.	00	2.	00	_
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position	TINA		SEVERS		41.
			JLVLNJ		41.
THELD DV THE COST FEDOLE DIEDATED IN COLUMNS 1 / 200 3	1				
held by the cost report preparer in columns 1, 2, and 3, respectively.					
respectively.	BLUE & CO., LL	С			42.
respecti vel y.	BLUE & CO., LL	с			42.
respectively. 2.00 Enter the employer/company name of the cost report preparer.	BLUE & CO., LL 317-713-7946	С	TSEVERS@BLUEAN	DCO. COM	42

Heal th	Financial Systems WITHAM MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0104	Peri od:	Worksheet S-2	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
				5/26/2017 10:	44 am
		3. 00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respectively.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet S-3 Part I	2552-10 3
					To 12/31/2016		
						I/P Days / 0/P Visits /	
						Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	60	21, 96	0.00	C	1.00
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					C	5.00
5.00	Hospital Adults & Peds. Swing Bed NF					C	6.00
7.00	Total Adults and Peds. (exclude observation		60	21, 96	0.00	C	7.00
	beds) (see instructions)						
3.00	INTENSIVE CARE UNIT	31.00	8	2, 92	0. 00	C	
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00				-	12.0
13.00 14.00	NURSERY	43.00	68	24.00	. 00		
14.00	Total (see instructions) CAH visits		08	24, 88	0.00		
16.00	SUBPROVIDER - IPF	40.00	10	3,66	<u></u>		
17.00	SUBPROVIDER - IRF	40.00	0		0	0	
8.00	SUBPROVI DER	42.00	0		0	C	
9.00	SKILLED NURSING FACILITY	44.00	18		38	C	
20.00	NURSING FACILITY			-,		-	20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				C	
7.00	Total (sum of lines 14-26)		96				27.0
8.00	Observation Bed Days					C	
9.00	Ambulance Trips						29.0
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF						30.0
32.00	Labor & delivery days (see instructions)		0		0		31.0
32.00 32.01	Total ancillary labor & delivery room		0		0		32.0
52.01	outpatient days (see instructions)						32.0
33 00	LTCH non-covered days						33.0

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CC	F	Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/26/2017 10:	pared:
			/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2, 274	171	5, 104	ŀ		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	482 0	1, 819 0				2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0 0	0 0	(4.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	2, 274	0 171	(5, 104			6.00 7.00
8.00 9.00 10.00 11.00 12.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)	847	0	1, 683	3		8.00 9.00 10.00 11.00 12.00
12.00 13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	3, 121	0 171 0	993 7, 780	0. 00	623.03	13.00
16.00 17.00 18.00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	2, 338 0	0 0 0	2, 755 (0. 00	0.00	16.00 17.00
19.00 20.00 21.00 22.00 23.00 24.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE	3, 286	O	4, 390	0. 00	17. 99	19.00 20.00 21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0	0	(24.10 25.00 26.00
26.25 27.00 28.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0 0	(1, 154	0.00		26.25
29.00 30.00 31.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	1, 715		140			29.00 30.00 31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	51	81 (32.00 32.01
33.00	LTCH non-covered days	О					33.00

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider (CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016		pared
		Full Time Equivalents		Dis	scharges		
	Component	Nonpai d Workers	Title V	Title XVII	I Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00			20 27		1.0
. 00	8 exclude Swing Bed, Observation Bed and		·	í í	20 27	2,207	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
00	HMO and other (see instructions)			1 1	59 454		2.
. 00	HMO I PF Subprovi der				0		3.
00	HMO IRF Subprovider				0		4.
00	Hospital Adults & Peds. Swing Bed SNF						5.
00	Hospital Adults & Peds. Swing Bed NF						6.
00	Total Adults and Peds. (exclude observation						7.
	beds) (see instructions)						
00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGICAL INTENSIVE CARE UNIT						11.
. 00	OTHER SPECIAL CARE (SPECIFY)						12.
. 00	NURSERY						13.
. 00	Total (see instructions)	0.00	(9	20 27	2, 289	14.
. 00	CAH visits						15.
. 00	SUBPROVIDER - IPF	0.00	(1 1	82 0	227	16.
. 00	SUBPROVIDER - IRF	0.00	(0 0	0	17
. 00	SUBPROVI DER	0.00	(0	0	18
. 00	SKILLED NURSING FACILITY	0.00					19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE						24
10	HOSPICE (non-distinct part)						24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
. 00	Total (sum of lines 14-26)	0.00					27
00	Observation Bed Days						28
. 00	Ambulance Trips						29.
. 00	Employee discount days (see instruction)						30.
. 00	Employee discount days - IRF						31
. 00	Labor & delivery days (see instructions)						32.
. 01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
. 00	LTCH non-covered days			1			33

	Financial Systems AL WAGE INDEX INFORMATION		WITHAM MEMORI	Provider C	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200.00	51, 543, 102	2, 694, 884	54, 237, 986	1, 374, 122. 00	39.47	1.00
2.00	instructions) Non-physician anesthetist Part		0	C	o	0.00	0.00	2.00
3.00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	В		0		_			
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01 5.00	Physicians - Part A - Teaching Physician and Non		0	0	0	0.00 0.00		
	Physician-Part B		0	0				
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	C	0	0.00	0.00	6.00
7.00	Interns & residents (in an	21.00	0	C	0	0.00	0.00	7.00
7. 01	approved program) Contracted interns and residents (in an approved		0	O	0	0. 00	0. 00	7.01
8.00	programs) Home office and/or related		0	0	o	0.00	0.00	8.00
9.00	organization personnel SNF	44.00	852, 873	14, 177	867, 050	37, 421. 00	23. 17	9.00
10.00	Excluded area salaries (see instructions)	44.00	20, 513, 360	1, 857, 458				10.00
11.00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 715, 267	0	1, 715, 267	21, 696. 00	79.06	11.00
12.00	Care Contract Labor: Top Level management and other		0	C	0	0.00	0.00	12.00
	management and administrative services							
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	C	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00		14.0
	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14.02 15.00
16.00	- Administrative Home office and Contract		0	0	0	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS			~			0.00	
17.00	Wage-related costs (core) (see instructions)		11, 172, 172	C	11, 172, 172			17.00
18.00	Wage-related costs (other)		0	0	0			18.00
19. 00	(see instructions) Excluded areas		6, 445, 789	0	6, 445, 789			19.00
20.00	Non-physician anesthetist Part		0	0	0			20.00
	Non-physician anesthetist Part B		0	O	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	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 approved program)		0	0	0			25.00
25. 50 25. 51	Home office wage-related Related orgainzation		0 0	C C	000			25.50 25.51
25. 52	wage-related Home office: Physician Part A - Administrative -		о	C	0			25.52
25. 53	wage-related Home office & Contract Physicians Part A - Teaching - wage-related		0	O	0			25. 53

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	631, 700	11, 555	643, 25	5 11, 144. 00	57.72	
27.00	Administrative & General	5.00	10, 367, 016	349, 720	10, 716, 73	6 183, 201. 00	58.50	27.00
28.00	Administrative & General under		665, 183	0	665, 18	3 7, 545. 00	88. 16	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00		29.00
30.00	Operation of Plant	7.00	563, 679	9, 288	572, 96	7 21, 236. 00	26. 98	30.00
31.00	Laundry & Linen Service	8.00	22, 392	578	22, 97	0 1, 995. 00	11. 51	31.00
32.00	Housekeepi ng	9.00	380, 134	8, 708	388, 84	2 29, 100. 00	13.36	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	722, 169	-306, 295	415, 87	4 21, 005. 00	19.80	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	321, 457	321, 45	7 22, 358. 00	14.38	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	526, 093	16, 762	542, 85	5 12, 554. 00	43.24	38.00
39.00	Central Services and Supply	14.00	0	0		0.00	0.00	39.00
40.00	Pharmacy	15.00	427, 478	8, 389	435, 86	7 13, 203. 00	33.01	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	1, 010, 703	21, 913	1, 032, 61	6 40, 339. 00	25.60	41.00
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		52, 208, 285	2, 694, 884	54, 903, 16	9 1, 381, 667. 00	39.74	1.00
	instructions)							
2.00	Excluded area salaries (see		21, 366, 233	1, 871, 635	23, 237, 86	8 518, 350. 00	44.83	2.00
	instructions)							
3.00	Subtotal salaries (line 1		30, 842, 052	823, 249	31, 665, 30	1 863, 317. 00	36.68	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 715, 267	0	1, 715, 26	7 21, 696. 00	79.06	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		11, 172, 172	0	11, 172, 17	2 0.00	35.28	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		43, 729, 491	823, 249	44, 552, 74	0 885, 013. 00	50.34	6.00
7.00	Total overhead cost (see		15, 316, 547	442,075	15, 758, 62	2 363, 680. 00	43.33	7.00
	instructions)					,		
	· · · · ·	1					I	

Heal th	Financial Systems V	/I THAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS			CCN: 15-0104	Period: From 01/01/2016	Worksheet S-3	pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETI REMENT COST						
1.00	401K Employer Contributions					2, 076, 818	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see in					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instr					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Or	gani zati on)					
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 F	ees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Heal th Insurance (Purchased or Self Funded)					9, 959, 226	8.00
8.01	Heal th Insurance (Self Funded without a Third					0	8.01
8.02	Health Insurance (Self Funded with a Third Par	ty Administrato	r)			0	8.02
8.03	Health Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					1, 565, 569	
10.00	Dental, Hearing and Vision Plan	ol on v)				387, 252	
11.00 12.00	Life Insurance (If employee is owner or benefi Accident Insurance (If employee is owner or be					98, 451 0	
12.00	Disability Insurance (If employee is owner or					172,657	
13.00						172,057	
14.00	Workers' Compensation Insurance	or beneficially)			314, 497	
16.00	Retirement Health Care Cost (Only current year	not the extra	ordinary a	conual roqui	rod by EASP 106	314, 497	16.00
10.00	Non cumulative portion)	, not the extra	or ur nar y a	cci uai i equi	ieu by IASB 100.	0	10.00
	TAXES						
17 00	FICA-Employers Portion Only					3, 038, 157	17.00
18.00	Medicare Taxes - Employers Portion Only					0,000,107	
19.00	Unemployment Insurance					-	19.00
	State or Federal Unemployment Taxes	0					
20100	OTHER						20100
21.00		tirement Cost R	eported on	lines 1 thr	ough 4 above. (see	0	21.00
22.00						0	22.00
22.00	Tui ti on Rei mbursement					0	22.00
	Total Wage Related cost (Sum of lines 1 -23)					17, 617, 961	
27.00	Part B - Other than Core Related Cost					17,017,901	27.00
25 00	EMPLOYEE RECOGNITION					132, 604	25 00
20.00					I		

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0104	Period: From 01/01/2016	Worksheet S-3 Part V	
				To 12/31/2016		pared: 44 am
	Cost Center Description		· .	Contract	Benefit Cost	
				Labor 1,00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	fi cati on:				
1.00	Total facility's contract labor and benefit	cost		1, 715, 267	17, 617, 961	1.00
2.00	Hospi tal			1, 715, 267	17, 617, 961	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	n Financial Systems	WITHAM MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
PROSPI	ECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provider C	CN: 15-0104 P	eriod: rom 01/01/2016	Worksheet S-7	
					o 12/31/2016		
					1.00	2.00	
1.00	If this facility contains a hospital-bas				1.00	2.00	1.00
	or was there no Medicare utilization? En complete the rest of this worksheet.	ter "Y" for yes in (column 1 and	do not			
2.00	Does this hospital have an agreement und swing beds? Enter "Y" for yes or "N" fo						2.00
	date (mm/dd/yyyy) in column 2.						
			Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
2.00			1.00	2.00	3.00	4.00	2.00
3.00 4.00			RUX RUL	0	0		3.00 4.00
5.00 6.00			RVX RVL	36			5.00 6.00
7.00			RHX	0	0	0	7.00
8.00 9.00			RHL RMX	0			8.00 9.00
10.00			RML	0	0	0	10.00
11.00 12.00			RLX RUC	223			11. 00 12. 00
13.00 14.00			RUB RUA	148			13.00 14.00
15.00			RVC	603	0	603	15.00
16.00 17.00			RVB RVA	303			16.00 17.00
18.00			RHC	224	0	224	18.00
19.00 20.00			RHB RHA	122			19.00 20.00
21.00 22.00			RMC RMB	30			21.00 22.00
23.00			RMA	27	0	27	23.00
24.00 25.00			RLB RLA		-		24.00 25.00
26.00 27.00			ES3 ES2				26.00 27.00
28.00			ES1	0	0	0	28.00
29.00 30.00			HE2 HE1				29.00 30.00
31.00			HD2	0	0	0	31.00
32.00 33.00			HD1 HC2	5			32.00 33.00
34.00 35.00			HC1 HB2	19		0 19	34.00 35.00
36.00			HB1	101	0	101	36.00
37.00 38.00			LE2 LE1	0 11	-	0	37.00 38.00
39.00			LD2	0	0	0	39.00
40. 00 41. 00			LD1 LC2			0 0	40. 00 41. 00
42.00 43.00			LC1 LB2			0	42.00 43.00
44.00			LB1	0	0	0	44.00
45.00 46.00			CE2 CE1	0			45.00 46.00
47.00 48.00			CD2 CD1	10	0		47.00 48.00
49.00			CC2	0	0	0	49.00
50.00 51.00			CC1 CB2				50.00 51.00
52.00 53.00			CB1 CA2	6			52.00 53.00
54.00			CA1	5	0	5	54.00
55.00 56.00			SE3 SE2				55.00 56.00
57.00			SE1	0	0	0	57.00
58.00 59.00			SSC SSB			0	58.00 59.00
60.00 61.00			SSA I B2				60. 00 61. 00
62.00			I B1	0	0	0	62.00
63.00 64.00			I A2 I A1				63.00 64.00
65.00			BB2	0	0	0	65.00
66.00 67.00			BB1 BA2				66.00 67.00
68.00			BA1	C			68.00

Health Financial Systems	WI THAM MEMORI AI	L HOSPI TAL		In Li	eu of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provider C	CN: 15-0104	Period: From 01/01/201	Worksheet S-	7
				To 12/31/201	6 Date/Time Pre 5/26/2017 10:	
		Group	SNF Days	Swing Bed SN Days	Total (sum of col. 2 + 3)	
	_	1.00	2.00	3.00	4.00	
69.00		PE2		0	0 0	69.00
70.00		PE1		0	0 0	70.00
71.00		PD2		0	o c	
72.00		PD1		0	0 0	
73.00		PC2		0	0 0	
74.00		PC1		0	0 0	
75.00 76.00		PB2 PB1		0		
77.00		PA2		0		
78.00		PA2 PA1		10	0 10	
199.00		AAA		0		199.00
200. 00 TOTAL			3, 2	-		200.00
	· · · · · ·			CBSA at	CBSA on/after	
				Beginning of		
				Cost	the Cost	
				Reporting	Reporting	
				Peri od	Period (if applicable)	
				1.00	2.00	
SNF SERVICES				1.00	2.00	
201.00 Enter in column 1 the SNF CBSA code or 5 cha	aracter non-CBSA	code if a ru	ral facility,	26900	26900	201.00
in effect at the beginning of the cost repor						
in effect on or after October 1 of the cost	reporting period	d (if applical	<u> </u>			
			Expenses	Percentage	Associ ated	
					with Direct Patient Care	
					and Related	
					Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register V	'olume 68, No. 14	9 August 4, 2	2003 provideo	for an increa	se in the RUG	
payments beginning 10/01/2003. Congress expe						
expenses. For lines 202 through 207: Enter i						
column 2 the percentage of total expenses fo 7, column 3. In column 3, enter "Y" for yes	or each category	to total SNF	revenue from	Worksheet G-2	Part I, line	
direct patient care and related expenses for				creases assocr	ated with	
202. 00 Staffing	each category.			0 0.0	0	202.00
203. 00 Recrui tment				0 0.0		203.00
204.00 Retention of employees				0 0.0		204.00
205. 00 Trai ni ng				0 0.0	0	205.00
206.00 OTHER (SPECI FY)				0 0.0	0	206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, li	ne 7, column 3)		2, 210, 2	15		207.00

Heal th	Financial Systems	WI THAM MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider C	CN: 15-0104	Peri od:	Worksheet S-1	0
					From 01/01/2016		
					To 12/31/2016		
						5/26/2017 10:	44 alli
						1.00	
	Uncompensated and indigent care cost comp	outation					
1.00	Cost to charge ratio (Worksheet C, Part I	line 202 column 3 c	livided by li	ine 202 colum	n 8)	0. 215116	1.00
	Medicaid (see instructions for each line)		.			•	
2.00	Net revenue from Medicaid					10, 988, 880	2.00
3.00	Did you receive DSH or supplemental payme						3.00
4.00	If line 3 is "yes", does line 2 include a	all DSH or supplement	al payments	from Medicai	d?		4.00
5.00	If line 4 is "no", then enter DSH or supp					0	5.00
6.00	Medi cai d charges					48, 448, 756	6.00
7.00	Medicaid cost (line 1 times line 6)					10, 422, 103	7.00
8.00	Difference between net revenue and costs	for Medicaid program	ı (line 7 miı	nus sum of li	nes 2 and 5; if	0	8.00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP	 e) (see instructions) 	for each lir	ne)		-	
9.00	Net revenue from stand-alone CHIP					0	
10.00	Stand-alone CHIP charges					0	
11.00	Stand-alone CHIP cost (line 1 times line					0	1
12.00	Difference between net revenue and costs	for stand-alone CHIF	'(line 11 mi	inus line 9;	if < zero then	0	12.00
	enter zero)						
	Other state or local government indigent					1	
	Net revenue from state or local indigent					0	
14.00	Charges for patients covered under state	or local indigent ca	re program	(Not included	in lines 6 or	0	14.00
45 00	10)						1
15.00	State or local indigent care program cost			(1)	45	0	
16.00	Difference between net revenue and costs	for state or local l	naigent care	e program (II	ne 15 minus line	0	16.00
	13; if < zero then enter zero)	aach line)					-
17.00	Uncompensated care (see instructions for Private grants, donations, or endowment i		funding cha	rity caro		0	17.00
18.00	Government grants, appropriations or trar					0	
19.00	Total unreimbursed cost for Medicaid, Ch				s (sum of lines		
19.00	8, 12 and 16)		ar margent		S (Suil OF THES	0	19.00
	0, 12 and 10)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col. 2)	
				1.00	2.00	3.00	
20.00	Charity care charges for the entire facil	ity (see instruction	s)	2, 278, 92			20.00
21.00	Cost of patients approved for charity car	re (line 1 times line	20)	490, 23	33 0	490, 233	21.00
22.00	Partial payment by patients approved for	charity care		1	0 0	0	22.00
23.00	Cost of charity care (line 21 minus line	22)		490, 23	33 0	490, 233	23.00
				•			
						1.00	
24.00	Does the amount in line 20 column 2 inclu			ond a length	of stay limit		24.00
	imposed on patients covered by Medicaid of						
25.00	If line 24 is "yes," charges for patient				th of stay limit		
	Total bad debt expense for the entire hos)		11, 472, 529	
27.00	Medicare bad debts for the entire hospita					149, 003	
						11, 323, 526	
29.00	Cost of non-Medicare and non-reimbursable		xpense (line	e 1 times lir	e 28)	2, 435, 872	
30.00	Cost of uncompensated care (line 23 colum					2, 926, 105	
31.00	Total unreimbursed and uncompensated care	e cost (line 19 plus	line 30)			2, 926, 105	31.00

ECLASSI	nancial Systems FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	WI THAM MEMORIAL	Provider CC	CN: 15-0104 F	Period: From 01/01/2016	u of Form CMS-: Worksheet A	
					o 12/31/2016		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	5/26/2017 10: Reclassified Trial Balance (col. 3 +- col. 4)	<u>44 am</u>
		1.00	2.00	3.00	4.00	5.00	
	NERAL SERVICE COST CENTERS 1100 NEW CAP REL COSTS-BLDG & FIXT		5, 107, 885	5, 107, 885	299, 817	5, 407, 702	1.0
	200 NEW CAP REL COSTS-BEDG & TTAT		5, 107, 885	5, 107, 885 C		3, 087, 919	
	300 OTHER CAPI TAL RELATED COSTS		0	C		0	1
	400 EMPLOYEE BENEFITS DEPARTMENT	631, 700	14, 625, 541	15, 257, 241			
	500 ADMINI STRATI VE & GENERAL	10, 367, 016	11,012,898	21, 379, 914			
	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE	563, 679 22, 392	2, 557, 618 281, 989	3, 121, 297 304, 381		3, 050, 496 304, 876	
	1900 HOUSEKEEPI NG	380, 134	203, 319	583, 453		590, 084	
0. 00 01	000 DI ETARY	722, 169	809, 258	1, 531, 427	-753, 716	777, 711	
	100 CAFETERI A	0	0	C		760, 777	
	300 NURSI NG ADMI NI STRATI ON 500 PHARMACY	526, 093 427, 478	87, 516	613, 609			
	600 MEDICAL RECORDS & LIBRARY	1,010,703	2, 459, 665 328, 353	2, 887, 143 1, 339, 056			
	PATIENT ROUTINE SERVICE COST CENTERS	1,010,100	020,000	1,007,000	10,700	1,000,021	
	000 ADULTS & PEDIATRICS	2, 818, 749	1, 121, 567	3, 940, 316		3, 700, 384	
	100 I NTENSI VE CARE UNI T 0000 SUBPROVI DER – I PF	1,003,831	528, 629	1, 532, 460		1, 411, 904	
	100 SUBPROVIDER - TPF 100 SUBPROVIDER - TRF	1, 109, 822	256, 397	1, 366, 219	1,843	1, 368, 062 0	40. C
	200 SUBPROVI DER	0	0	C	0	0	
3.00 04	300 NURSERY	0	2, 720	2, 720	0	2, 720	43.0
	400 SKILLED NURSING FACILITY	852, 873	458, 681	1, 311, 554	-85, 566	1, 225, 988	44. C
	CILLARY SERVICE COST CENTERS	1 004 595	6, 922, 716	0 0 0 0 0 1	-5, 629, 288	3, 200, 013	50.0
	400 RADI OLOGY-DI AGNOSTI C	1, 906, 585 1, 128, 913	0, 922, 710 1, 712, 971	8, 829, 301 2, 841, 884		2, 670, 672	
	500 RADI OLOGY-THERAPEUTI C	0	0	2, 041, 004		2,070,072	
	501 ULTRA SOUND	329, 163	123, 273	452, 436	-717	451, 719	55.0
	700 CT SCAN	160, 591	566, 714	727, 305		718, 433	
	800 MAGNETIC RESONANCE I MAGI NG (MRI)	274,001	892, 437	1, 166, 438		866, 856	
	900 CARDI AC CATHETERI ZATI ON 9000 LABORATORY	129, 776 2, 009, 307	540, 587 4, 011, 794	670, 363 6, 021, 101		429, 352 5, 871, 633	
	300 BLOOD STORING, PROCESSING & TRANS.	2,007,007	75, 747	75, 747		75, 747	
	400 INTRAVENOUS THERAPY	0	0	C	0	0	64.0
	600 PHYSI CAL THERAPY	1, 434, 808	250, 244	1, 685, 052		1, 701, 975	
	700 OCCUPATI ONAL THERAPY 701 AUDI OLOGY	331, 247 186, 187	35, 198 222, 636	366, 445 408, 823		373, 972 395, 788	
	800 SPEECH PATHOLOGY	108, 062	8, 331	408, 823		118, 362	
	900 ELECTROCARDI OLOGY	0	0	C		0	
	901 CARDI OLOGY	861, 498	250, 239	1, 111, 737		1, 058, 076	
	100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-12, 913	-12, 913		2, 580, 601	
	200 I MPL. DEV. CHARGED TO PATI ENT 300 DRUGS CHARGED TO PATI ENTS	0	0	C		3, 824, 332 1, 761, 685	
	TPATIENT SERVICE COST CENTERS	0	0		1,701,005	1,701,003	/ 3. (
0. 00 09	000 CLINIC	0	0	C		0	
	001 OTHER OUTPATIENT SERVICE COST CENTER	174, 215	121, 237	295, 452		287, 295	
	2002 CLINIC 2003 DERMATOLOGY CLINIC	0	0 1, 754	C 1, 754	-	0 1, 754	
	004 ENT CLINIC	0	1, 734	1, 734 C		1, 734	
0. 05 09	005 SURGERY CLINIC	0	4, 547	4, 547	-1, 332	3, 215	
	007 UROLOGY CLINIC	0	6, 306	6, 306		3, 579	
	009 GASTROENTEROLOGY CLINIC	798	8, 265	9,063		11, 458	
	011 NEUROLOGY CLINIC 012 OPTHAMOLOGY CLINIC	0	34 46, 465	34 46, 465		34 5, 379	
	013 ALLERGY CLINIC	100, 905	37, 261	138, 166		138, 306	
	014 WOUND CARE	296, 730	246, 584	543, 314		503, 790	
	100 EMERGENCY	2, 270, 139	2, 177, 639	4, 447, 778	-367, 017	4, 080, 761	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	HER REIMBURSABLE COST CENTERS	1, 487, 957	449, 220	1, 937, 177	-134, 804	1, 802, 373	95 0
	ECIAL PURPOSE COST CENTERS	1, 101, 101	1177220		101,001	1,002,070	
18.00	SUBTOTALS (SUM OF LINES 1-117)	33, 627, 521	58, 541, 322	92, 168, 843	-1, 603, 574	90, 565, 269	118. C
	NREIMBURSABLE COST CENTERS			-		2	100 0
	2000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 2000 PHYSICIANS' PRIVATE OFFICES	0 17, 616, 092	0 7, 919, 275	C 25, 535, 367			190.0
	950 THORNTOWN OFFICE BUILDING	0	7,919,275	25, 535, 367			192.0
94.0107	951 CAFE/BOUTI QUE	o	o	C	0		194.0
94. 02 07	952 BOUTI QUE SERVI CES	66, 035	101, 776	167, 811			
<i>¥</i> 4 03 07	953 RETAIL PHARMACY	233, 454	1, 535, 555	1, 769, 009 119, 641, 030		1, 769, 846 119, 641, 030	
00.00	TOTAL (SUM OF LINES 118-199)	51, 543, 102	68, 097, 928		0		

LASSI FI CAT	ION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-0104	Period: Worksheet From 01/01/2016	A
				To 12/31/2016 Date/Time	
С	ost Center Description	Adjustments	Net Expenses	5/26/2017	10:44
		(See A-8)	For		
		6.00	Allocation 7.00		
GENERAL	SERVICE COST CENTERS	0.00	7.00		
	EW CAP REL COSTS-BLDG & FIXT	-92, 020	5, 315, 682		1
	EW CAP REL COSTS-MVBLE EQUIP	0	3, 087, 919		2
	THER CAPITAL RELATED COSTS	0 E 244 224	0		3
	MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL	-5, 244, 324 -4, 315, 423	7, 629, 209 15, 741, 343		4
	PERATION OF PLANT	4, 515, 425	3, 050, 496		7
00800 L	AUNDRY & LINEN SERVICE	0	304, 876		8
	OUSEKEEPING	0	590, 084		9
00 01000 D		-286, 414	491, 297		10
	AFETERIA URSING ADMINISTRATION	0	760, 777 586, 731		11
00 01500 P		0	1,067,432		15
	EDICAL RECORDS & LIBRARY	- 181	1, 354, 843		16
	NT ROUTINE SERVICE COST CENTERS	-11			
	DULTS & PEDIATRICS	0	3, 700, 384		30
	NTENSI VE CARE UNI T UBPROVI DER – I PF	0 -34, 318	1, 411, 904 1, 333, 744		31
	UBPROVIDER – IRF	-34, 318	1, 333, 744		40
	UBPROVI DER	0	0		42
00 04300 N		0	2, 720		43
	KILLED NURSING FACILITY	-2, 600	1, 223, 388		44
	IRY SERVICE COST CENTERS	-754, 367	2 445 444		
	ADI OLOGY-DI AGNOSTI C	-754, 367 -54	2, 445, 646 2, 670, 618		50 54
	ADI OLOGY-THERAPEUTI C	0	0		55
	LTRA SOUND	0	451, 719		55
00 05700 C		0	718, 433		57
	AGNETIC RESONANCE IMAGING (MRI)	0	866, 856		58
	ARDI AC CATHETERI ZATI ON ABORATORY	0 -251, 000	429, 352 5, 620, 633		59
	LOOD STORING, PROCESSING & TRANS.	-231,000	75, 747		63
	NTRAVENOUS THERAPY	0	0		64
	HYSI CAL THERAPY	0	1, 701, 975		66
	CCUPATIONAL THERAPY	0	373, 972		67
	UDI OLOGY PEECH PATHOLOGY	-238, 055 0	157, 733 118, 362		67
	LECTROCARDI OLOGY	0	0		69
	ARDI OLOGY	0	1, 058, 076		69
	EDICAL SUPPLIES CHARGED TO PATIENTS	-107, 844	2, 472, 757		71
	MPL. DEV. CHARGED TO PATIENT	0	3, 824, 332		72
	RUGS CHARGED TO PATIENTS ENT SERVICE COST CENTERS	0	1, 761, 685		73
00 09000 C		0	0		90
	THER OUTPATIENT SERVICE COST CENTER	0	287, 295		90
02 09002 C		0	0		90
	ERMATOLOGY CLINIC	-1, 754	0		90
	NT CLINIC URGERY CLINIC	0 -3, 215	0		90 90
	ROLOGY CLINIC	-3, 215	0		90
	ASTROENTEROLOGY CLINIC	-11, 458	0		90
11 09011 N	EUROLOGY CLINIC	0	34		90
	PTHAMOLOGY CLINIC	0	5, 379		90
		0	138, 306		90
14 09014 W 00 09100 E		0 -1, 376, 750	503, 790 2, 704, 011		90 91
	BSERVATION BEDS (NON-DISTINCT PART)	1, 370, 750	2, 707, 011		92
	REIMBURSABLE COST CENTERS				
00 09500 A	MBULANCE SERVICES	-95	1, 802, 278		95
	PURPOSE COST CENTERS	40.755.157	77.044.040		
	UBTOTALS (SUM OF LINES 1-117)	-12, 723, 451	77, 841, 818		118
	IBURSABLE COST CENTERS	0	0		190
	HYSICIANS' PRIVATE OFFICES	0	27, 137, 518		190
	HORNTOWN OFFICE BUILDING	0	0		194
. 01 07951 C	AFE/BOUTI QUE	0	0		194
	OUTI QUE SERVI CES	0	168, 397		194
13107053 P	ETAIL PHARMACY	0	1, 769, 846		194

	Financial Systems		WI THAM MEMORI			In Lieu of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN	From 01	Worksheet A-6 /01/2016
					To 12	2/31/2016 Date/Time Prepared: 5/26/2017 10:44 am
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00 A - EMPLOYEE BENEFITS	3.00	4.00	5.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	302, 566		1.00
	TOTALS		o	302, 566		
	B – INSURANCE		1			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	614, 243		1.00
	FI XT	+	— — — ₀	614, 243		
	C - CAFETERIA			011,210		
1.00	CAFETERI A	11.00	321, 457	439, 320		1.00
	TOTALS		321, 457	439, 320		
1 00	D - MME DEPRECIATION	2 00	0	2 007 010		1.00
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 087, 919		1.00
2.00		0.00	О	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0 0		5.00
6.00 7.00		0.00 0.00	0	0		6.00 7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00 13.00		0.00 0.00	0	0		12.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00 20.00		0.00 0.00	0	0 0		19.00 20.00
20.00		0.00	0	0		20.00
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 27.00		0.00 0.00	0	0		26.00 27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00 33.00		0.00 0.00	0	0		32.00 33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00	TOTALS		— — — o	0000000		38.00
	E - DRUGS		UU	3,007,919		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 815, 415		1.00
	TOTALS		0	1, 815, 415		
	F - MED SUPPLY IMPLANTS		-			
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3, 824, 332		1.00
2.00		0.00	О	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	О		4.00
5.00		0.00	0	0		5.00
6.00	TOTALS		0	<u>0</u> 3, 824, 332		6.00
	G - CHARGABLE MED SUPPLIES		0	3, 024, 332		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 599, 099		1.00
	PATI ENTS					
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
4.00 5.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0.00 0.00	0	0 0		9.00 10.00
10.00	1	0.00	U	U		10.00

In Lieu of Form CMS-2552-10

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provider (CCN: 15-0104	Peri od:	Worksheet A-	6
						From 01/01/2016		
						To 12/31/2016	Date/Time Pro	
		Increases					5/26/2017 10	. 44 am
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
11.00	2.00	0.00	4.00	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	o	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00	0	0				22.00
23.00		0.00	o	0				23.00
24.00		0.00	0	0				24.00
24.00	TOTALS		— — — o	2, 599, 099				24.00
	H - BONUS		<u> </u>	2, 377, 077	I			1
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	11, 555	0				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	349, 720	0				2.00
3.00	OPERATION OF PLANT	7.00	9, 288	0				3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	578	0				4.00
5.00	HOUSEKEEPING	9.00	8, 708	0				5.00
6.00	DIFTARY	10.00	15, 162	0				6.00
7.00	NURSING ADMINISTRATION	13.00	16, 762	0				7.00
8.00	PHARMACY	15.00	8, 389	0				8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	21, 913	0				9.00
10.00	ADULTS & PEDIATRICS	30, 00	70, 691	0				10.00
11.00	I NTENSI VE CARE UNI T	31.00	20, 356	0				11.00
12.00	SUBPROVIDER - IPF	40.00	28, 771	0				12.00
13.00	SKILLED NURSING FACILITY	44.00	14, 177	0				13.00
14.00	OPERATI NG ROOM	50.00	46, 274	0				14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	36, 829	0				15.00
16.00	ULTRA SOUND	55.01	7, 395	0				16.00
17.00	CT SCAN	57.00	4,053	0				17.00
18.00	MAGNETIC RESONANCE IMAGING	58.00	6, 912	0				18.00
	(MRI)							
19.00	CARDI AC CATHETERI ZATI ON	59.00	5, 354	0				19.00
20.00	LABORATORY	60.00	51, 596	0				20.00
21.00	PHYSI CAL THERAPY	66.00	32, 855	0				21.00
22.00	OCCUPATI ONAL THERAPY	67.00	8, 181	0				22.00
23.00	AUDI OLOGY	67.01	4, 045	0				23.00
24.00	SPEECH PATHOLOGY	68.00	2, 033	0				24.00
25.00	CARDI OLOGY	69.01	18, 664	0				25.00
26.00	OTHER OUTPATIENT SERVICE	90.01	4, 044	0				26.00
	COST CENTER							
27.00	GASTROENTEROLOGY CLINIC	90.09	2, 395	0				27.00
28.00	ALLERGY CLINIC	90. 13	1, 709	0				28.00
29.00	WOUND CARE	90.14	5, 174	0				29.00
30.00	EMERGENCY	91.00	52, 614	0				30.00
31.00	AMBULANCE SERVICES	95.00	32, 550	0				31.00
32.00	PHYSICIANS' PRIVATE OFFICES	192.00	1, 792, 001	0				32.00
33.00	BOUTIQUE SERVICES	194.02	1, 495	0				33.00
34.00	RETAIL PHARMACY	1 <u>94.</u> 03	2, 641	0				34.00
	TOTALS		2, 694, 884	0				
500.00	Grand Total: Increases		3, 016, 341	12, 682, 894				500.00

	Financial Systems		WI THAM MEMORI A	AL HOSPITAL Provider CCN	: 15-0104	In Lie Period:	u of Form CMS- Worksheet A-	
					. 10 0101	From 01/01/2016 To 12/31/2016	Date/Time Pr 5/26/2017 10	epared:
	Cost Conton	Decreases	Callany	Othor		•]	372072017 10	
	Cost Center 6.00	Line #	Salary 8.00	<u>0ther</u> Wks 9.00	<u>st. A-7 Ref</u> 10.00	<u>·</u>		
	A - EMPLOYEE BENEFITS							
00	ADMI NI STRATI VE & GENERAL		0	302, 566		<u>o</u>		1.00
	TOTALS B - INSURANCE		U	302, 566				-
	ADMI NI STRATI VE & GENERAL	5.00	0	<u>614, 2</u> 43	1	2		1.00
	TOTALS		0	614, 243				-
00	C – CAFETERIA DI ETARY	10.00	321, 457	439, 320		0		1.00
	TOTALS		321, 457	439, 320				
	D - MME DEPRECIATION	4.00		214 424				
	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	314, 426		9		1.0
	EMPLOYEE BENEFITS DEPARTMENT	4.00	о	2, 945		o		2.00
	ADMI NI STRATI VE & GENERAL	5.00	0	756, 059		0		3.0
	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7.00 8.00	0	80, 089 83		0		4.0
	HOUSEKEEPI NG	9.00	0	2, 077		0		6.0
	DI ETARY	10.00	Ō	7, 924		0		7.0
-	NURSING ADMINISTRATION	13.00	0	43, 640		0		8.0
	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	1, 963 5, 945		0		9.0 10.0
	ADULTS & PEDIATRICS	30.00	0	95, 056		0		11.0
	INTENSIVE CARE UNIT	31.00	0	32, 953		0		12.0
	SUBPROVIDER - IPF	40.00	0	3, 578		0		13.0
	SKILLED NURSING FACILITY OPERATING ROOM	44.00	0	66, 414		0		15.0
	RADI OLOGY-DI AGNOSTI C	50. 00 54. 00	0	267, 178 181, 100		0		16. C
	ULTRA SOUND	55.01	Ő	2, 541		0		18.0
	CT SCAN	57.00	0	712		0		19.0
00	MAGNETIC RESONANCE IMAGING	58.00	0	302, 134		0		20.0
00	(MRI) CARDIAC CATHETERIZATION	59.00	0	151, 841		0		21.0
	LABORATORY	60.00	Ō	187, 972		0		22.0
	PHYSI CAL THERAPY	66.00	0	13, 029		0		23.0
	OCCUPATI ONAL THERAPY AUDI OLOGY	67.00 67.01	0	645 17, 074		0		24. C
	SPEECH PATHOLOGY	68.00	0	64		0		26.0
	CARDI OLOGY	69.01	0	66, 903		0		27.0
	OTHER OUTPATIENT SERVICE	90. 01	0	6, 813		0		28.0
	COST CENTER SURGERY CLINIC	90. 05	0	1, 332		0		29.0
	UROLOGY CLINIC	90.03	0	2, 538		0		30.0
00	OPTHAMOLOGY CLINIC	90.12	0	41, 086		0		31.0
	ALLERGY CLINIC	90.13	0	1, 237		0		32.0
	WOUND CARE EMERGENCY	90. 14 91. 00	0	21, 209 76, 078		0		33.0
	AMBULANCE SERVICES	95.00	0	152, 990		0		35.0
	PHYSICIANS' PRIVATE OFFICES	192.00	о	177, 578		o		36.0
	BOUTI QUE SERVI CES	194. 02 194. 03	0	909		o		37.0
00	RETALL PHARMACY		o o	<u>1, 804</u> 3, 087, 919				30.0
	E - DRUGS		- 4					1
0	PHARMACY	<u>15.</u> 00	º	1,815,415		o		1.0
	TOTALS F - MED SUPPLY IMPLANTS		0	1, 815, 415				
	OPERATING ROOM	50.00	0	3, 657, 671		0		1.0
-	RADI OLOGY-DI AGNOSTI C	54.00	Ō	21, 209		o		2.0
	CARDI AC CATHETERI ZATI ON	59.00	0	84, 988		0		3.0
-	MEDI CAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5, 585		0		4.0
	DRUGS CHARGED TO PATIENTS	73.00	о	53, 730		o		5.0
	WOUND CARE	90.14	o	1, 149		o		6.0
			0	3, 824, 332				-
	G - CHARGABLE MED SUPPLIES DIETARY	10.00	0	177		0		1.0
	PHARMACY	10.00 15.00	0	10, 722		0		2.0
	ADULTS & PEDIATRICS	30.00	Ő	215, 567		0		3.0
	INTENSIVE CARE UNIT	31.00	0	107, 959		0		4.0
	SUBPROVIDER - IPF	40.00	0	23, 350		0		5.0
	SKILLED NURSING FACILITY OPERATING ROOM	44.00 50.00	0	33, 329 1, 750, 713		0		6.0
	RADI OLOGY-DI AGNOSTI C	54.00	0	5, 732		0		8.0
0	ULTRA SOUND	55.01	0	5, 571		0		9.0
00	CT SCAN	57.00	0	12, 213		0		10.0

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	IS

WITHAM MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems		WI THAM MEMORI	AL HOSPI TAL		In Lieu of Form CMS	5-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-0104	Period: Worksheet A	-6
						From 01/01/2016	
						To 12/31/2016 Date/Time Pi	
		Decreases				5/26/2017 10	0:44 am
	Cost Costor	Decreases	Colora	Othor	What A 7 Def		
	Cost Center	Line #	Salary	Other 0	Wkst. A-7 Ref	-	
11.00		7.00	8.00	9.00	10.00		11.00
11.00	MAGNETIC RESONANCE IMAGING	58.00	0	4, 360			11.00
10.00	(MRI)	50.00		0 50/			10.00
12.00	CARDIAC CATHETERIZATION	59.00	0	9, 536			12.00
13.00	LABORATORY	60.00	0	13, 092		0	13.00
14.00	PHYSICAL THERAPY	66.00	0	2, 903			14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	9	(15.00
16.00	AUDI OLOGY	67.01	0	6	(16.00
17.00	CARDI OLOGY	69.01	0	5, 422	(17.00
18.00	OTHER OUTPATIENT SERVICE	90. 01	0	5, 388	(18.00
	COST CENTER						
19.00	UROLOGY CLINIC	90.07	0	189	(19.00
20.00	ALLERGY CLINIC	90. 13	0	332	(20.00
21.00	WOUND CARE	90. 14	0	22, 340	(21.00
22.00	EMERGENCY	91.00	0	343, 553	(22.00
23.00	AMBULANCE SERVICES	95.00	o	14, 364	(23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12, 272	(24.00
	TOTALS			2, 599, 099		-	
	H - BONUS	· · · · ·	•		L.		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 694, 884	(1.00
2.00		0.00	o	0		bl	2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0			5.00
6.00		0.00	0	0			6.00
7.00		0.00	Ö	0			7.00
8.00		0.00	Ö	0			8.00
9.00		0.00	0	0			9.00
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
12.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
14.00		0.00	0	0			
16.00			0	0			15.00
		0.00				5	16.00
17.00		0.00	0	0			17.00
18.00		0.00	0	0			18.00
19.00		0.00	0	0			19.00
20.00		0.00	0	0			20.00
21.00		0.00	0	0			21.00
22.00		0.00	0	0		0	22.00
23.00		0.00	0	0			23.00
24.00		0.00	0	0		0	24.00
25.00		0.00	0	0		D	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			28.00
29.00		0.00	0	0	(0	29.00
30.00		0.00	0	0	(30.00
31.00		0.00	0	0	(31.00
32.00		0.00	0	0	(32.00
33.00		0.00	0	0	(33.00
34.00	L	0.00	0	0		<u>ן</u>	34.00
	TOTALS		0	2, 694, 884			
500.00	Grand Total: Decreases		321, 457	15, 377, 778			500.00

Heal th	Financial Systems	WITHAM MEMORIA	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0104	Peri From To	od: n 01/01/2016 12/31/2016		pared:
				Acquisition	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES			_			
1.00	Land	15, 081, 204	187, 970		0	187, 970	34, 651	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	83, 152, 207	739, 356		0	739, 356	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	2, 240, 495	0		0	0	169, 293	5.00
6.00	Movable Equipment	47, 274, 222	5, 209, 591		0	5, 209, 591	258, 387	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	147, 748, 128	6, 136, 917		0	6, 136, 917	462, 331	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	147, 748, 128	6, 136, 917		0	6, 136, 917	462, 331	10.00
		Endi ng	Fully			-,,		
		Bal ance	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	15, 234, 523	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	83, 891, 563	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	2,071,202	0					5.00
6.00	Movable Equipment	52, 225, 426	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	153, 422, 714	0					8.00
9.00	Reconciling Items	0	0					9.00
	Total (line 8 minus line 9)	153, 422, 714	0					10.00

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet A-7 Part II	
						Date/Time Pre	pared:
					1 7 41	5/26/2017 10:	44 am
			SU	JMMARY OF CAP	TTAL		
	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			and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	5, 107, 885	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)	5, 107, 885			0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)	1			
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5, 107, 885				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5, 107, 885				3.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prep 5/26/2017 10:4	pared: 44 am
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	<u>col.2)</u> 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	83, 856, 912	0	83, 856, 912	0. 975896	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2, 071, 202	0	2, 071, 202	0. 024104	0	2.00
3.00 Total (sum of lines 1-2)	85, 928, 114		85, 928, 114			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		4, 758, 412	-56, 973	1.00
2.00 NEW CAP REL COSTS-BLOG & FIXT	0			3, 087, 919		2.00
3.00 Total (sum of lines 1-2)	0			7, 846, 331	-56, 973	3.00
		SL	IMMARY OF CAPI			0100
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see		Capital -Relat		
		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	ENTERS 0	614 242			E 21E 402	1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT		614, 243			5, 315, 682 3, 087, 919	2.00
3.00 Total (sum of lines 1-2)	0	614, 243			8, 403, 601	2.00
	0	1 011,240			0, 100, 001	0.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

	MENTS TO EXPENSES		In the weather the second second	AL HOSPITAL Provider CCN: 15-0104 P		Worksheet A-8	
ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2016 o 12/31/2016		
				Expense Classification on To/From Which the Amount is		372072017 10.	tt din
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	-	(2)	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	О	2.00
3.00	2) Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	В	-5, 106	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 419, 035		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -221, 614	DI ETARY	0. 00 10. 00	0	13.00 14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of	В	-1, 792 0	DI ETARY	10. 00 0. 00	0 0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)				0.00		
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review – physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		0	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***	19.00		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 00 30. 00
	limitation (chapter 14)						30. 99

Heal th	Fi nan	ici a	I Systems
AD JUST	MENTS	TO	EXPENSES

Health Financial Systems		WI THAM MEMORI	AL_HOSPITAL	In Lieu of Form CMS-2552			
ADJUSTMENTS TO EXPENSES				Provider CCN: 15-0104	Peri od:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	pared.
					10 12/31/2010	5/26/2017 10:	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	···· · · · · · · · · · · · · ·	(2)				Ref.	
		1.00	2.00	3.00	4.00	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		0		0.00	0	32.00
22.00	Depreciation and Interest	٨	4 250		F 00	0	22.00
33.00	HOSPI TAL ADMI NI STRAT SPONSORSHI PS/DO	A	-4,230	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	LEASE I NCOME	В	-11 500	NEW CAP REL COSTS-BLDG &	1.00	10	33.01
00.01		D		FIXT	1.00	10	00.01
33.02	RENTAL REVENUE	В		NEW CAP REL COSTS-BLDG &	1.00	10	33.02
				FIXT			
33.03	1208 N LEBANON RENTAL INCOME	В	-10, 200	NEW CAP REL COSTS-BLDG &	1.00	10	33.03
		_		FI XT			
33.04	WELLNESS REVENUE	В		EMPLOYEE BENEFITS DEPARTMEN			
33.05	MEDICAL STAFF FEES	В		ADMI NI STRATI VE & GENERAL	5.00		33.05
33.06	VOLUNTEER MISC REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.07	PATIENT ACCOUNTS	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08	MISC INCOME RECEIVED	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.08
33.09	MEALS ON WHEELS	В		DI ETARY	10.00	0	33.09
33.10	HEAD START & CASH(SHORT) OVER	В	-11, 378	DI ETARY	10.00	0	33.10
33.11	CASH(SHORT) OVER	В	118	DI ETARY	10.00	0	33.11
33.12	CICOA MEAL VOUCHERS	В	-3, 800	DI ETARY	10.00	0	33.12
33.13	MEDI CAL RECORDS	В	- 181	MEDICAL RECORDS & LIBRARY	16.00	0	33.13
33.14	RADI OLOGY	В	-54	RADI OLOGY-DI AGNOSTI C	54.00	0	33.14
	DI AGNOSTI C-PURCHASI NG DI SC						
33.15	CENTRAL SUPPLY PURCHASING	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	33.15
00.4/	DI SCOUNTS	P		PATIENTS	05.00		00.4/
33.16	AMBULANCE	В		AMBULANCE SERVICES	95.00		
33.17	DERMATOLOGY CLINIC RENT	A		DERMATOLOGY CLINIC	90.03		33.17
33.18	SURGERY CLINIC RENT	A		SURGERY CLINIC	90.05		33.18
33.19	UROLOGY CLINIC RENT	A		UROLOGY CLINIC	90.07	0	33.19
33.20	GASTROENTEROLOGY CLINIC RENT	A		GASTROENTEROLOGY CLINIC	90.09		33.20
33.21	2010 PREMIUM AMORTIZATION	В		NEW CAP REL COSTS-BLDG &	1.00	9	33. 21
22 22	2010 ROND INTERECT ON LAWERT	П		FIXT	1 00	_	22.22
33.22	2010 BOND INTEREST ON INVEST	В		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.22
33 23	2015 BOND INTEREST ON INVEST	В		NEW CAP REL COSTS-BLDG &	1.00	0	33.23
JJ. ZJ	2010 DOND FINTEREDT ON FINVEST	U		FIXT	1.00	9	00.20
33.24	VOLUNTEER REVENUE INTEREST	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.24
33.25	GAIN/(LOSS) CI HA	В		ADMI NI STRATI VE & GENERAL	5.00		
33.25	GALN/(LOSS) SHO SPC	B		ADMI NI STRATI VE & GENERAL	5.00		
33.27	GAIN/(LOSS) SHO BIG	B		ADMI NI STRATI VE & GENERAL	5.00		
33.27	LOBBYING EXPENSE-IHA DUES	A		ADMINISTRATIVE & GENERAL	5.00		
33.20	LOBBYING EXPENSE-AHA DUES	A		ADMINISTRATIVE & GENERAL	5.00		
33.29	NON-REI MBURSABLE ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5.00		
00.00	COSTS		200, 110		0.00		
33.31	SELF INSURANCE CLAIMS PAID	В	-5, 181, 598	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	33. 31
33.32	1	A		ADMI NI STRATI VE & GENERAL	5.00		
33.33	EMPLOYEE HEALTH REV CLIENT	В		ADMI NI STRATI VE & GENERAL	5.00		
33.34	1 1	В		ADMI NI STRATI VE & GENERAL	5.00		
33.35	BANK FEES	A		ADMI NI STRATI VE & GENERAL	5.00		
33.36	1 1	В		ADMI NI STRATI VE & GENERAL	5.00		
33.37	INTEREST ON INVESTMENTS	В		ADMI NI STRATI VE & GENERAL	5.00		
33.37	HEARING AID COSTS	A		AUDI OLOGY	67.01	0	
50.00	TOTAL (sum of lines 1 thru 49)	-	-12, 723, 451		07.01	0	50.00
55.00	(Transfer to Worksheet A,		12, 120, 401				
	column 6, line 200.)						
(1) D-	scription - all chapter referen	ana in thia an	lump postol p t			I	

(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 BASED PHYSICIAN ADJUSTMENT Provider COX: 15:010 Period: To Period: To Period: To Workshet A-6-2 Image: Cox: A Line # Cost Center/Physician Identifier Total Identifier Provider Component Component Provider Reauuer/Physician/P	Heal th	Financial Syste	ems	WI THAM MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
Identifier Remuneration Component Component Identifier Identifier 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 40.00 SUBPROVIDER - IPF 120.000 0 120.000 181.300 983 1.00 2.00 44.00 SKILLED NURSING FACILITY 2.600 2.600 0 0 0 3.00 4.00 91.00 EMERCENCY 1.076.750 1.076.750 0	PROVI DE	ER BASED PHYSIC			Provider (From 01/01/2016	5 Date/Time Pre	epared:
1.00 2.00 3.00 4.00 5.00 6.00 7.00 7.00 1.00 40.00 SKILLED NURSING FACILITY 2.600 2.600 120.000 181.300 983 1.00 2.00 44.00 SKILLED NURSING FACILITY 2.600 2.600 0<		Wkst. A Line #					RCE Amount	ider Component	
1.00 40.00SUBPROVIDER - IPF 120.000 0 120.000 181.300 983 1.00 2.00 44.00SKLED NURSING FACILITY 2.600 2.600 120.000 0 0 0 0.00 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0		1.00	2.00	3.00	4.00	5.00	6.00		
3:00 91.00EVERGENCY 300.000 300.000 0 <td< td=""><td>1.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>983</td><td>1.00</td></td<>	1.00							983	1.00
4.00 91.00 [MERGENCY 1.076,750 1.076,750 0	2.00	44.00	SKILLED NURSING FACILITY	2,600	2, 600	(0	0	2.00
5.00 S0.00 OPERATING RCOM 754,367 754,367 0 <	3.00	91.00	EMERGENCY	300, 000	300, 000	(0	0	3.00
6.00 6.00 LABORATORY 251,000 251,000 0	4.00	91.00	EMERGENCY	1, 076, 750	1, 076, 750	(0	0	4.00
7.00 0.00 9.00 1.20.000 9.00 9.00 1.20.000 Provider Component Insurance Provider Component Provider Share of col. Provider Component 0 0 0 0 0 0 0 0 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 1.00 44.00Ski LLED NURSING FACILLITY 85,682 4,284 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00	50.00	OPERATING ROOM	754, 367	754, 367	(0 0	0	5.00
8.00 0.00 0.00 0	6.00	60.00	LABORATORY	251,000	251,000	(0 0	0	6.00
9.00 0.00 0.00 0	7.00	0.00		0	0	(0	0	7.00
10.00 0.00 0 0 0 0 0 0 0 0 0 10.00 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE 5 Percent of Limit Cost of Cost of Limit Cost of Cost of Limit Provider Component P	8.00	0.00		0	0	(0	0	8.00
200.00 2,504,717 2,384,717 120,000 983 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Limit Cost of Limit Provider Cost of Limit O 0	9.00			0	0	(0	0	9.00
NKst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cercent of Unadjusted RCE Limit Cost of Unadjusted RCE Limit Provider Memberships & Continuing Education Provider Share of col. Physician Cost of Malpractice Insurance 1.00 40.00 SUBPROVIDER - IPF 85,682 4,284 0		0.00		0	0	(0	0	10.00
Identifier Limit Unadjusted RCE Limit Remberships & Component Education Component Share of col. 12 of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 40.00 SkILLED NURSING FACILITY 85,662 4,284 0 0 0 0 2.00 3.00 91.00 EMERGENCY 0	200.00								200.00
Image:		Wkst. A Line #							
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1.00 40.00 SUBPROVI DER - 1 PF 85,682 4,284 0 0 0 1.00 2.00 44.00/SKI LLED NURSI NG FACI LI TY 0		1.00	0.00	0.00				11.00	
2.00 44.00 SKI LLED NURSI NG FACI LI TY 0	1 00								1.00
3.00 91.00 EMERGENCY 0 0 0 0 0 0 0 3.00 4.00 91.00 EMERGENCY 0									
4.00 91.00 EMERGENCY 0				Ŭ					
5.00 50.00 OPERATING ROOM 0				0	-			-	
6.00 60.00 LABORATORY 0				0	0				
7.00 0.00 0 0 0 0 0 0 7.00 8.00 0.00 0				0	0			-	
8.00 0.00 0.00 0			LABURATURY	0	0			-	
9.00 0.00 0.00 0.00 <				0	0			-	
10.00 0.00 0 0 0 0 0 0 10.00 200.00 85,682 4,284 0 0 0 200.00 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adjusted RCE Limit RCE Disallowance Adjustment Adjustment 1.00 2.00 15.00 16.00 17.00 18.00 1.00 2.00 44.00 SkilLED NURSING FACILITY 0 0 2.00 2.00 1.00 40.00 SUBPROVIDER - IPF 0 85,682 34,318 34,318 1.00 2.00 44.00 SkilLED NURSING FACILITY 0 0 0 2.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 6.00 7.00 8.00 9.00 0 0 0 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.00				0	0			°,	
200.00 85,682 4,284 0 0 200.00 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adjusted RCE Limit RCE Disallowance Adjustment Adjustment Image: Component Disallowance Adjustment Image: Component Disallowance Adjustment Image: Component Disallowance Image:				0	0			-	
Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. 14 Adjusted RCE Limit RCE Disal Iowance Adjustment 1.00 2.00 16.00 17.00 18.00 1.00 40.00 SUBPROVI DER - IPF 0 85,682 34,318 34,318 1.00 2.00 44.00 SKI LLED NURSI NG FACI LI TY 0 0 0 2.00 300,000 3.00 3.00 91.00 EMERGENCY 0 0 0 0 2.00 4.00 SKI LLED NURSI NG FACI LI TY 0 0 0 2.00 3.00 91.00 EMERGENCY 0 0 0 2.00 3.00 1,076,750 4.00 5.00 50.00 OPERATI NG ROOM 0 0 0 0 0 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 7.00 8.00 7.00 0 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00		0.00		85 682	1 284		-	-	
Identifier Component Share of col. 14 Limit Disal Iowance Image: Component Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 40.00 SUBPROVI DER - IPF 0 85,682 34,318 34,318 1.00 2.00 44.00 SKI LLED NURSI NG FACI LI TY 0 0 0 2.00 300,000 3.00 3.00 91.00 EMERGENCY 0 0 0 1,076,750 4.00 5.00 50.00 OPERATI NG ROOM 0 0 0 0 251,000 6.00 6.00 60.00 0 0 0 0 7.00 8.00 7.00 0.00 0 0 0 0 9.00 7.00 6.00 8.00 0.00 0 0 0 0 9.00 9.00 9.00 9.00 0.00 0 0 0 0 0 9.00 9.00 9.00 10.00		Wkst Aline #	Cost Center/Physician				- -	0	200.00
Image: Note of col. Share of col. Image: Name of col.							/ aj as tillorre		
Image: Note of the image in the image. Image in the image inthe image in the image in the image in the image in the									
1.00 40.00 SUBPROVI DER - IPF 0 85,682 34,318 34,318 1.00 2.00 44.00 SKI LLED NURSI NG FACI LI TY 0 0 0 2,600 2.00 3.00 91.00 EMERGENCY 0 0 0 0 300,000 3.00 4.00 91.00 EMERGENCY 0 0 0 0 1,076,750 4.00 5.00 50.00 OPERATI NG ROOM 0 0 0 754,367 5.00 6.00 60.00 LABORATORY 0 0 0 0 7.00 6.00 7.00 8.00 9.00 0 9.00 9.00 9.00 9.00 10.00 9.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
2.00 44.00 SKI LLED NURSI NG FACI LI TY 0 0 0 2,600 2.00 3.00 91.00 EMERGENCY 0 0 0 300,000 3.00 4.00 91.00 EMERGENCY 0 0 0 1,076,750 4.00 5.00 50.00 OPERATI NG ROOM 0 0 0 754,367 5.00 6.00 60.00 LABORATORY 0 0 0 251,000 6.00 7.00 0.00 0 0 0 0 7.00 8.00 9.00 0.00 0 0 0 9.00 9.00 9.00 10.00 0.00 0 0 0 0 9.00 10.00		1.00	2.00	15.00	16.00	17.00	18.00		
3.00 91.00 EMERGENCY 0 0 300,000 3.00 4.00 91.00 EMERGENCY 0 0 0 1,076,750 4.00 5.00 50.00 OPERATING ROOM 0 0 0 754,367 5.00 6.00 60.00 LABORATORY 0 0 0 251,000 6.00 7.00 0.00 0 0 0 0 7.00 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 9.00 10.00 0.00 0 0 0 0 9.00 10.00	1.00	40.00	SUBPROVI DER – I PF	0	85, 682	34, 318	34, 318		1.00
4.00 91.00 EMERGENCY 0 0 1,076,750 4.00 5.00 50.00 OPERATING ROOM 0 0 754,367 5.00 6.00 60.00 LABORATORY 0 0 0 251,000 6.00 7.00 0.00 0 0 0 7.00 7.00 8.00 0.00 0 0 0 9.00 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 0.00 0 0 0 10.00	2.00	44.00	SKILLED NURSING FACILITY	0	0	(2,600		2.00
5.00 50.00 OPERATING ROOM 0 0 754,367 5.00 6.00 60.00 LABORATORY 0 0 0 251,000 6.00 7.00 0.00 0 0 0 0 7.00 3.00 7.00 8.00 0 0 9.00 9.00 9.00 9.00 0 9.00 9.00 10.00 </td <td>3.00</td> <td>91.00</td> <td>EMERGENCY</td> <td>0</td> <td>0</td> <td>(</td> <td>300, 000</td> <td></td> <td>3.00</td>	3.00	91.00	EMERGENCY	0	0	(300, 000		3.00
6.00 60.00 LABORATORY 0 0 251,000 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 0.00 0 0 0 0 10.00	4.00			0	0	(4.00
7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00				0	0	(
8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 9.00 9.00 10.00			LABORATORY	0	-				
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10.00 0.00 0 0 0 10.00				0	0	-	, s		
				0	0	(0		
200. 00 0 85, 682 34, 318 2, 419, 035 200. 00		0.00		0	0	(0		
	200.00			0	85, 682	34, 318	8 2, 419, 035		200.00

Heal th	Financial Systems	WITHAM MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
			CAPITAL RELATED COSTS			5/26/2017 10:	44 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col. 7) 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS		5 015 (00				1
1.00 2.00 4.00 5.00 7.00 8.00 9.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	5, 315, 682 3, 087, 919 7, 629, 209 15, 741, 343 3, 050, 496 304, 876 590, 084	5, 315, 682 12, 089 386, 358 506, 170 0 58, 286	3, 087, 919 7, 023 224, 438 294, 038 0 33, 859	7, 648, 321 1, 529, 353 81, 766 3, 278	17, 881, 492 3, 932, 470 308, 154 737, 719	1.00 2.00 4.00 5.00 7.00 8.00 9.00
10. 00 11. 00 13. 00 15. 00 16. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	491, 297 760, 777 586, 731 1, 067, 432 1, 354, 843	130, 468 0 0 40, 277 63, 624	75, 790 0 23, 397 36, 960	59, 348 45, 874 77, 469 62, 201	756, 903 806, 651 664, 200 1, 193, 307 1, 602, 789	10.00 11.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 700, 384	423, 187	245, 832	412, 343	4, 781, 746	30.00
30.00 31.00 40.00 41.00 42.00 43.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	1, 411, 904 1, 333, 744 0 0 2, 720	116, 219 133, 065 0 0	67, 512 67, 298 77, 298 0	146, 159 162, 485	1, 741, 794 1, 706, 592 0 0 2, 720	31.00 40.00 41.00 42.00
44.00	04400 SKILLED NURSING FACILITY	1, 223, 388	100, 765	58, 535	123, 734	1, 506, 422	44.00
50.00 54.00 55.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 445, 646 2, 670, 618 0	337, 752 413, 071 0	196, 202 239, 956 0	166, 360	3, 258, 287 3, 490, 005 0	50.00 54.00 55.00
55.01 57.00 58.00 59.00 60.00	05501 ULTRA SOUND 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	451, 719 718, 433 866, 856 429, 352 5, 620, 633	0 0 35, 437 29, 870 192, 639	0 0 20, 586 17, 352 111, 905	40, 088 19, 284	499, 748 741, 929 962, 967 495, 858 6, 219, 282	55. 01 57. 00 58. 00
63.00 64.00 66.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	75, 747 0 1, 701, 975	0 0 186, 449	0 0 108, 310	0 0	75, 747 2, 206, 180	63.00 64.00
67.00 67.01 68.00	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	373, 972 157, 733 118, 362	0 0 0		48, 439 27, 147 15, 711	422, 411 184, 880 134, 073	67.00 67.01 68.00
69.00 69.01 71.00 72.00	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	0 1, 058, 076 2, 472, 757 3, 824, 332	0 19, 214 0 0	0 11, 162 0 0	125, 605 0	0 1, 214, 057 2, 472, 757 3, 824, 332	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 761, 685	0	C		1, 761, 685	
90. 00 90. 01 90. 02	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	0 287, 295 0	0 79, 390 0	C 46, 118 C	25, 439	0 438, 242 0	90. 00 90. 01 90. 02
90. 03 90. 04 90. 05 90. 07 90. 09 90. 11	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC 09005 SURGERY CLINIC 09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	0 0 0 0 0 34	0 0 0 0 0	0 0 0 0 0	0 0 0 456 0	0 0 0 456 34	90. 03 90. 04 90. 05 90. 07 90. 09 90. 11
90. 11 90. 12 90. 13 90. 14 91. 00 92. 00	09012 OPTHAMOLOGY CLINIC	5, 379 5, 379 138, 306 503, 790 2, 704, 011	0 0 72, 785 510, 283	0 0 42, 281 296, 427	0 14, 644 43, 084	5, 379 5, 379 152, 950 661, 940 3, 842, 194 0	90. 12 90. 13 90. 14 91. 00
95.00	OTHER REIMBURSABLE COST CENTERS	1, 802, 278	98, 874	57, 437	216, 987		
118.00	SUBTOTALS (SUM OF LINES 1-117)	77, 841, 818	3, 946, 272	2, 292, 418	4, 835, 342	72, 863, 928	118.00
192.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 THORNTOWN OFFICE BUILDING	0 27, 137, 518 0	12, 962 891, 987 0	7, 530 518, 162 0	2, 769, 650	20, 492 31, 317, 317	190.00
194.02	07951 CAFE/BOUTIQUE 207952 BOUTIQUE SERVICES 307953 RETAIL PHARMACY Cross Foot Adjustments	0 168, 397 1, 769, 846	29, 413 426, 739 8, 309	17, 086 247, 896 4, 827	9, 637	46, 499 852, 669 1, 816, 674 0	194.01 194.02 194.03 200.00
201.00	Negative Cost Centers		0	C	0	0	201.00

Health Financ	cial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-0104		Period: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Pre 5/26/2017 10:		pared: 44 am
			CAPI TAL REL	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	
202.00	TOTAL (sum lines 118-201)	106, 917, 579	5, 315, 682	3, 087, 919	7, 648, 321	106, 917, 579	202.00

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2016	Worksheet B Part I	
					o 12/31/2016		pared:
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	44 am
	cost center bescription	E & GENERAL	PLANT	LINEN SERVICE	HOUSEREELTING	DILIAN	
		5.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	17, 881, 492					5.00
7.00	00700 OPERATION OF PLANT	789, 774	4, 722, 244				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	61,888					8.00
9.00 10.00	01000 DI ETARY	148, 159 152, 012	72, 087 161, 362		957, 965 59, 397	1, 129, 674	9.00
11.00	01100 CAFETERI A	162,003	0		19, 804	0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	133, 394	0	-	8, 955	0	
15.00	01500 PHARMACY	239, 657	49, 814		18, 082	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	321, 895	78, 690	0	39, 607	0	16.00
30.00	03000 ADULTS & PEDIATRICS	960, 337	523, 392	19, 088	300, 885	421, 428	30.00
31.00	03100 INTENSIVE CARE UNIT	349, 811	143, 738		79, 903	136, 763	
40.00	04000 SUBPROVI DER – I PF	342, 742	164, 573		95, 016	220, 360	
41.00	04100 SUBPROVIDER - IRF	0	0	-	0	0	
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 546	0	-	0	0	42.00
44.00	04400 SKILLED NURSING FACILITY	302, 541	124, 625	.,,,	0	351, 123	•
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	654, 375	417, 727			0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	700, 912	510, 881 0		80, 248 0	0	54.00 55.00
55.00	05501 ULTRA SOUND	100, 366	0		-	0	55.00
57.00	05700 CT SCAN	149,005	0		7, 921	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	193, 397	43, 828	18, 282	7, 577	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	99, 585	36, 943		0	0	59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	1, 249, 043 15, 213	238, 254 0		33, 924 0	0	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	15, 213	0		0	0	64.00
66.00	06600 PHYSI CAL THERAPY	443, 076	230, 598		12, 227	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	84, 834	0		5, 855	0	67.00
67.01		37, 130	0		4, 305	0	67.01
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	26, 926	0		2, 583	0	68.00 69.00
69.01	06901 CARDI OLOGY	243, 824	23, 764	-	26, 003	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	496, 614	0	7, 772	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	768, 056	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	353, 806	0	17, 190	18, 770	0	73.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	88, 014	98, 189		46, 151	0	
	09002 CLI NI C	0	0		67, 849	0	
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	
90.04 90.05	09004 ENT CLINIC 09005 SURGERY CLINIC	0	0	0	0	0	
90.07	09007 UROLOGY CLINIC	0	0	177	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	92	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	7	0	108	0	0	90.11
90. 12 90. 13	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	1, 080 30, 718	0	0 814	0	0	90.12 90.13
90. 13 90. 14	09014 WOUND CARE	132, 940	90, 019		0	0	90.13
91.00	09100 EMERGENCY	771, 643			0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	404 000	15 045	7.05/			
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	436, 930	45, 215	7, 856	0	0	95.00
118.00		11, 042, 345	3, 684, 811	370, 042	957, 965	1, 129, 674	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4, 115			0		190.00
	19200 PHYSI CLANS' PRIVATE OFFICES	6, 289, 598	974, 748	0	0		192.00
	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	0 9, 339	0 36, 378		0		194.00 194.01
194.02	07952 BOUTI QUE SERVI CES	171, 245	0	0	0		194.01
194.03	07953 RETAIL PHARMACY	364, 850	10, 276	0	0	0	194.03
200.00		_	-	-	_		200.00
201.00 202.00		0 17, 881, 492	0 4, 722, 244	0 370, 042	0 957, 965		201.00
202.00		1 17,001,472	7, 122, 244	1 570,042	757,705	1, 127, 074	1-02.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	WI THAM MEMORI	AL HOSPITAL Provider CC	Fr	eriod: com 01/01/2016	of Form CMS-: Worksheet B Part I	
				Тс	0 12/31/2016	Date/Time Pre 5/26/2017 10:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	
	·	11.00	13.00	15.00	16.00	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.00 7.00	00200 NEW CAP REL COSTS-BUDG & TTAT 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT						2.00 4.00 5.00 7.00
8.00 9.00 10.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY						8.00 9.00 10.00
11.00	01100 CAFETERI A	988, 458					11.00
	01300 NURSI NG ADMI NI STRATI ON	19, 125		1 520 110			13.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	38, 250 77, 506		1, 539, 110 0	2, 120, 487		15.00 16.00
	INPATIENT ROUTINE SERVICE COST CENTERS		-				
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	260, 703		798 188	521,093	7,964,220	30.00 31.00
	04000 SUBPROVI DER – I PF	21, 138 33, 217	80, 083	23	108, 346 128, 983	2, 637, 728 2, 775, 355	1
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
	04200 SUBPROVI DER	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0 66, 119	7, 761 9, 640	0	12, 941 2, 363, 237	43.00 44.00
11.00	ANCILLARY SERVICE COST CENTERS			7,010		2,000,201	11.00
50.00	05000 OPERATING ROOM	23, 151	125, 045	15, 265	187, 026	4, 751, 855	50.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	28, 184	0	3, 888 0	500, 456 0	5, 338, 138 0	54.00 55.00
	05501 ULTRA SOUND	3, 020	J J	1, 404	54, 173	674, 096	
57.00	05700 CT SCAN	4, 026		351	61, 912	1, 010, 734	1
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	10, 066	0 7, 958	0	33, 536 0	1, 269, 653 644, 511	58.00 59.00
60.00	06000 LABORATORY	82, 539		71	51, 593	7, 937, 433	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	91, 957	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	3, 297	64.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	41, 270 17, 112		3, 228 0	100, 607 43, 854	3, 109, 444 607, 120	1
67.01	06701 AUDI OLOGY	18, 118		0	0	245, 740	
68.00	06800 SPEECH PATHOLOGY	19, 125		0	0	188, 598	1
	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	0 41, 270	-	0 200	0 96, 738	0 1, 716, 042	69.00 69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 138		0	0	2, 998, 281	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0		0	0	4, 603, 060	1
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	2, 151, 451	73.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER	34, 224	9, 954	69	216, 692	931, 535	
	09002 CLI NI C 09003 DERMATOLOGY CLI NI C	0	0	0	0	67, 849 0	
	09004 ENT CLINIC	0	0	0	0	0	
	09005 SURGERY CLINIC	0	0	10	0	10	90.05
	09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC	0	0 8, 292	2, 099	0	2, 276 8, 840	
	09011 NEUROLOGY CLINIC	0	0, 272	23	0	172	1
	09012 OPTHAMOLOGY CLINIC	0	0	0	0	6, 459	1
	09013 ALLERGY CLINIC 09014 WOUND CARE	0	5, 680 15, 720	1, 110	0	191, 272	90.13 90.14
	09100 EMERGENCY	64, 421		4, 360 81, 827	o	908, 801 5, 550, 296	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				_		92.00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	130, 855		14, 962	0	2, 811, 394	95.00
95.00	SPECIAL PURPOSE COST CENTERS	130, 855	0	14, 902	0	2,011,394	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	988, 458	819, 432	147, 277	2, 105, 009	63, 573, 795	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	40,638	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		1, 277, 375	15, 478	39, 876, 744	1
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
	07951 CAFE/BOUTI QUE	0	0	0	0	92, 216	
	07952 BOUTI QUE SERVI CES 07953 RETAI L PHARMACY		4, 014	0 114, 458	0	1, 027, 928 2, 306, 258	
200.00				111, 100	0		200.00
201.00	Ũ	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	988, 458	825, 674	1, 539, 110	2, 120, 487	106, 917, 579	1202. UU

		WI THAM MEMORIAL		In Lieu of Form (
COSTA	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-010	04 Period: Worksheet From 01/01/2016 Part I	В
				To 12/31/2016 Date/Time 5/26/2017	Prepared: 10.44 am
	Cost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
	GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT				5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE				7.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON				11.00
	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	7,964,220		30.00
31.00 40.00	04000 SUBPROVI DER – I PF	0	2, 637, 728 2, 775, 355		31.00 40.00
	04100 SUBPROVI DER – I RF	0	0		41.00
42.00	04200 SUBPROVI DER	0	0		42.00
	04300 NURSERY	0	12, 941		43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	2, 363, 237		44.00
50.00	05000 OPERATING ROOM	0	4, 751, 855		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 338, 138		54.00
55.00		0	0		55.00
55.01 57.00	05501 ULTRA SOUND 05700 CT SCAN	0	674,096		55.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 010, 734 1, 269, 653		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	644, 511		59.00
60.00	06000 LABORATORY	0	7, 937, 433		60.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	91, 957 3, 297		63.00
66.00	06600 PHYSI CAL THERAPY	0	3, 109, 444		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	607, 120		67.00
67.01	06701 AUDI OLOGY	0	245, 740		67.01
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	188, 598 0		68.00 69.00
		0	1, 716, 042		69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 998, 281		71.00
72.00		0	4, 603, 060		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 151, 451		73.00
90.00	OUTPATI ENT SERVI CE COST CENTERS	0	0		90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	931, 535		90.01
	09002 CLI NI C	0	67, 849		90.02
		0	0		90.03
90.04 90.05	09004 ENT CLINIC 09005 SURGERY CLINIC	0	10		90.04
90.07	09007 UROLOGY CLINIC	0	2, 276		90.07
	09009 GASTROENTEROLOGY CLINIC	0	8, 840		90.09
90.11	09011 NEUROLOGY CLINIC	0	172		90.11
	09012 OPTHAMOLOGY CLINIC 09013 ALLERGY CLINIC	0	6, 459 191, 272		90.12
	09014 WOUND CARE	0	908, 801		90.13
91.00	09100 EMERGENCY	0	5, 550, 296		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	2, 811, 394		95.00
<i>,</i> ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	SPECIAL PURPOSE COST CENTERS	- U	2,011,374		
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	63, 573, 795		118.00
100.07	NONREI MBURSABLE COST CENTERS		40 (00		100.0
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	40, 638 39, 876, 744		190.00 192.00
	07950 THORNTOWN OFFICE BUILDING	0	0		192.00
	07951 CAFE/BOUTI QUE	0	92, 216		194.01
194.02	07952 BOUTI QUE SERVI CES	0	1, 027, 928		194.02
	07953 RETAIL PHARMACY	0	2, 306, 258		194.03
200.00		0	0		200.00 201.00
201.00		U U	U		

	Financial Systems	WITHAM MEMORIA			In Lieu	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		Date/Time Pre 5/26/2017 10:	44 am
	Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
2.00 4.00 5.00 7.00 8.00 9.00	00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING		12, 089 386, 358 506, 170 0 58, 286	7, 023 224, 438 294, 038 0 33, 859 75, 700	610, 796 800, 208 0 92, 145	19, 112 3, 826 205 8 139	2.00 4.00 5.00 7.00 8.00 9.00
10.00 11.00 13.00 15.00 16.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		130, 468 0 0 40, 277 63, 624	75, 790 0 23, 397 36, 960	0 0 63, 674	148 115 194 156 369	10.00 11.00 13.00 15.00 16.00
31.00 40.00 41.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER		423, 187 116, 219 133, 065 0 0	245, 832 67, 512 77, 298 0 0	183, 731	1, 032 366 406 0 0	40.00 41.00 42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0 100, 765	0 58, 535	0 159, 300	0 310	43.00 44.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	0	337, 752 413, 071	196, 202 239, 956	533, 954	697 416	50.00 54.00
55.00 55.01 57.00 58.00 59.00 60.00	05500 RADIOLOGY-THERAPEUTIC 05501 ULTRA SOUND 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY		0 0 35, 437 29, 870 192, 639	0 0 20, 586 17, 352 111, 905	47, 222	0 120 59 100 48 736	55.00 55.01 57.00 58.00 59.00 60.00
63.00 64.00 66.00 67.00 67.01 68.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06701 AUDIOLOGY 06800 SPEECH PATHOLOGY		0 0 186, 449 0 0	0 0 108, 310 0 0	0 0 294, 759 0 0	0 0 524 121 68 39	63.00 64.00 66.00 67.00 67.01 68.00
69.00 69.01 71.00 72.00	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS		0 19, 214 0 0 0	0 0 11, 162 0 0 0	0 30, 376 0 0 0	0 314 0 0	69.00 69.01 71.00
90.00	OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	90.00
90. 01 90. 02 90. 03 90. 04	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC 09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	000000000000000000000000000000000000000	79, 390 0 0	46, 118 0 0	125, 508 0 0	64 0 0	90. 01 90. 02 90. 03 90. 04
90. 05 90. 07 90. 09 90. 11	09005 SURGERY CLINIC 09007 UROLOGY CLINIC 09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC		0 0 0 0 0	0 0 0 0 0 0	0 0 0 0	0 0 1 0 0	90.05 90.07 90.09 90.11 90.12
90. 13 90. 14 91. 00 92. 00	09013 ALLERGY CLINIC 09014 WOUND CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0	0 72, 785 510, 283	0 42, 281 296, 427		37 108 829	90. 13 90. 14 91. 00 92. 00
95.00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		98, 874	57, 437	-	543	
	SPECIAL PURPOSE COST CENTERS						
	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		3, 946, 272 12, 962 891, 987	2, 292, 418 7, 530 518, 162	20, 492		190.00 192.00
194.00 194.01 194.02	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTI QUE 07952 BOUTI QUE SERVICES 07953 RETAIL PHARMACY		0 29, 413 426, 739 8, 309	0 17, 086 247, 896 4, 827	0 46, 499 674, 635	0 0 24	192.00 194.00 194.01 194.02 194.03
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers	0	0 5, 315, 682	0 3, 087, 919	0		200. 00 201. 00

Heal th	Financial Systems	WITHAM MEMORI	AL HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2016	Worksheet B Part II	
				T		Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	5/26/2017 10: DI ETARY	44 811
		E & GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00		10100	
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	614, 622					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	27, 146 2, 127	827, 559 0				7.00 8.00
9.00	00900 HOUSEKEEPI NG	5, 092	12, 633		110, 009		9.00
		5, 225	28, 278		6, 821	246, 730	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	5, 568 4, 585	0		2, 274 1, 028	0	11.00
15.00	01500 PHARMACY	8, 237	8, 730	0	2, 076	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	11, 064	13, 790	0	4, 548	0	16.00
30.00	03000 ADULTS & PEDIATRICS	33, 008	91, 723	107	34, 553	92, 044	30.00
	03100 I NTENSI VE CARE UNI T	12, 024	25, 190		9, 176	29, 870	31.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	11, 781 0	28, 841 0		10, 911 0	48, 128 0	40.00
	04200 SUBPROVI DER	0	0		0	0	42.00
		19	0	11	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	10, 399	21, 840	15	0	76, 688	44.00
	05000 OPERATING ROOM	22, 492	73, 205		2,037	0	50.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	24, 092	89, 530 0		9, 215 0	0	54.00 55.00
55.00	05501 ULTRA SOUND	3, 450	0		593	0	55.00
	05700 CT SCAN	5, 122	0		910	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	6, 647 3, 423	7, 681 6, 474		870 0	0	58.00 59.00
	06000 LABORATORY	42, 932	41, 753		3, 896	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	523	0		0	0	63.00
64.00 66.00	06400 I NTRAVENOUS THERAPY 06600 PHYSI CAL THERAPY	0 15, 229	0 40, 412		0 1, 404	0	64.00 66.00
	06700 OCCUPATI ONAL THERAPY	2, 916	0		672	0	67.00
67.01 68.00	06701 AUDI OLOGY 06800 SPEECH PATHOLOGY	1, 276 926	0		494 297	0	67.01 68.00
	06900 ELECTROCARDI OLOGY	928	0	-	297	0	69.00
	06901 CARDI OLOGY	8, 381	4, 165		2, 986	0	69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	17, 069 26, 399	0		0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	12, 161	0		2, 156	0	73.00
~~~~~	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 OTHER OUTPATIENT SERVICE COST CENTER	0 3, 025	0 17, 207	0	0 5, 300	0	90.00 90.01
90.02	09002 CLI NI C	0	0	0	7, 792	0	90.02
	09003 DERMATOLOGY CLINIC 09004 ENT CLINIC	0	0	0	0	0	90.03 90.04
	09005 SURGERY CLINIC	0	0	0	0	0	90.04
	09007 UROLOGY CLINIC	0	0	1	0	0	90.07
90. 09 90. 11	09009 GASTROENTEROLOGY CLINIC 09011 NEUROLOGY CLINIC	3	0	0	0	0	90.09 90.11
	09012 OPTHAMOLOGY CLINIC	37	0	0	0	0	90.12
	09013 ALLERGY CLINIC	1, 056	0	5	0	0	90.13
	09014 WOUND CARE 09100 EMERGENCY	4, 569 26, 523	15, 776 110, 601		0	0	90.14 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	20, 323	110,001	213	0	0	92.00
05 00		15, 018	7.024		0	0	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	15,018	7, 924	44	0	0	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	379, 544	645, 753	2, 135	110, 009	246, 730	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	141	2, 809	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	216, 189	170, 821		0	0	192.00
	07950 THORNTOWN OFFICE BUILDING 07951 CAFE/BOUTIQUE	0	0 4 375	0	0		194.00 194.01
	07951 CAFEZ BOUTT QUE 07952 BOUTT QUE SERVI CES	321 5, 886	6, 375 0	0	0		194.01 194.02
194.03	07953 RETAIL PHARMACY	12, 541	1, 801	0	0		194.03
200.00 201.00			Ω		0	0	200. 00 201. 00
201.00		614, 622	827, 559	2, 135	110, 009	246, 730	

Heal th	Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0104	Period: From 01/01/2016	Worksheet B Part II	
					To 12/31/2016	Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG	PHARMACY	MEDI CAL	5/26/2017 10: Subtotal	44 am
			ADMI NI STRATI O		RECORDS &		
		11.00	N 13.00	15.00	LI BRARY 16.00	24.00	
	GENERAL SERVICE COST CENTERS	1	1		-		
1.00 2.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A	7, 957	,				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	154	5, 961				13.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	308 624	1	83, 18	1 0 130, 979		15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		· · · · ·				10.00
30.00	03000 ADULTS & PEDIATRICS	2, 101		4		957, 083	30.00
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	170	1	1	0 6, 692 1 7, 967	267, 626 319, 264	31.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0		41	0 0 9 0	0 449	42.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	0		52		269, 550	
50.00	ANCI LLARY SERVICE COST CENTERS	40/	000			( 4 ( - 4 4 0	50.00
50.00 54.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	186 227		82 21		646, 149 807, 761	50.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
55.01 57.00	05501 ULTRA SOUND 05700 CT SCAN	24		7		7, 666 10, 221	55.01 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	81			0 2,071	73, 575	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	57, 247	59.00
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	664			4 3, 187 0 0	398, 132 529	60.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	18	64.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	332	1	17	4 6, 214 0 2, 709	359, 554 6, 789	66.00 67.00
67.00	06701 AUDI OLOGY	136			0 2,709	1, 991	67.01
68.00	06800 SPEECH PATHOLOGY	154			0 0	1, 457	68.00
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI OLOGY	332		1	0 0 1 5,975	0 53, 024	69.00 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	170	0		0 0	17, 282	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0			0 0 0 0	26, 459 14, 413	1
73.00	OUTPATIENT SERVICE COST CENTERS				0 0	14, 413	73.00
		0	-		0 0	0	
90. 01 90. 02	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	275			4 13, 385 0 0	164, 840 7, 792	90.01 90.02
90.03	09003 DERMATOLOGY CLINIC	0	0		0 0	0	90.03
90. 04 90. 05	09004 ENT CLINIC 09005 SURGERY CLINIC	0	-		0 0 1 0	0	90.04 90.05
90.03 90.07	09007 UROLOGY CLINIC	0	0	11	-	114	90.03
90.09	09009 GASTROENTEROLOGY CLINIC	0			0 0	64	90.09
90. 11 90. 12	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC		0		0 0	2 37	90. 11 90. 12
90.13	09013 ALLERGY CLINIC	0	41	6	0 0	1, 199	90.13
90. 14 91. 00	09014 WOUND CARE 09100 EMERGENCY	0 519		23 4, 42		135, 889 950, 690	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	517	075	4,42	2 0	750, 070	92.00
05 00	OTHER REIMBURSABLE COST CENTERS	1.052		00		101 700	
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 053	0	80	9 0	181, 702	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7, 957	5, 916	7, 95	9 130, 023	5, 738, 569	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	23 442	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1	69, 03		1, 874, 073	
	07950 THORNTOWN OFFICE BUILDING	0	-		0 0		194.00
	07951 CAFE/BOUTI QUE 207952 BOUTI QUE SERVI CES		0 29		0 0	53, 195 680, 574	194.01 194.02
194.03	07953 RETAIL PHARMACY	0	0	6, 18		33, 748	194.03
200.00 201.00		0			0 0		200. 00 201. 00
201.00		7, 957		83, 18	0		

Health Financial Systems	WI THAM MEMORI A			rm CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0104   Period:   Worksh From 01/01/2016   Part I To 12/31/2016   Date/1	1
Cost Center Description	Intern &	Total		2017 10: 44 am
	Resi dents	Total		
	Cost & Post Stepdown			
	Adjustments	24.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				2.00
5. 00 00500 ADMI NI STRATI VE & GENERAL				5.00
7. 00  00700  OPERATI ON OF PLANT 8. 00  00800  LAUNDRY & LI NEN SERVI CE				7.00
9. 00 00900 HOUSEKEEPING				9.00
10. 00 01000 DI ETARY				10.00
11. 00  01100  CAFETERI A 13. 00  01300  NURSI NG ADMI NI STRATI ON				11.00 13.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS				16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	957, 083		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	267, 626		31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	319, 264 0		40.00 41.00
42. 00 04200 SUBPROVI DER	0	0		42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	0	449 269, 550		43.00 44.00
44.00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	0	209, 550		44.00
50. 00 05000 OPERATING ROOM	0	646, 149		50.00
54. 00  05400  RADI 0L0GY-DI AGNOSTI C 55. 00  05500  RADI 0L0GY-THERAPEUTI C	0	807, 761 0		54.00 55.00
55. 01 05501 ULTRA SOUND	0	7,666		55.01
57.00 05700 CT SCAN	0	10, 221		57.00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	73, 575 57, 247		58.00 59.00
60. 00 06000 LABORATORY	0	398, 132		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	529 18		63.00 64.00
66. 00 06600 PHYSI CAL THERAPY	0	359, 554		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 789		67.00
67. 01  06701  AUDI OLOGY 68. 00  06800  SPEECH PATHOLOGY	0	1, 991 1, 457		67.01 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
69. 01  06901 CARDI OLOGY 71. 00  07100 MEDI CAL_SUPPLI ES_CHARGED_T0_PATI ENTS	0	53, 024 17, 282		69.01 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	26, 459		72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	14, 413		73.00
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	0		90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	164, 840		90.01
90. 02  09002  CLINIC 90. 03  09003  DERMATOLOGY CLINIC	0	7, 792 0		90. 02 90. 03
90. 04 09004 ENT CLINIC	0	0		90.03
90. 05 09005 SURGERY CLINIC	0	1		90.05
90. 07 09007 UROLOGY CLINIC 90. 09 09009 GASTROENTEROLOGY CLINIC	0	114 64		90.07 90.09
90. 11 09011 NEUROLOGY CLINIC	0	2		90.11
90. 12 09012 0PTHAMOLOGY CLINIC 90. 13 09013 ALLERGY CLINIC	0	37		90. 12 90. 13
90. 14 09014 WOUND CARE	0	1, 199 135, 889		90.13
91.00 09100 EMERGENCY	0	950, 690		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0			92.00
95.00 09500 AMBULANCE SERVICES	0	181, 702		95.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)	0	5 729 560		118.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	5, 738, 569	1	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23, 442		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 THORNTOWN OFFICE BUILDING	0	1, 874, 073 0		192.00 194.00
194. 01 07951 CAFE/BOUTI QUE	0	53, 195		194.01
194. 02 07952 BOUTI QUE SERVI CES 194. 03 07953 RETAI L PHARMACY	0	680, 574		194.02 194.03
200.00 Cross Foot Adjustments	0	33, 748 0		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00   TOTAL (sum lines 118-201)	0	8, 403, 601	1	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	WITHAM MEMORI	AL HOSPITAL Provider CO	CN: 15-0104 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2016 o 12/31/2016		pared:
		CAPI TAL REL	ATED COSTS			372072017 10.	44 011
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00 2.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	255, 907	255, 907				1.00
4.00 5.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	582 18, 600 24, 368	582 18, 600 24, 368	53, 594, 731 10, 716, 736 572, 967	-17, 881, 492 0	89, 036, 087 3, 932, 470	4.00 5.00 7.00
8.00 9.00 10.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	0 2, 806 6, 281	0 2, 806 6, 281	22, 970 388, 842 415, 874	0	308, 154 737, 719 756, 903	8.00 9.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	0 0	321, 457 542, 855	0	806, 651 664, 200	11.00 13.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 939 3, 063	1, 939 3, 063	435, 867 1, 032, 616	0	1, 193, 307 1, 602, 789	15.00 16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.070	00.070	0.000.440		4 704 744	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	20, 373 5, 595	20, 373 5, 595	2, 889, 440 1, 024, 187		4, 781, 746 1, 741, 794	30.00 31.00
40.00	04000 SUBPROVI DER – I PF	6, 406	6, 406	1, 138, 593	0	1, 706, 592	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00 42.00
43.00	04300 NURSERY	0	0	0	0	2, 720	43.00
44.00	04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 851	4, 851	867,050	0	1, 506, 422	44.00
50.00	05000 OPERATING ROOM	16, 260	16, 260				50.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	19, 886	19, 886 0	1, 165, 742 0	0	3, 490, 005 0	54.00 55.00
55.01	05501 ULTRA SOUND	0	0	336, 558	0	499, 748	55.01
57.00 58.00	05700 CT SCAN	0	0	164, 644	0	741, 929	57.00 58.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	1, 706 1, 438	1, 706 1, 438	280, 913 135, 130	0	962, 967 495, 858	
60.00	06000 LABORATORY	9, 274	9, 274	2, 060, 903		6, 219, 282	1
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	75, 747 0	63.00 64.00
66.00	06600 PHYSI CAL THERAPY	8, 976	8, 976	1, 467, 663	0	2, 206, 180	66.00
67.00 67.01	06700 OCCUPATI ONAL THERAPY 06701 AUDI OLOGY	0	0	339, 428 190, 232	0	422, 411 184, 880	67.00 67.01
68.00	06800 SPEECH PATHOLOGY	0	0	110, 095	0	134, 073	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	06901 CARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	925 0	925 0	880, 162 0	0	1, 214, 057 2, 472, 757	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		3, 824, 332	72.00
73.00	07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	1, 761, 685	73.00
	09000 CLI NI C	0	0	0		0	90.00
	09001 OTHER OUTPATIENT SERVICE COST CENTER 09002 CLINIC	3, 822	3, 822	178, 259	0	438, 242 0	90. 01 90. 02
	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.02
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
	09005 SURGERY CLINIC 09007 UROLOGY CLINIC	0	0	0	0	0	90.05 90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	3, 193	0	456	90.09
	09011 NEUROLOGY CLINIC 09012 OPTHAMOLOGY CLINIC	0	0	0	0	34 5, 379	90. 11 90. 12
	09013 ALLERGY CLINIC	0	0	102, 614	0	152, 950	1
90.14	09014 WOUND CARE	3, 504	3, 504	301, 904		661, 940	90.14
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 566	24, 566	2, 322, 753	0	3, 842, 194	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS				-		
95.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	4, 760	4, 760	1, 520, 507	0	2, 175, 576	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	189, 981	189, 981	33, 883, 013	-17, 881, 492	54, 982, 436	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	Ω	0	20, 492	190 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	42, 942	42, 942	19, 408, 093	0		1
	07950 THORNTOWN OFFICE BUILDING	0	0	0	0		194.00
	07951 CAFE/BOUTI QUE 07952 BOUTI QUE SERVI CES	1, 416 20, 544	1, 416 20, 544	0 67, 530	0	46, 499 852, 669	1
194.03	07953 RETAIL PHARMACY	400	400	236, 095		1, 816, 674	194.03
200.00 201.00							200. 00 201. 00
201.00	I Inegative obst centers	1			1	I	201.00

Health Financial Systems	WI THAM MEMORI A	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1	
				Го 12/31/2016	Date/Time Pre 5/26/2017 10:	
	CAPI TAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FI XT (SQUARE	NEW MVBLE EQUI P (SQUARE	EMPLOYEE BENEFI TS DEPARTMENT	Reconciliatio n	E & GENERAL (ACCUM.	
	FEET)	FEET)	(GROSS SALARI ES)		COST)	
	1.00	2.00	4.00	5A	5.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 315, 682	3, 087, 919	7, 648, 32	1	17, 881, 492	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	20. 771929	12.066567	0. 14270	7	0. 200834	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			19, 11:	2	614, 622	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0.00035	7	0. 006903	205.00

Health Financial Systems	WI THAM MEMORI				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016	Worksheet B-1	
		_	T	o 12/31/2016	Date/Time Pre 5/26/2017 10:	
Cost Center Description	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG (HOURS OF	DI ETARY (MEALS	CAFETERIA (MEALS	
	(SQUARE	(GROSS	SERVICE)	SERVED)	SERVED)	
	FEET)	CHARGES)	0.00	10.00	11 00	
GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	183, 813					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0 2, 806		139, 073			8.00 9.00
10. 00 01000 DI ETARY	6, 281		8, 623			10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0		2,875		982	11.00
15. 00 01500 PHARMACY	1, 939		1, 300 2, 625		19 38	•
16.00 01600 MEDICAL RECORDS & LIBRARY	3, 063	0	5, 750		77	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	20, 373	15, 245, 904	43, 681	16, 646	259	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 595		11, 600		21	31.00
40. 00 04000 SUBPROVIDER - IPF	6, 406		13, 794		33	•
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	-	0		0	41.00
43. 00 04300 NURSERY	0		0		0	43.00
44.00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	4, 851	2, 210, 215	0	13, 869	0	44.00
50. 00 05000 OPERATI NG ROOM	16, 260	42, 525, 174	2, 575	0	23	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 886				28	•
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 ULTRA SOUND	0		0 750		0 3	55.00 55.01
57. 00 05700 CT SCAN	0		1, 150		4	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 706				10	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	1, 438 9, 274				0 82	59.00 60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0		0	0	0	63.00
64. 00 06400 INTRAVENOUS THERAPY	0 8, 976	_,			0	64.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	8,978			-	41 17	66.00 67.00
67. 01 06701 AUDI OLOGY	0	1,044,246	625		18	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0		375		19 0	68.00 69.00
69. 01 06901 CARDI 0L0GY	925		3, 775	-	41	69.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS			0		21	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0				0	•
OUTPATIENT SERVICE COST CENTERS			2,720		-	10100
90. 00 09000 CLINIC 90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	03,822		0 6, 700		0	90.00 90.01
90.02 09002 CLINIC	3, 822	0	9, 850		34 0	90.01
90. 03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90. 04 09004 ENT CLINIC 90. 05 09005 SURGERY CLINIC	0	0	0	0	0	90.04 90.05
90. 07 09007 UROLOGY CLINIC	0	141, 010	0	-	0	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0	0		0	90.09
90. 11 09011 NEUROLOGY CLINIC 90. 12 09012 OPTHAMOLOGY CLINIC	0	86, 589 0	0	0	0	90.11 90.12
90. 13 09013 ALLERGY CLINIC	0	650, 461	0	0	0	90.13
90. 14 09014 WOUND CARE	3, 504			0	0	90.14
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 566	30, 440, 785	0	0	64	91.00 92.00
OTHER REIMBURSABLE COST CENTERS		( 074 005			100	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	1, 760	6, 274, 895	0	0	130	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	143, 431	295, 532, 009	139, 073	44, 621	982	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	37, 942	0	0		0	192.00
194. 00 07950 THORNTOWN OFFICE BUILDING 194. 01 07951 CAFE/BOUTIQUE	0	-	0	0		194.00 194.01
194. 02 07952  BOUTI QUE_SERVI CES	1, 416		0	0		194.01
194. 03 07953 RETAIL PHARMACY	400	0	0	0		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00 201.00
202.00 Cost to be allocated (per Wkst. B,	4, 722, 244	370, 042	957, 965	1, 129, 674	988, 458	
Part I) 203.00 Unit cost multiplier (Wkst. B, Part	1) 25.690479	0. 001252	6. 888217	25. 317093	1, 006. 576375	203 00
200.00 Joint COSt multipiter (WKSt. D, Palt	1/1 23.0704/9	0.001232	0.000217	23.317073	1,000.070070	<u>1∼00.00</u>

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				rom 01/01/2016 o 12/31/2016		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	(MEALS	
	(SQUARE	(GROSS	SERVI CE)	SERVED)	SERVED)	
	FEET)	CHARGES)				
	7.00	8.00	9.00	10.00	11.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	827, 559	2, 135	110, 009	246, 730	7, 957	204.00
205.00 Unit cost multiplier (Wkst. B, Part	4. 502179	0. 000007	0. 791016	5. 529459	8. 102851	205.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	WI THAM MEMORIA	AL HOSPITAL Provider CC	N· 15-0104	In Lieu of Form CMS Period: Worksheet B	
			F	From 01/01/2016 To 12/31/2016 Date/Time P	
Cost Conton Decorintion	NURSI NG	PHARMACY	MEDICAL	5/26/2017 1	
Cost Center Description	ADMI NI STRATI O	(COSTED	RECORDS &		
	N (DI RECT	REQUIS.)	LI BRARY (TI ME		
	NRSING HRS)		SPENT)	_	
GENERAL SERVICE COST CENTERS	13.00	15.00	16.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00 8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00  01100  CAFETERI A 13. 00  01300  NURSI NG ADMI NI STRATI ON	390, 613				11.00 13.00
15.00 01500 PHARMACY	0	2, 259, 682			15.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY	0	0	41, 100	)	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	82, 671	1, 172	10, 100		30.00
31.00 03100 I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER – I PF	24, 340 37, 886	276 34	2, 100 2, 500		31.00 40.00
41.00 04100 SUBPROVIDER - IRF	0	0	2,000		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0 11, 395	(		42.00 43.00
44. 00 04400 SKILLED NURSING FACILITY	31, 280	14, 153	(	-	44.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	59, 157	22, 411	3, 625	-	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	59, 157	5, 708	9, 700		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(	•	55.00
55. 01  05501 ULTRA_SOUND 57. 00  05700 CT_SCAN	0	2, 061 516	1, 050 1, 200		55.01 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	650		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	3, 765	0 104	0 1,000	•	59.00 60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	(		63.00
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY	0 29, 670	0 4, 740	( 1, 950		64.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	14, 052	0	850		67.00
67. 01 06701 AUDI OLOGY 68. 00 06800 SPEECH PATHOLOGY	0 2, 370	0	(		67.01 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(		69.00
69. 01 06901 CARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	26, 476	294 0	1, 875 (		69.01 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	•	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	0	0	(	)	73.00
90. 00 09000 CLINIC	0	0	(	-	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 90. 02 09002 CLINIC	4, 709	102	4, 200		90.01 90.02
90. 03 09003 DERMATOLOGY CLINIC	0	0	(	5	90.03
90. 04 09004 ENT CLINIC 90. 05 09005 SURGERY CLINIC	0	0 14	(		90.04 90.05
90. 07 09007 UROLOGY CLINIC	0	3, 082	(		90.03
90. 09 09009 GASTROENTEROLOGY CLINIC 90. 11 09011 NEUROLOGY CLINIC	3, 923	0	(		90.09
90. 11 09011 NEUROLOGY CLINIC 90. 12 09012 0PTHAMOLOGY CLINIC	0	34 0	(		90. 11 90. 12
90. 13 09013 ALLERGY CLINIC	2,687	1,629	(		90.13
90. 14 09014 WOUND CARE 91. 00 09100 EMERGENCY	7, 437 57, 237	6, 401 120, 136	(		90.14 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		_	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	0	21, 967	(	)	95.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	387, 660	216, 229	40, 800	)	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 THORNTOWN OFFI CE BUILDI NG	1,054	1, 875, 409 0	300		192.00 194.00
194. 01 07951 CAFE/BOUTI QUE	0	0	(		194.01
194. 02 07952  BOUTI QUE_SERVI CES 194. 03 07953  RETAI L_PHARMACY	1, 899	0 168, 044	(		194.02 194.03
200.00 Cross Foot Adjustments	0	100, 044	C		200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	825, 674	1, 539, 110	2, 120, 487	7	201.00 202.00
Part I)	020,074	1, 337, 110	2, 120, 407		202.00

Health Financial Systems	WI THAM MEMORI A	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2016	Worksheet B-7	1
				To 12/31/2016		epared: 44 am
Cost Center Description	NURSI NG	PHARMACY	MEDI CAL			
	ADMI NI STRATI O	(COSTED	RECORDS &			
	N	REQUIS.)	LI BRARY			
	(DI RECT		(TIME			
	NRSING HRS)		SPENT)			
	13.00	15.00	16.00			
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 113790	0. 681118	51.59335	58		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	5, 961	83, 181	130, 97	79		204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 015261	0. 036811	3. 18683	37		205.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	narod
				10 12/31/2010	5/26/2017 10:	44 am
	1	Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I, col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 964, 220		7, 964, 220	0 0	7, 964, 220	30.00
31.00 03100 INTENSIVE CARE UNIT	2, 637, 728		2, 637, 728		2,637,728	
40. 00 04000 SUBPROVI DER – I PF	2, 775, 355		2, 775, 355	34, 318	2, 809, 673	40.00
41.00 04100 SUBPROVIDER - IRF	0		(	-	0	41.00
42. 00 04200 SUBPROVI DER	0		(		0	42.00
43.00 04300 NURSERY	12,941		12, 941		12, 941	43.00
44. 00 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	2, 363, 237		2, 363, 237	/ 0	2, 363, 237	44.00
50. 00 05000 OPERATING ROOM	4, 751, 855		4, 751, 855	5 0	4, 751, 855	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 338, 138		5, 338, 138		5, 338, 138	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		(		0,000,100	55.00
55. 01 05501 ULTRA SOUND	674,096		674, 096		674,096	
57.00 05700 CT SCAN	1, 010, 734		1, 010, 734		1, 010, 734	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 269, 653		1, 269, 653	3 0	1, 269, 653	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	644, 511		644, 511	0	644, 511	59.00
60. 00 06000 LABORATORY	7, 937, 433		7, 937, 433		7, 937, 433	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	91, 957		91, 957		91, 957	
64. 00 06400 I NTRAVENOUS THERAPY	3, 297		3, 297		3, 297	64.00
66.00 06600 PHYSI CAL THERAPY	3, 109, 444	0			3, 109, 444	
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 AUDI 0LOGY	607, 120	0			607, 120	67.00 67.01
68. 00 06800 SPEECH PATHOLOGY	245, 740 188, 598	0			245, 740 188, 598	
69. 00 06900 ELECTROCARDI OLOGY	100, 370	0	100, 370	0	00, 370	69.00
69. 01 06901 CARDI OLOGY	1, 716, 042		1, 716, 042		1, 716, 042	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 998, 281		2, 998, 281		2, 998, 281	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	4, 603, 060		4, 603, 060		4, 603, 060	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 151, 451		2, 151, 451	0	2, 151, 451	73.00
OUTPATIENT SERVICE COST CENTERS	1			11		
90. 00 09000 CLI NI C	0		0		0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	931, 535		931, 535		931, 535	90.01
90. 02 09002 CLINIC	67, 849		67, 849		67, 849	90.02
90. 03 09003 DERMATOLOGY CLINIC	0				0	90.03
90. 04 09004 ENT CLINIC 90. 05 09005 SURGERY CLINIC	0		10		0 10	90.04 90.05
90. 03  09005 30kGERT CLINIC 90. 07  09007 UROLOGY CLINIC	2, 276		2, 276		2, 276	90.05
90. 09 09009 GASTROENTEROLOGY CLINIC	8, 840		8, 840		8, 840	
90. 11 09011 NEUROLOGY CLINIC	172		172		172	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	6, 459		6, 459		6, 459	
90. 13 09013 ALLERGY CLINIC	191, 272		191, 272		191, 272	
90. 14 09014 WOUND CARE	908, 801		908, 801		908, 801	
91.00 09100 EMERGENCY	5, 550, 296		5, 550, 296		5, 550, 296	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 468, 638		1, 468, 638	3	1, 468, 638	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	2, 811, 394		2, 811, 394		2, 811, 394	
200.00 Subtotal (see instructions)	65,042,433	0			65, 076, 751	
201.00Less Observation Beds202.00Total (see instructions)	1, 468, 638 63, 573, 795	~	1, 468, 638 63, 573, 795		1, 468, 638 63, 608, 113	
	03, 573, 795	0	03, 573, 795	34, 318	03, 000, 113	202.00

Health Financial Systems	WI THAM MEMOR	M MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider (	F	Period: From 01/01/2016	Worksheet C Part I	
			[]	To 12/31/2016	Date/Time Pre 5/26/2017 10:	epared: 44 am
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	iti ent Outpati ent	Total (col. 6		TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	. 00 7. 00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CEN						
30.00 03000 ADULTS & PEDIATRICS	12, 638, 150		12, 638, 150			30.00
31.00 03100 I NTENSI VE CARE UNI T	3, 671, 40		3, 671, 401			31.00
40. 00 04000 SUBPROVI DER - I PF	3, 008, 160		3, 008, 160			40.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER		0				41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	1, 528, 80	-	1, 528, 801			42.00
44. 00 04400 SKILLED NURSING FACILITY	2, 210, 215		2, 210, 215			44.00
ANCI LLARY SERVICE COST CENTERS	2,210,210	210,210	2,210,210			11.00
50.00 05000 OPERATING ROOM	7, 791, 694	791, 694 34, 733, 48	42, 525, 174	0. 111742	0. 000000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 330, 051	330, 051 17, 491, 26	1 18, 821, 312		0.00000	
55. 00 05500 RADI OLOGY-THERAPEUTI C		-	0 0		0.000000	
55.01 05501 ULTRA SOUND		482, 643 7, 679, 69			0.00000	
57.00 05700 CT SCAN	4, 114, 196				0.00000	
58.00 05800 MAGNETIC RESONANCE IMAGING (N 59.00 05900 CARDIAC CATHETERIZATION		546, 973 14, 055, 62			0. 000000 0. 000000	
60. 00 06000 LABORATORY	1, 138, 960 8, 597, 820				0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & T		395, 908 400, 67			0. 000000	
64. 00 06400 I NTRAVENOUS THERAPY	1, 200, 838				0. 000000	
66.00 06600 PHYSI CAL THERAPY	2, 179, 538				0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	2,043,203				0.000000	
67. 01 06701 AUDI OLOGY	(	0 1,044,24	5 1, 044, 246	0. 235328	0.000000	67.01
68.00 06800 SPEECH PATHOLOGY	130, 718	130, 718 572, 76			0.000000	
69.00 06900 ELECTROCARDI OLOGY	(	-			0.00000	
69. 01 06901 CARDI OLOGY	4, 650, 19				0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO F 72.00 07200 IMPL. DEV. CHARGED TO PATIENT					0. 000000 0. 000000	
73. 00 07200 TMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 699, 242				0. 000000	
OUTPATIENT SERVICE COST CENTERS	0,077,242	1,001,001	5 15,750,240	0. 100074	0.00000	/ 5.00
90. 00 09000 CLINIC	(	0		0. 000000	0.00000	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST	CENTER	0			0.00000	90.01
90. 02 09002 CLI NI C		-			0.00000	
90. 03 09003 DERMATOLOGY CLINIC		-	0 0		0.00000	
90. 04 09004 ENT CLINIC		-			0.00000	
90. 05 09005 SURGERY CLINIC 90. 07 09007 UROLOGY CLINIC		-			0.00000	
90. 07 09007 UROLOGY CLINIC 90. 09 09009 GASTROENTEROLOGY CLINIC		1, 307 139, 70	3 141, 010		0. 000000 0. 000000	
90. 11 09011 NEUROLOGY CLINIC		0 86, 58			0. 000000	
90. 12 09012 OPTHAMOLOGY CLINIC			00,00		0. 000000	
90. 13 09013 ALLERGY CLINIC		59 650, 40	650, 461		0. 000000	
90. 14 09014 WOUND CARE	29, 266	29, 266 3, 023, 40			0.000000	
91.00 09100 EMERGENCY	3, 513, 518				0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINC	T PART)	0 2,607,75	4 2, 607, 754	0. 563181	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	10.05	12.050 ( 2/1.02)	4 074 005	0 440000	0,000000	05 00
95.00 09500 AMBULANCE SERVICES 200.00 Subtotal (see instructions)	74, 047, 950	13, 858 6, 261, 03 047, 950 221, 484, 05			0.00000	95.00 200.00
201.00 Less Observation Beds	74, 047, 950	221,404,00	275, 552, 009			200.00
202.00 Total (see instructions)	74, 047, 950	047, 950 221, 484, 05	295, 532, 009			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CON: 15-0104         Provider CON: 15-0104         Worksheet C From 07/01/2016         <	Health Fina	ncial Systems	WITHAM MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
To         12/31/2016         Date/Time Prepared S22/2017         Date/Time Prepared PPS           InvArt ENT ROUTINE SERVICE COST CENTERS         30.00         30000 ADULTS A PEDIATRICS         30.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         300.00         <				Provider CCN: 15-0104			
Cost Center Description         PPS Inpati ent Batio         Formula intervention         PPS Inpati ent Batio         Formula intervention         PPS Inpati ent Batio         PPS In							
Cost Centro Description         PPS Inpatient Ratio         Title XVIII         Hospital         PPS           11.00         IMPATIENT ROUTINE SERVICE COST CENTERS         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0         30.0					10 12/31/2016	Date/lime Pre	epared:
Cost Center Description         PPS Inpatient Ratio         Number of the state           11.00         IMPATTENT ROUTINE SERVICE COST CENTERS         30.00         3000 ADULTS A PEDIATRICS         31.0           11.00         INFONT CENTROL THENSIVE CARE UNIT         31.0         31.0         31.0           11.00         INFENSIVE CARE UNIT         31.0         31.0         31.0           11.00         Ottool SUBPROVIDER - IPF         41.0         41.0         41.0           11.00         Ottool SUBPROVIDER - IPF         41.0         42.0         42.0           11.00         Ottool SUBPROVIDER - IPF         42.0         43.0         43.0           11.00         Ottool SUBPROVIDER - IPF         43.0         43.0         43.0           11.00         Discool OPFEAITING ROAM         0.111742         50.0         55.0         55.5         55.5         55.7         57.7         57.7         57.7         57.7         58.0         55.9         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0         59.0 </td <td></td> <td></td> <td></td> <td>Title XVIII</td> <td>Hospi tal</td> <td></td> <td>44 dili</td>				Title XVIII	Hospi tal		44 dili
INPACT ENT ROUTINE SERVICE COST CENTERS         11.00           0.00         03000 AND LITS & PEDIATRICS         30.0           31.00         03100 INTENSIVE CARE UNIT         31.00           0.00         03000 INTENSIVE CARE UNIT         41.00           42.00         04000 SUBERCUIDER - IFF         41.00           42.00         04000 SUBERCUIDER - IFF         41.00           42.00         04000 SUBERCUIDER         42.1           44.00         04000 SUBERCUIDER         42.1           44.00         04000 SUBERCUIDER         44.1           44.00         04000 SULLED NURSING FACILITY         44.1           45.00         04000 OPERATING ROM         0.111742         54.1           56.00         05000 OPERATING ROM         0.022566         55.4           57.00         05500 RADIOLOCY-THEAPEUTIC         0.0202566         55.6           56.00         05500 CARDIA C CATHETERIZATION         0.193227         57.0           56.00         05500 CARDIA C CATHETERIZATION         0.193227         64.0           66.00         066000 PHYSICAL THERAPY         0.407777         57.6           57.00         05500 CLARDIA C CATHETERIZATION         0.193227         64.0           66.00         066000 CUPARTING, PROCE		Cost Center Description	PPS Inpatient		nospi tui	110	
INPATI ENT ROUTINE SERVICE COST CENTERS         30.0           30.00         03000 ADULTS & PEDIATRICS         31.1           40.00         04000 SUBPROVIDER - IPF         40.0           41.00         41.0         41.0           42.00         04000 SUBPROVIDER - IPF         41.0           43.00         43.00         43.0           43.00         04000 SWIESERY         42.0           44.00         04400 SKILLED NURSING FACILITY         44.0           44.00         04400 SKILLED NURSING FACILITY         44.0           44.00         04400 CSKILLED NURSING FACILITY         44.0           45.00         05500 MRDIOLOGY-INFERS         55.0           55.00         05500 MADIOLOGY-INFERS         55.0           56.00         05600 MADIOLIC - NOTIN NG, PROCESSING & TRA							
30.00       03000       ADULTS & PEDIATRICS       30.0         31.00       03100       THERSING CARE UNIT       31.0         40.00       04000       SUBPROVIDER - IRF       41.0         41.00       04100       SUBPROVIDER - IRF       42.0         43.00       04300       SUBPROVIDER       42.0         43.00       04300       SUBPROVIDER       43.1         44.00       04400 SKILLED NURSING FACILITY       43.4         44.00       04400 SKILLED NURSING FACILITY       43.4         45.00       04500 RADIOLOGY THERAPEUTIC       0.238262       54.4         55.00       05500 RADIOLOGY THERAPEUTIC       0.28362       55.6         55.00       05500 CARDIAC CATHETER IZATION       0.027757       57.0         56.00       05500 CARDIAC CATHETER IZATION       0.193627       59.0         66.00       06000 LABORATORY       0.18526       60.0         66.00       06000 PHYSICAL THERAPY       0.23528       61.0         67.00       67.00       67.00       67.0       63.0         68.00       06000 OCULABORATORY       0.23528       67.0         67.00       06700 CARDIAL THERAPY       0.23528       67.0         67.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
131.00       INTERSIVE CARE UNIT       31.1         40.00       04000 SUBPROV DER - 1 FF       40.1         41.00       04100 SUBPROV DER - 1 FF       42.1         42.00       04200 SUBPROV DER - 1 FF       42.1         42.00       04200 SUBPROV DER       43.1         43.00       04300 MURSERY       44.1         ANCILLARY SERVICE COST CENTERS       44.1         ANCILLARY SERVICE COST CENTERS       54.1         55.00       05500 MADIO LOGY-DIAGNOSTIC       0.283622         55.00       05500 UCT SCAN       0.002755         55.00       05500 MACHTIC RESONANCE INAGING (MRI)       0.082586         55.00       05600 MACHTIC RESONANCE INAGING (MRI)       0.086647         56.00       05600 MACHTIC RESONANCE INAGING (MRI)       0.16852         66.00       066000 LABORATORY       0.15439         66.00       06000 LABORATORY       0.001252         66.00       06000 INTRINC, PROCESSING & TRANS.       0.115439         67.00       05700 CELECTROCAND LOGY       0.28682         67.00       06700 CELECTROCAND LOGY       0.28682         67.00       06700 CELECTROCAND LOGY       0.28682         66.00       06600 CABORATORY       0.286872         67.00 <td>I NPAT</td> <td>FIENT ROUTINE SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td>	I NPAT	FIENT ROUTINE SERVICE COST CENTERS					
40.00       [40.00]       SUBPROVI DER - 1 PF       40.0         41.00       41.00       41.00       41.00         42.00       SUBPROVI DER - 1 RF       41.0         43.00       43.00       43.00         43.00       43.00       43.00         44.00       50.00       50.00         44.00       50.00       50.00         44.00       50.00       50.00         50.00       50.00       50.00         50.00       50.00       50.00         50.00       50.00       50.00         50.00       50.00       50.00         55.01       50.00       55.00         55.00       50.00       50.00         55.00       50.00       50.00         55.00       50.00       50.00         55.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00         56.00       50.00       50.00 </td <td>30.00 03000</td> <td>D ADULTS &amp; PEDIATRICS</td> <td></td> <td></td> <td></td> <td></td> <td>30.00</td>	30.00 03000	D ADULTS & PEDIATRICS					30.00
11.00       04100       SUBPROVI DER       41.1         42.00       04300       SERV       42.4         43.00       04300       SERVICE       COST         AMCILLARY SERVICE       COST CENTERS       43.4         ANCILLARY SERVICE       COST CENTERS       50.0         55.00       OSDOO PREATING ROM       0.111742       50.0         55.00       DSDOO RADIOLOGY-DI ASNOSTIC       0.283622       54.0         55.00       DSDOO RADIOLOGY-DI ASNOSTIC       0.0027757       57.1         56.00       DSDOO CARDIA CCATHETERIZATION       0.082586       55.5         57.00       DSTOO CARDIA CCATHETERIZATION       0.115439       50.0         65.00       DAGOO DAROTORY       0.22552       64.0         66.00       DAGOO DEVESTIN KG, PROCESSING & TRANS.       0.115439       63.3         67.00       DOSTOO DOCUPATIONAL THERAPY       0.01252       64.6         66.00       DAGOO DAROTORY       0.235328       67.7         67.00       DOROD COUPTIONAL THERAPY       0.235328       67.7         71.00       DOROD COUPTIONAL THERAPY       0.235328       67.7         72.00       DOROD COUPTIONAL THERAPY       0.2407977       64.0         73.00<	31.00 03100	INTENSIVE CARE UNIT					31.00
42.00       04200       SUBPROVIDER       42.0         43.00       04400       SKILLED       NURSING FACILITY       43.0         AM       ANDILLED       NURSING FACILITY       43.0         AM       OLAGOO SKILLED       NURSING FACILITY       43.0         AMOLILARY SERVIDE COST CENTERS       0.111742       50.0         50.00       05000 (PRDIDLOCY-THERAPEUTIC       0.283622       54.0         57.00       05700 (CT SCAN       0.02757       57.0         58.00       05800 (ARDI ACCY-THERAPEUTIC       0.082866       55.0         59.00       05800 (ARDI ACCY-THERAPEUTIC       0.082867       55.0         59.00       05900 (CT SCAN       0.013627       59.0         60.00       06000 (ARDI ACCATHERENZATION       0.183629       63.0         61.00       06000 (PHSICAC ATHERAPY       0.001252       64.0         66.00       06000 SPECCH PATHOLOGY       0.226552       67.1         67.00       06700 OCCUPATIONAL THERAPY       0.266092       66.0         68.00       06000 SPECCH PATHOLOGY       0.286092       67.1         69.00       06900 OFLICTTOCARGED TO PATIENT       0.482969       77.1         70.00       07000 OCCUPATIONAL THERAPY       0.26	40.00 04000	SUBPROVIDER - IPF					40.00
43.00       04300 NURSERY       43.         44.00       04400 SKI LEE NURSING FACILITY       44.         ANCILLARY SERVICE COST CENTERS       50.         50.00       05000 OPERATING ROM       0.111742         51.00       0500 ROD LOCO-DI AGNOSTIC       0.283622         55.00       05500 RADI LOCO-THERAPEUTIC       0.000000         55.00       0500 CT SCAN       0.027757         57.00       05700 CT SCAN       0.027757         58.00       05800 CARDI AC CATHETERI ZATI ON       0.193627         59.00       05900 CARDI AC CATHETERI ZATI ON       0.193627         60.00       04000 LABORATORY       0.158526         60.00       04000 INTRAVENUS THERAPY       0.01252         64.00       04000 INTRAVENUS THERAPY       0.01252         65.00       05800 SPECT PATHOLOGY       0.285852         67.00       05000 CONDATIOR REAPY       0.225852         67.10       0.00000       669         0.112010LIDICOCY       0.285892       67         66.00       06800 SPECED PATHOLOGY       0.285828       67         71.00       000000       0.000000       66.6         67.00       0.00000       0.000000       67.7         68.00<	41.00 04100	SUBPROVIDER – IRF					41.00
44.00       04400[SK1LED_NURSING_FACILITY       44.1         ARCILLARY SERVICE COST CENTERS       50.00       05000[PERATING_ROM       0.111742         56.00       05000[RADDILOGY-THERAPEUTIC       0.283622       54.1         56.00       05500[RADILOGY-THERAPEUTIC       0.000000       55.5         57.00       05700[CT SCAN       0.02757       56.0         58.00       05800[RADILOGY-THERAPEUTIC       0.002757       58.0         59.00       05800[RADILTC RESONANCE IMAGING (MRI.)       0.082886       56.1         59.00       05800[RADIRATORY       0.115439       56.1         60.00       06000[LABORATORY       0.01522       66.0         61.00       06400[INTRAVENUOS THERAPY       0.01252       66.1         61.00       06400[INTRAVENUOS THERAPY       0.226652       67.1         63.00       06300[SECCH PATHOLOCY       0.286892       67.1         64.00       06600[SECCH PATHOLOCY       0.286892       67.1         65.00       06000[SECCH PATHOLOCY       0.286892       67.1         65.00       06000[SECCH PATHOLOCY       0.286892       67.1         66.00       06000[SECCH PATHOLOCY       0.286892       67.1         71.00       07200[LECTROCARRED TO PATIENTS<	42.00 04200	SUBPROVI DER					42.00
ARCILLARY SERVICE COST CENTERS	43.00 04300	NURSERY					43.00
50.00         05000         05000         05000         50.0           54.00         055000         RADIOLOGY-THERAPEUTIC         0.000000         55.           55.01         05500         RADIOLOGY-THERAPEUTIC         0.000000         55.           57.00         055700         CT SCAN         55.         55.           58.00         05600         CT SCAN         50.         55.           59.00         05000         CARDEX CATHETER LATION         0.027757         55.           50.00         05000         CARDIAC CATHETER LATION         0.193627         60.           60.00         06000         ABORATORY         0.01252         64.           60.00         06000         DHERAPY         0.01252         64.           60.00         06000         DHERAPY         0.027577         66.           61.00         06000         DHERAPY         0.001252         64.           62.00         06000         DHERAPY         0.001252         67.           63.00         05300         CARDIOLOGY         0.236328         67.           64.00         06800         SPEECH PATHERAPY         0.0407977         66.           69.00         056900 <t< td=""><td>44.00 04400</td><td>SKILLED NURSING FACILITY</td><td></td><td></td><td></td><td></td><td>44.00</td></t<>	44.00 04400	SKILLED NURSING FACILITY					44.00
54.00       05400       RADIOLOGY-DIAGNOSTIC       0.283622       54.         55.00       05500       RADIOLOGY-DIAGNOSTIC       0.000000       55.         55.00       05500       RADIOLOGY-HERAPEUTIC       0.000000       55.         57.00       05700       CT SCAN       0.027757       57.         59.00       05900       CREDIAC CATHERIZ ZATION       0.193627       65.         60.00       06000       LABORATORY       0.013627       65.         63.00       06300 BLOOD STORING, PROCESSING & TRANS.       0.1158326       66.         64.00       06400 INTRAVENDUST THERAPY       0.001252       64.         65.00       06500 CALBORATORY       0.226852       67.         66.00       06500 SPEECH PATHOLOGY       0.235328       67.         67.10       06701 AUDIOLOGY       0.286902       68.         67.00       0700 OCUPATIONALT THERAPY       0.268002       69.         67.00       0700 OCUPATIOLOGY       0.280002       68.         67.00       0700 OCUPATIONALTHERAPY       0.28002       68.         67.00       0700 MELOLOGY       0.000000       69.         67.10       0701 AUDIOLOGY       0.0000000       69.	ANCI L	LARY SERVICE COST CENTERS					
55:00         NS500         RADIOLOGY-THERAPEUTIC         0.000000         55.1           55:01         NS500         ULTRA SOUND         0.027757         57.0           56:00         NS500         CT SCAN         57.0         0.027757           58:00         NS000         CARDEC T ACOUND         0.027757         58.0           60:00         OS000 CARDIA CC ATHETERIZATION         0.193627         60.0           60:00         OS000 CARDIA CC ATHETERIZATION         0.193627         64.0           60:00         OS000 CARDIA CC ATHETERIZATION         0.193627         64.0           60:00         OS000 DENDOS TORIN G, PROCESSING & TRANS.         0.115139         63.0           61:00         OS000 PHYSICAL THERAPY         0.001252         64.1           60:00         OS000 OLPATIONAL THERAPY         0.226523         67.1           61:01         OS700 OCCUPATIONAL THERAPY         0.226528         67.1           62:00         OS000 PHYSICAL THERAPY         0.226528         67.1           63:00         OS000 PHYSICAL THERAPY         0.226528         67.1           64:00         OS000 PHYSICAL THERAPY         0.235328         67.1           71:00         OT200 DRUEDIAS CHAREDID OLGY         0.200000         6			0. 111742				50.00
55.01       US501       ULTRA SOUND       0.022566         57.00       05700       CT SCAN       57.7         58.00       05800       MAGNETI C RESONANCE IMAGING (MR1)       0.0266947       58.         59.00       05900       CARDIAC CATHETERI ZATI (N       0.193627       59.         60.00       06000       LABORATORY       0.158526       60.         61.00       06000       INTRAVENUOS THERAPY       0.001252       64.         64.00       06400       INTRAVENUOS THERAPY       0.263652       67.         67.01       06701       CUPTATI ONAL THERAPY       0.226352       67.         67.00       06900       ELECTROCARDI OLGY       0.286092       68.         69.00       06900       ELECTROCARDI OLGY       0.151074       69.         69.00       06900       ELECTROCARDI OLGY       0.156694       71.         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0.42699       72.         73.00       07200       INPL.       DEV. CHARGED TO PATI ENT       0.430000       90.         90.10       09001       CHARGED TO PATI ENT       0.430499       73.       73.         74.00       07200       INPL.	54.00 05400	D RADI OLOGY-DI AGNOSTI C	0. 283622				54.00
57.00       D5700       CT SCAN       0.027757       57.1         58.00       D58000       MAGNETI C RESONANCE IMAGING (MRI)       0.068947       58.0         59.00       D5900 CARDI AC CATHETERI ZATI ON       0.158526       60.0         60.00       06000 LABORATORY       0.158526       60.1         61.00       06000 BL00D STORI NG, PROCESSI NG & TRANS.       0.115439       63.1         64.00       06400 INTRAVENOUS THERAPY       0.001252       64.1         60.00       06000 PHYSI CAL THERAPY       0.226852       67.1         67.10       06700 OCCUPATI ONAL THERAPY       0.226852       67.1         68.00       06800 SPEECH PATHOLOGY       0.23528       66.1         69.00       06900 CLECTROCARDI OLOGY       0.208092       66.1         69.00       06900 CLECTROCARDI OLOGY       0.000000       69.0         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATIENT       0.482969       71.1         72.00       07200 IMPL. DEV. CHARGED TO PATIENT       0.480040       72.1         73.00       07300 DRUGS CHARGED TO PATIENTS       0.480040       72.1         73.00       07300 DRUGS CHARGED TO PATIENTS       0.480040       90.0         70.00       00000 CLI NI C       0.000000			0. 000000				55.00
58.00       DS00       MGNETIC RESONANCE IMAGING (MRI)       0.086947       59.0         59.00       DS900       CARDIA C CATHETERI ZATION       0.158526       60.0         63.00       DAGONO LABLORATORY       0.0158526       63.0         64.00       GAGONO INTRAVENUS THERAPY       0.01252       64.0         65.00       DG6000       LABLORATORY       0.235328         67.00       DG700       DCUPTATIONAL THERAPY       0.226852         67.00       DG6000       SPECH PATHOLOGY       0.235328         68.00       OB6000       SELECTROCARDIOLOGY       0.000000         69.00       D6900 ELECTROCARDIOLOGY       0.000000       69.0         69.01       DG6001 ELECTROCARDIOLOGY       0.151074       69.0         71.00       OTOO MEDICAL SUPPLIES CHARGED TO PATIENT       0.482969       71.0         72.00       O7200 IMPL. DEV. CHARGED TO PATIENTS       0.156094       73.         00.01       OP000 CLINIC       0.000000       90.0         00.01       OP000 CLINIC       0.000000       90.0         00.02       OP0002 CLINIC       0.000000       90.0         00.01       OP0001 CTHER OUTPATIENT SERVICE COST CENTER       90.0         00.02       OP000	55.01 05501	1 ULTRA SOUND	0. 082586				55.01
59.00       05900       CARDI AC CATHETERI ZATI ON       0. 193627       59.0         60.00       060000       LABORATORY       0. 158526       60.0         63.00       06300       BLOOD STORING, PROCESSI NG & TRANS.       0. 115439       63.0         64.00       06400       INTRAVENOUS THERAPY       0. 001252       64.0         60.00       66000       PKSI CLA THERAPY       0. 226852       67.1         67.01       06701       AUDI LOGY       0. 236802       68.         69.00       06900 ELECTROCARDI OLOGY       0. 268092       68.         69.00       06900 ELECTROCARDI OLOGY       0. 151074       69.0         0.00000       CASTO OLOGY       0. 151074       69.0         71.00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0. 482969       71.0         72.00       170.00       DAVID SERVICE COST CENTERS       73.0         01.00000       CLINIC       0.000000       90.0         0.000000       CLINIC       0.000000       90.0         0.000000       CLINIC       0.000000       90.0         0.000000       CLINIC       0.000000       90.0         0.000000       CLINIC       0.000000       90.0			0. 027757				57.00
60.00         06000         LABORATORY         0.158526         60.0           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0.115439         63.0           64.00         06400         INTRAVENOUS THERAPY         0.001252         64.0           66.00         06500         PHYSI CAL THERAPY         0.407977         66.0           67.00         06701         AUDI OLOGY         0.235328         67.1           67.00         06690         SPECH PATHOLOGY         0.268092         68.0           69.00         06900 ELECTROCARDI OLOGY         0.000000         69.0         69.0           69.01         06901 CARDI OLOGY         0.151074         69.0         71.0           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.482969         71.1           72.00         07200 I IMPL. DEV. CHARGED TO PATI ENTS         0.156694         72.0           73.00         00100 CILINIC         0.000000         90.0         90.0         90.00           90.01         099001 OTHER OUTPATI ENT SERVI CE COST CENTER         0.000000         90.0         90.0           90.02         09002 CLINI C         0.000000         90.0         90.00         90.0         90.00         90.00 <t< td=""><td>58.00 05800</td><td>D MAGNETIC RESONANCE IMAGING (MRI)</td><td>0. 086947</td><td></td><td></td><td></td><td>58.00</td></t<>	58.00 05800	D MAGNETIC RESONANCE IMAGING (MRI)	0. 086947				58.00
63.00       66300       BLOOD STORING, PROCESSING & TRANS.       0.115439       64.00         64.00       06400       INTRAVENOUS THERAPY       0.001252       64.0         60.00       06600       PHYSICAL THERAPY       0.226852       67.0         67.01       06701       AUDIOLOGY       0.35328       67.0         68.00       06800       SPECH PATHOLOGY       0.28692       68.0         69.01       06900       ELECTROCARDIOLOGY       0.151074       69.0         71.00       07100       MEDICAL SUPPLIES CHARGE TO PATIENTS       0.482969       71.0         72.00       70200       IMPL. DEV. CHARGED TO PATIENT       0.540024       72.0         72.00       70200       IMPL. DEV. CHARGED TO PATIENT       0.540024       73.0         70.00       07000       RUS CHARGED TO PATIENT       0.540024       73.0         90.00       09000 CLINIC       0.000000       90.0       90.0         90.00       09000 CLINIC       0.000000       90.0       90.0         90.00       09003 DERMATOLOGY CLINIC       0.000000       90.0       90.0         90.00       09003 SURGERY CLINIC       0.000000       90.0       90.0       90.0       90.0       90.0	59.00 05900	CARDI AC CATHETERI ZATI ON	0. 193627				59.00
64.00       06400       INTRAVENOUS THERAPY       0.001252       64.0         66.00       06600       PHYSI CAL THERAPY       0.407977       66.0         67.00       06700       0CCUPATI ONAL THERAPY       0.226852       67.0         68.00       06800       SPEECH PATHOLOGY       0.235328       67.0         68.00       06800       SPEECH PATHOLOGY       0.268092       68.0         69.00       06900       ELECTROCARDI OLOGY       0.151074       69.0         69.01       06901       CARDI OLOGY       0.151074       69.0         71.00       07100       MEDICA SUPPLIES CHARGED TO PATIENTS       0.482969       71.0         71.00       07300       DRUSS CHARGED TO PATIENTS       0.540024       72.0         70.00       07000       CLINIC       0.000000       90.0         90.00       09001       OTHAR OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.01       09001       CLINIC       0.000000       90.0         90.02       09002       CLINIC       0.000000       90.0         90.03       DERMATOLOGY CLINIC       0.000000       90.0         90.04       09004       ENTEQUICEY CLINIC       0.000000	60.00 06000	DLABORATORY	0. 158526				60.00
66.00       06000       PHYSI CAL THERAPY       0.40797       66.0         67.00       06700       0CCUPATI ONAL THERAPY       0.226852       67.1         68.00       06800       SPEECH PATHOLOGY       0.235328       68.0         69.00       06900       ELECTROCARDI OLOGY       0.268092       68.0         69.01       06901       CALSTOLAL SUPPLIES CHARGED TO PATIENTS       0.42699       71.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.426094       72.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.540024       73.0         0.00000       CLINIC       0.000000       90.0       90.0       90.00         0.00       09001       OTHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         0.00       09002       CLINIC       0.000000       90.0         0.00       09003       DENKATLOGY CLINIC       0.000000       90.0         0.00       09004       CLINIC       0.000000       90.0         0.00       09005       SURGERY CLINIC       0.0016411       90.0         0.00       09009       GASTROENTERBLOGY CLINIC       0.000000       90.1         0.01       09	63.00 06300	D BLOOD STORING, PROCESSING & TRANS.	0. 115439				63.00
67.00       06700       00CUPATI 0NAL THERAPY       0.226852       67.0         67.01       06701       AUDI 0LOGY       0.235328       67.0         68.00       06800       SPEECH PATHOLOGY       0.268092       68.0         69.00       06900       ELECTROCARDI 0LOGY       0.151074       69.0         69.01       06901       CARDI 0LOGY       0.151074       69.0         71.00       MOI CAL SUPPLIES CHARGED TO PATI ENTS       0.482969       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.156094       72.0         73.00       07300 DRUGS CHARGED TO PATI ENTS       0.156694       73.0         00100001       THER OUTPATI ENT SERVICE COST CENTERS       0.000000       90.0         90.01       OPGOD CLI NI C       0.0000000       90.0         90.02       O9002 CLI NI C       0.0000000       90.0         90.03       09003 DERMATOLOGY CLI NI C       0.0000000       90.0         90.04       ENT CLI NI C       0.0000000       90.0         90.05       SURGERY CLI NI C       0.0000000       90.0         90.09       OSASTROENT CLI NI C       0.0000000       90.0         90.09       OSASTROENT CLI NI C       0.0000000<	64.00 06400	INTRAVENOUS THERAPY	0. 001252				64.00
67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       67.01       68.00       SPECH PATHOLOGY       0.268092       68.01       68.01       68.01       68.01       68.01       68.01       68.01       69.00       69.00       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.02       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01       69.01 </td <td>66.00 06600</td> <td>PHYSI CAL THERAPY</td> <td>0. 407977</td> <td></td> <td></td> <td></td> <td>66.00</td>	66.00 06600	PHYSI CAL THERAPY	0. 407977				66.00
68.00       06800       SPEECH PATHOLOGY       0.268092       68.0         69.00       06900       CLECTROCARDIOLOGY       0.000000       69.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.482969       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.156694       72.0         07300       DRUGS CHARGED TO PATIENTS       0.156694       73.0         00170ATIENT SERVICE COST CENTERS       0.000000       90.0         00001       OTHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.00       09001       OTHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.01       09004       ELINIC       0.000000       90.0         90.02       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.03       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.04       09005       SURGERY CLINIC       0.000000       90.0         90.05       09005       SURGERY CLINIC       0.001986       90.0         90.10       09011       NEUROLOGY CLINIC       0.001986       90.0         90.11       09011       NEUROLOGY CLINIC       0.001986	67.00 06700	OCCUPATIONAL THERAPY	0. 226852				67.00
69.00       06900       ELECTROCARDIOLOGY       0.000000       69.0         69.00       06900       ELECTROCARDIOLOGY       0.151074       69.0         71.00       0FDICAL SUPPLIES CHARGED TO PATIENTS       0.482969       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.540024       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0.156694       73.0         00000       CLINIC       0.000000       90.0         90.00       09000       CLINIC       0.000000       90.0         90.01       09001       CHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.00       09002       CLINIC       0.000000       90.0         90.01       09001       CHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.02       09002       CLINIC       0.000000       90.0         90.03       DERMATOLOGY CLINIC       0.000000       90.0       90.0         90.04       09004       ENT CLINIC       0.000000       90.0         90.05       09007       KROLOGY CLINIC       0.0014141       90.0         90.12       097147       CLINIC       0.001986       90.0			0. 235328				67.01
69.01       06901       CARDI OLOGY       0.151074       69.0         71.00       OT100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.482969       71.0         72.00       OT200 IMPL DEV. CHARGED TO PATIENTS       0.540024       72.0         00       OT300       DRUGS CHARGED TO PATIENTS       0.156694       73.0         00.00       OUTPATIENT SERVICE COST CENTERS       0.000000       90.0         90.00       O9000       CLINIC       0.000000       90.0         90.01       O9002       CLINIC       0.000000       90.0         90.02       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.03       O9007       UROLOGY CLINIC       0.000000       90.0         90.04       09007       UROLOGY CLINIC       0.000000       90.0         90.05       09005       SURGERY CLINIC       0.000000       90.0         90.01       OPO07       UROLOGY CLINIC       0.0016141       90.0         90.02       O9007       UROLOGY CLINIC       0.001986       90.0         90.11       OPO11       NERGENCLINIC       0.090000       90.0         90.12       OPO12       OPO14       CLINIC       0.090000       90.0<	68.00 06800	SPEECH PATHOLOGY	0. 268092				68.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.482969       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.540024       72.0         73.00       O7300       DRUGS CHARGED TO PATIENT       0.156694       73.0         90.00       O9000       CLINIC       0.000000       90.0         90.01       O9000       CLINIC       0.000000       90.0         90.02       O9002       CLINIC       0.000000       90.0         90.03       O9003       DERMATOLOGY CLINIC       0.000000       90.0         90.04       O9004       ENT CLINIC       0.000000       90.0         90.05       SURGERY CLINIC       0.000000       90.0       90.0         90.05       O9005       SURGERY CLINIC       0.0104000       90.0         90.07       UPOLOGY CLINIC       0.016141       90.0       90.0         90.11       O9012       DETHAMOLOGY CLINIC       0.000000       90.0       90.0         90.11       NO11       NULLAUCA       0.000000       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0       90.0	69.00 06900	ELECTROCARDI OLOGY	0. 000000				69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0.540024       72.0         73.00       07300       DRUGS CHARGED TO PATIENTS       0.156694       73.0         00TPATIENT SERVICE COST CENTERS       0.000000       90.0       90.0         90.00       09000       CLINIC       0.000000       90.0         90.01       09001       OTHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.02       09002       CLINIC       0.000000       90.0         90.03       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.04       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.05       09005       SURGERY CLINIC       0.000000       90.0         90.05       09009       GASTROENTEROLOGY CLINIC       0.000000       90.0         90.01       09009       GASTROENTEROLOGY CLINIC       0.001986       90.0         90.12       09012       DPTHAMOLOGY CLINIC       0.294056       90.0         90.13       09013       ALLERGY CLINIC       0.294707       90.0         91.00       09100       EMBURSABLE COST CENTERS       0.182331       91.0         92.00       09200       BERVATION BEDS (N			0. 151074				69.01
73.00       07300       DRUGS CHARGED TO PATIENTS       0.156694       73.00         90.00       09000       CLINIC       0.000000       90.0         90.01       09001       OTHER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.02       09002       CLINIC       0.000000       90.0         90.03       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.04       09004       ENT ALLINIC       0.000000       90.0         90.05       SURGERY CLINIC       0.000000       90.0         90.07       09007       UROLOGY CLINIC       0.000000       90.0         90.07       UROLOGY CLINIC       0.000000       90.0       90.0         90.0909       GASTROENTEROLOGY CLINIC       0.000000       90.0       90.0         90.11       OP011       NEUROLOGY CLINIC       0.001986       90.0         90.12       OPTHAMOLOGY CLINIC       0.001986       90.1         90.13       0913       ALLERGY CLINIC       0.294056       90.1         90.14       09104       WUND CARE       0.297707       90.1         91.00       09100       SUBRGRATION BEDS (NON-DISTINCT PART)       0.563181       92.0							71.00
OUTPATI ENT SERVICE COST CENTERS           90.00         09000 CLINIC         0.000000           90.01         09001         OTHER OUTPATI ENT SERVICE COST CENTER         0.000000           90.02         09002 CLINIC         0.000000         90.0           90.03         09003 DERMATOLOGY CLINIC         0.000000         90.0           90.04         09004 ENT CLINIC         0.000000         90.0           90.05         09005 SURGERY CLINIC         0.000000         90.0           90.05         09007 UROLOGY CLINIC         0.000000         90.0           90.07         09007 UROLOGY CLINIC         0.000000         90.0           90.09         90007 UROLOGY CLINIC         0.0016141         90.0           90.09         90007 UROLOGY CLINIC         0.001986         90.0           90.11         09011 NEUROLOGY CLINIC         0.001986         90.1           90.12         09114 MOUND CARE         0.294056         90.1           90.13         09013 ALLERGY CLINIC         0.294056         90.1           91.00         09100 EMERGENCY         0.182331         91.1           92.00         095ERVATION BEDS (NON-DISTINCT PART)         0.563181         92.0           91.00         09500 AMBULANCE SERVI			0. 540024				72.00
90.00       09000       CLINIC       0.000000       90.0         90.01       09001       0THER OUTPATIENT SERVICE COST CENTER       0.000000       90.0         90.02       09002       CLINIC       0.000000       90.0         90.03       09003       DERMATOLOGY CLINIC       0.000000       90.0         90.04       09004       ENT CLINIC       0.000000       90.0         90.05       09005       SURGERY CLINIC       0.000000       90.0         90.07       09007       UROLOGY CLINIC       0.000000       90.0         90.07       09007       UROLOGY CLINIC       0.000000       90.0         90.0909       GASTROENTEROLOGY CLINIC       0.001141       90.0       90.0         90.11       09011       NEUROLOGY CLINIC       0.000000       90.0         90.12       09012       OPTHAMOLOGY CLINIC       0.001986       90.0         90.13       09013       ALERGY CLINIC       0.294056       90.0         91.00       OHAMOLOGY CLINIC       0.297707       90.7         91.00       OP100 EMERGENCY       0.182331       91.0         92.00       095ERVATION BEDS (NON-DISTINCT PART)       0.563181       92.0         91.00 </td <td>73.00 07300</td> <td>D DRUGS CHARGED TO PATIENTS</td> <td>0. 156694</td> <td></td> <td></td> <td></td> <td>73.00</td>	73.00 07300	D DRUGS CHARGED TO PATIENTS	0. 156694				73.00
90.01         09001         OTHER OUTPATIENT SERVICE COST CENTER         0.000000         90.0           90.02         09002         CLINIC         0.000000         90.0           90.03         09003         DERMATOLOGY CLINIC         0.000000         90.0           90.04         09004         ERT CLINIC         0.000000         90.0           90.05         09005         SURGERY CLINIC         0.000000         90.0           90.07         09007         UROLOGY CLINIC         0.000000         90.0           90.09         95009         GASTROENTEROLOGY CLINIC         0.016141         90.0           90.11         09011         NEUROLOGY CLINIC         0.001986         90.1           90.12         09012         OPTHAMOLOGY CLINIC         0.001986         90.1           90.13         09013         ALLERGY CLINIC         0.0294056         90.1           90.14         09014         WOUND CARE         0.297707         90.1           91.00         09100         EMEGENCY         0.182331         91.0           91.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.563181         92.0           92.00         095000         MBULANCE SERVICES         0.448038							
90.02         09002         CLINIC         0.00000         90.0           90.03         09003         DERMATOLOGY CLINIC         0.00000         90.0           90.04         09004         ENT CLINIC         0.00000         90.0           90.05         09005         SURGERY CLINIC         0.00000         90.0           90.07         09007         UROLOGY CLINIC         0.00000         90.0           90.09         GASTROENTEROLOGY CLINIC         0.016141         90.0           90.11         09011         NEUROLOGY CLINIC         0.00000         90.0           90.12         09012         OPTHAMOLOGY CLINIC         0.000000         90.0           90.13         09013         ALLERGY CLINIC         0.000000         90.7           90.14         09014         WOUND CARE         0.297707         90.7           91.00         09100         EMERGENCY         0.182331         91.0           91.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.563181         91.0           920.00         Subtotal (see instructions)         0.448038         200.00         201.00           200.00         Subtotal (see instructions)         200.00         201.00         Subtotal (see							90.00
90.03         09003         DERMATOLOGY CLINIC         0.000000         90.0           90.04         09004         ENT CLINIC         0.000000         90.0           90.05         09005         SURGERY CLINIC         0.000000         90.0           90.07         09007         UROLOGY CLINIC         0.016141         90.0           90.09         09009         GASTROENTEROLOGY CLINIC         0.001986         90.0           90.12         09012         OPTHAMOLOGY CLINIC         0.000000         90.0           90.13         09013         ALLERGY CLINIC         0.000000         90.0           90.14         09014         WOUND CARE         0.294056         90.0           91.00         09100         EMERGENCY         0.182331         91.0           91.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.563181         92.0           95.00         09500         AMBULANCE SERVICES         0.448038         95.0         95.0           200.00         Subtotal (see instructions)         Less Observation Beds         200.0         201.0							90.01
90.04       09004       ENT CLINIC       0.000000       90.0         90.05       09005       SURGERY CLINIC       0.000000       90.0         90.07       09007       UROLOGY CLINIC       0.016141       90.0         90.09       09009       GASTROENTEROLOGY CLINIC       0.000000       90.0         90.11       09011       NEUROLOGY CLINIC       0.000000       90.0         90.12       09012       OPTHAMOLOGY CLINIC       0.000000       90.0         90.13       09013       ALLERGY CLINIC       0.294056       90.0         90.14       09014       WOUND CARE       0.297707       90.0         91.00       09100       EMERGENCY       0.182331       91.0         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0.563181       91.0         95.00       OPSOO AMBULANCE SERVICES       0.448038       95.0         200.00       Subtotal (see instructions)       200.0       201.00       Less Observation Beds       200.0							90.02
90.05       09005       SURGERY CLINIC       0.000000       90.0         90.07       09007       UROLOGY CLINIC       0.016141       90.0         90.09       09009       GASTROENTEROLOGY CLINIC       0.000000       90.0         90.11       09011       NEUROLOGY CLINIC       0.001986       90.0         90.12       09704       OPTHAMOLOGY CLINIC       0.000000       90.0         90.13       09013       ALERGY CLINIC       0.000000       90.0         90.14       09014       WOUND CARE       0.294056       90.1         90.14       09100       EMERGENCY       0.182331       91.0         91.00       09100       BERGENCY       0.182331       91.0         92.00       OSED AMBULANCE SERVICES       0.448038       95.0       95.00         09050       Subtotal (see instructions)       200.0       201.00       Less Observation Beds       200.0							90.03
90.07       09007       UR0LOGY CLINIC       0.016141       90.0         90.09       09009       GASTROENTEROLOGY CLINIC       0.000000       90.0         90.11       09011       NEUROLOGY CLINIC       0.001986       90.0         90.12       09012       OPTHAMOLOGY CLINIC       0.000000       90.1         90.13       09013       ALLERGY CLINIC       0.000000       90.1         90.14       09014       WOUND CARE       0.294056       90.1         91.00       09100       EMERGENCY       0.182331       91.0         92.00       09500       AMBULANCE SERVICE PART)       0.563181       91.0         95.00       09500       AMBULANCE SERVICES       0.448038       95.0         200.00       Subtotal (see instructions)       200.0       201.00       24056       201.00							90.04
90.09         09009         GASTROENTEROLOGY CLINIC         0.00000         90.0           90.11         09011         NEUROLOGY CLINIC         0.001986         90.0           90.12         09012         OPTHAMOLOGY CLINIC         0.000000         90.0           90.13         09013         ALLERGY CLINIC         0.294056         90.0           90.14         09014         WOUND CARE         0.297707         90.0           91.00         09100         EMERGENCY         0.182331         91.0           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         0.563181         91.0           07HER         REIMBURSABLE COST CENTERS         0.448038         95.0           95.00         09500         AMBULANCE SERVICES         0.448038         200.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00         201.00         201.00         201.00							90.05
90.11       09011       NEUROLOGY CLINIC       0.001986       90.1         90.12       09012       OPTHAMOLOGY CLINIC       0.000000       90.1         90.13       09013       ALLERGY CLINIC       0.294056       90.1         90.14       09014       WOUND CARE       0.297707       90.1         91.00       09100       EMERGENCY       0.182331       91.0         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       0.563181       92.0         001HER       REI MBURSABLE COST CENTERS       95.0       95.00       95.00         90.00       Subtotal (see instructions)       0.448038       95.0       200.00         201.00       Less Observation Beds       0.2418038       200.00       201.00							90.07
90.12         09012         0PTHAMOLOGY CLINIC         0.000000         90.1           90.13         09013         ALLERGY CLINIC         0.294056         90.1           90.14         09014         WOUND CARE         0.297707         90.1           91.00         09100         EMERGENCY         0.182331         91.0           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         0.563181         91.0           0THER REIMBURSABLE COST CENTERS         0.448038         95.0           200.00         Subtotal (see instructions)         0.448038         200.0           201.00         Less Observation Beds         201.0         201.00							90.09
90.13       09013       ALLERGY CLINIC       0.294056       90.1         90.14       09014       WOUND CARE       0.297707       90.1         91.00       09100       EMERGENCY       0.182331       91.0         92.0       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.563181       91.0         95.00       09500       AMBULANCE SERVICES       0.448038       95.0         200.00       Subtotal (see instructions)       200.0       201.00       201.00       201.00       201.00       201.00       201.00							90.11
90. 14         09014         WOUND CARE         0. 297707         90. 1           91. 00         09100         EMERGENCY         0. 182331         91. 0           92. 00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0. 563181         92. 0           0THER         REIMBURSABLE COST CENTERS         95. 0         09500         AMBULANCE SERVICES         0. 448038         95. 0           200. 00         Subtotal (see instructions)         Less Observation Beds         200. 0         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00         201. 00							90.12
91.00         09100         EMERGENCY         0.182331         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0.563181         92.0           0THER         REI MBURSABLE COST CENTERS         95.00         9500         AMBULANCE SERVICES         0.448038         95.0           200.00         Subtotal (see instructions)         Less Observation Beds         201.0         201.0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201							90.13
92.00         O9200         OBSERVATION BEDS (NON-DISTINCT PART)         0.563181         92.0           OTHER REIMBURSABLE COST CENTERS         0.448038         95.0         95.00         9500         AMBULANCE SERVICES         0.448038         95.0         95.00         95.00         200.00         Subtotal (see instructions)         200.00         201.00         Less Observation Beds         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00							90.14
OTHER REIMBURSABLE COST CENTERS         95.00       09500       AMBULANCE SERVI CES       0. 448038       95.0         200.00       Subtotal (see instructions)       200.00       200.00       200.00       201.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.0							91.00
95.00         09500         AMBULANCE SERVICES         0.448038         95.0           200.00         Subtotal (see instructions)         200.0         200.0         200.0         200.0           201.00         Less Observation Beds         201.0         201.0         201.0         201.0			0. 563181				92.00
200.00Subtotal (see instructions)200.0201.00Less Observation Beds201.0							0.0.0.0
201.00 Less Observation Beds 201.0			0. 448038				95.00
							200.00
							201.00
	202.00	Total (see instructions)					202.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	F	Period: From 01/01/2016	Worksheet C Part I	norodi
				To 12/31/2016	Date/Time Pre 5/26/2017 10:	44 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 964, 220		7, 964, 220		7, 964, 220	1
31. 00 03100 I NTENSI VE CARE UNI T	2,637,728		2, 637, 728		2, 637, 728	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	2, 775, 355 0		2, 775, 355		2, 809, 673 0	40.00
41.00 04100 SUBPROVI DER	0			-	0	41.00
43. 00 04300 NURSERY	12, 941		12, 94	-	12, 941	43.00
44.00 04400 SKI LLED NURSI NG FACI LI TY	2, 363, 237		2, 363, 23		2, 363, 237	
ANCI LLARY SERVICE COST CENTERS					,,	
50. 00 05000 OPERATI NG ROOM	4, 751, 855		4, 751, 855		4, 751, 855	
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 338, 138		5, 338, 138		5, 338, 138	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		(7,1,00)	-	0	55.00
55. 01 05501 ULTRA SOUND	674,096		674,096		674,096	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 010, 734 1, 269, 653		1, 010, 734 1, 269, 653		1, 010, 734 1, 269, 653	
59. 00 05900 CARDI AC CATHETERI ZATI ON	644, 511		644, 51		644, 511	
60. 00 06000 LABORATORY	7, 937, 433		7, 937, 433		7, 937, 433	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	91, 957		91, 95		91, 957	
64.00 06400 INTRAVENOUS THERAPY	3, 297		3, 297		3, 297	64.00
66. 00 06600 PHYSI CAL THERAPY	3, 109, 444	0			3, 109, 444	66.00
67.00 06700 OCCUPATI ONAL THERAPY	607, 120	0	607, 120	0 0	607, 120	67.00
67. 01 06701 AUDI OLOGY	245, 740	0	245, 740	0 0	245, 740	
68.00 06800 SPEECH PATHOLOGY	188, 598	0			188, 598	1
69. 00 06900 ELECTROCARDI OLOGY	0		)	-	0	69.00
69. 01 06901 CARDI OLOGY	1, 716, 042		1, 716, 042		1, 716, 042	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 998, 281 4, 603, 060		2, 998, 28 ² 4, 603, 060		2, 998, 281 4, 603, 060	1
73. 00 07300 DRUGS CHARGED TO PATTENT	2, 151, 451		2, 151, 45		2, 151, 451	72.00
OUTPATIENT SERVICE COST CENTERS	2,101,401	L	2,101,40		2, 131, 431	/ 5. 00
90. 00 09000 CLINIC	0		(	0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	931, 535		931, 535	5 0	931, 535	90.01
90. 02 09002 CLINIC	67, 849		67, 849	9 0	67, 849	1
90. 03 09003 DERMATOLOGY CLINIC	0		(		0	90.03
90. 04 09004 ENT CLINIC	0		(	-	0	90.04
90. 05 09005 SURGERY CLINIC	10		10		10	
90. 07  09007  UROLOGY CLINIC 90. 09  09009  GASTROENTEROLOGY CLINIC	2, 276 8, 840		2, 276 8, 840		2, 276 8, 840	1
90. 11  09011  NEUROLOGY CLINIC	172		172		172	
90. 12 09012 OPTHAMOLOGY CLINIC	6, 459		6, 459		6, 459	1
90. 13 09013 ALLERGY CLINIC	191, 272		191, 272		191, 272	
90. 14 09014 WOUND CARE	908, 801		908, 80			
91.00 09100 EMERGENCY	5, 550, 296		5, 550, 296		5, 550, 296	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 468, 638		1, 468, 638	3	1, 468, 638	92.00
OTHER REIMBURSABLE COST CENTERS	0.011.051		0.011.77		0.011.051	05 00
95.00 09500 AMBULANCE SERVICES	2, 811, 394		2, 811, 394		2,811,394	
200.00Subtotal (see instructions)201.00Less Observation Beds	65, 042, 433 1, 468, 638		65, 042, 433 1, 468, 638		65, 076, 751 1, 468, 638	
202.00 Total (see instructions)	63, 573, 795					
		0	1 00,010,170	01,010	00,000,110	

Health Fina	ncial Systems	WI THAM MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016	Date/Time Pre 5/26/2017 10:	epared: 44 am
				e XIX	Hospi tal	Cost	
			Charges			TEEDA	
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
				+ COL. 7)	Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDIATRICS	12, 638, 150		12, 638, 15			30.00
		3, 671, 401		3, 671, 40			31.00
	O SUBPROVIDER - IPF	3, 008, 160		3, 008, 16			40.00
	0 SUBPROVI DER – I RF 0 SUBPROVI DER	0			0		41.00
	0 NURSERY	1, 528, 801		1, 528, 80	-		42.00
	O SKILLED NURSING FACILITY	2, 210, 215		2, 210, 21			44.00
	LLARY SERVICE COST CENTERS	2/210/210					
	O OPERATING ROOM	7, 791, 694	34, 733, 480	42, 525, 17	4 0. 111742	0. 000000	50.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	1, 330, 051	17, 491, 261	18, 821, 31	2 0. 283622	0.000000	54.00
	0 RADI OLOGY-THERAPEUTI C	0	0		0 0. 000000	0. 000000	
	1 ULTRA SOUND	482, 643	7, 679, 699			0. 000000	
	O CT SCAN	4, 114, 196	32, 299, 696			0.00000	
	O MAGNETIC RESONANCE IMAGING (MRI)	546, 973	14,055,625			0.00000	
	O CARDI AC CATHETERI ZATI ON	1, 138, 960	2, 189, 666			0.00000	
	O LABORATORY O BLOOD STORING, PROCESSING & TRANS.	8, 597, 820 395, 908	41, 472, 445 400, 678			0. 000000 0. 000000	
	O I NTRAVENOUS THERAPY	1, 200, 838	1, 432, 847			0. 000000	
	O PHYSI CAL THERAPY	2, 179, 538	5, 442, 077			0. 000000	
	O OCCUPATI ONAL THERAPY	2,043,203	633, 076			0. 000000	
	1 AUDI OLOGY	0	1,044,246			0.000000	
68.00 0680	O SPEECH PATHOLOGY	130, 718	572, 764	703, 48	2 0. 268092	0. 000000	68.00
	0 ELECTROCARDI OLOGY	0	0		0 0. 000000	0. 000000	
	1 CARDI OLOGY	4, 650, 191	6, 708, 746			0.000000	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 754, 347	3, 453, 667			0.00000	
	O I MPL. DEV. CHARGED TO PATI ENT	3, 376, 893	5, 146, 920			0.00000	
	O DRUGS CHARGED TO PATIENTS ATIENT SERVICE COST CENTERS	6, 699, 242	7,031,006	13, 730, 24	8 0. 156694	0. 000000	73.00
	O CLINIC	0	0		0 0. 000000	0. 000000	90.00
	1 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0.000000	0. 000000	
	2 CLINIC	0	0		0.000000	0. 000000	
90.03 0900	3 DERMATOLOGY CLINIC	0	0		0. 000000	0. 000000	90.03
90.04 0900	4 ENT CLINIC	0	0		0. 000000	0. 000000	90.04
	5 SURGERY CLINIC	0	0		0 0. 000000	0. 000000	
	7 UROLOGY CLINIC	1, 307	139, 703			0. 000000	
	9 GASTROENTEROLOGY CLINIC	0	0		0 0. 000000	0.00000	
	1 NEUROLOGY CLINIC	0	86, 589			0.00000	
	2 OPTHAMOLOGY CLINIC	0 59	0 450 403		0 0.000000	0.00000	
	3 ALLERGY CLINIC 4 WOUND CARE	29, 266	650, 402 3, 023, 408			0. 000000 0. 000000	
	0 EMERGENCY	3, 513, 518	26, 927, 267			0. 000000	
	O OBSERVATION BEDS (NON-DISTINCT PART)	0, 515, 516	2, 607, 754			0. 000000	
	R REIMBURSABLE COST CENTERS	· · · · ·					
	O AMBULANCE SERVI CES	13, 858	6, 261, 037			0.00000	
200.00	Subtotal (see instructions)	74, 047, 950	221, 484, 059	295, 532, 00	9		200.00
201.00	Less Observation Beds	74 6 17 65	004 101 5	005 500 55			201.00
202.00	Total (see instructions)	74, 047, 950	221, 484, 059	295, 532, 00	۲ <u> </u>		202.00

Heal th Financial Systems         WI THAM MEMORIAL HOSPITAL         In Lieu of Fo           COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-0104         Period: From 01/01/2016 To 12/31/2016         Period: From 01/01/2016 To 12/31/2016         Pate/1           Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital           INPATIENT ROUTINE SERVICE COST CENTERS         11.00         Title XIX         Hospital           30:00 03000 ADULTS & PEDIATRICS         11.00         14.00         4.00         6.00         5.00         0.00000 SUBPROVIDER - IPF         4.00         4.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00         6.00	eet C
To         12/31/2016         Date/1 5/26/2           Title XIX         Hospital           Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital           INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000         ADULTS & PEDIATRICS         11.00           INPATIENT ROUTINE SERVICE COST CENTERS           31.00         03100         INTENSIVE CARE UNIT         40.00           0.4000         SUBPROVIDER - IPF         41.00         41.00           41.00         04200         SUBPROVIDER         42.00           42.00         04200         SUBPROVIDER         42.00           43.00         04300         NULED. NURSING FACILITY         44.00           ANCILLARY SERVICE COST CENTERS         0.000000         55.00           50.00         05500         RADIOLOGY-DIAGNOSTIC         0.000000           51.00         05500         RADIOLOGY-THERAPEUTIC         0.000000           55.00         05500         RADIOLOGY-THERAPEUTIC         0.000000           58.00         05800         MARNETIC RESONANCE IMAGING (MRI )         0.000000           59.00         05900         CATHETERIZATION         0.0000000           60.00 <td>ime Prepared: 017 10:44 am</td>	ime Prepared: 017 10:44 am
Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital           INPATIENT ROUTINE SERVICE COST CENTERS         11.00         11.00         11.00           INPATIENT ROUTINE SERVICE COST CENTERS         11.00         11.00         11.00           VA000 SUBPROVIDER - IPF         11.00         11.00         11.00         11.00           A0.00 (04000 SUBPROVIDER - IPF         10.00         10.00         10.00         10.00         10.00         10.00         10.00           41.00 (04100 SUBPROVIDER - IPF         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00 </td <td>017 10:44 am</td>	017 10:44 am
Image: Cost Center Description         PPS Inpatient Ratio         Inpatient Ratio           0         03000         ADULTS & PEDIATRICS         11.00           1         0.00         03000         ADULTS & PEDIATRICS         11.00           30.00         03000         ADULTS & PEDIATRICS         11.00           40.00         04000         SUBPROVI DER - 1 PF         11.00           41.00         04100         SUBPROVI DER - 1 RF         11.00           42.00         04200         SUBPROVI DER         18F           43.00         04300         NURSERY         11.00           44.00         O4400         SKILLED NURSING FACILITY         0.000000           55.00         05000         OPERATING ROOM         0.000000           55.01         05500         RADIOLOGY-THERAPEUTIC         0.000000           55.01         05501         ULTRA SOUND         0.000000           55.01         05500         CADH CATHERIZATION         0.000000           55.01         05500         CADH CATHERIZATION         0.000000           55.01         05500         CADH AC CATHERIZATION         0.000000           56.00         05600         ABORATORY         0.0000000           59.00 <td></td>	
Cost Center Description         PPS Inpatient Ratio           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           11.00           0.000           0.000           0.000           0.000           0.000           0.00000           0.00000           0.00000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000           0.000000	0031
Ratio           30.00         03000         ADULTS & PEDIATRICS           31.00         03100         INTENSIVE CARE UNIT           40.00         04000         SUBPROVIDER - IPF           41.00         04100         SUBPROVIDER - IFF           42.00         04200         SUBPROVIDER           43.00         04300         NURSERY           44.00         O4400         SKI LLED NURSI NG FACI LI TY           ANCI LLARY SERVICE COST CENTERS         0.000000           50.00         05500         OPERATI NG ROOM         0.000000           54.00         O5400         RADI OLOGY-DI AGNOSTI C         0.000000           55.01         0LTRA SOUND         0.000000         0.000000           55.01         0LTRA SOUND         0.000000         0.000000           57.00         05700         CT SCAN         0.000000           58.00         05800 MAGNETI C RESONANCE I MAGI NG (MRI )         0.000000           59.00         OS900 CARDI AC CATHETERI ZATI ON         0.000000           60.00         06300         BLODD STORI NG, PROCESSI NG & TRANS.         0.000000           63.00         06300         BLODD STORI NG, PROCESSI NG & TRANS.         0.000000           64.00         06400	
11.00           INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRI CS           31.00         03100 INTENSI VE CARE UNI T           40.00         04000 SUBPROVI DER - IPF           41.00         04100 SUBPROVI DER - IRF           42.00         04200 SUBPROVI DER - IRF           43.00         04300 NRSERY           44.00         04400 SKI LLED NURSI NG FACI LI TY           ANCI LLARY SERVICE COST CENTERS           50.00         055000 OPERATI NG ROM           0.000000         0.000000           55.01         05500 RADI OLOGY-THERAPEUTI C           0.000000         0.000000           55.01         05500 ULTRA SOUND           0.000000         0.000000           55.01         05500 ULTRA SOUND           0.000000         0.000000           58.00         05800 MAGNETI C RESONANCE IMAGI NG (MRI )           0.000000         0.000000           59.00         05900 CARDI AC CATHETERI ZATI ON           0.000000         0.000000           63.00         0.6300 BLODD STORI NG, PROCESSI NG & TRANS.           0.000000         0.6400 INTRAVENOUS THERAPY           0.000000         0.6400 INTRAVENUS THERAPY           0.000000 <td></td>	
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRICS           31.00         03100 INTENSIVE CARE UNIT           40.00         04000 SUBPROVIDER - IPF           41.00         04100 SUBPROVIDER - IRF           42.00         04200 SUBPROVIDER           43.00         04300 NURSERY           44.00         04400 SKILLED NURSING FACILITY           ANCILLARY SERVICE COST CENTERS           50.00         05500 OPERATING ROOM           0.000000         05500 RADIOLOGY-THERAPEUTIC           0.000000         059.00 O5500 RADIOLOGY-THERAPEUTIC           0.000000         059.00 O5500 RADIOLOGY-THERAPEUTIC           0.000000         059.00 O5500 CARDIAC CATHETERIZATION           0.000000         059.00 O5500 CARDIAC CATHETERIZATION           0.000000         059.00 O5900 CARDIAC CATHETERIZATION           0.000000	
30.00       03000       ADULTS & PEDIATRICS         31.00       03100       INTENSIVE CARE UNIT         40.00       04000       SUBPROVIDER - IPF         41.00       O4100       SUBPROVIDER - IRF         42.00       04200       SUBPROVIDER         43.00       04300       NURSERY         44.00       O4400       SKILLED NURSING FACILITY         ANCILLARY SERVICE COST CENTERS       0.000000         50.00       05000       OPERATING ROM       0.000000         54.00       05400 RADIOLOGY-DIAGNOSTIC       0.000000         55.00       05500 RADIOLOGY-THERAPEUTIC       0.000000         55.01       ULTRA SOUND       0.000000         55.00       05500 CT SCAN       0.000000         57.00       05500 MAGNETIC RESONANCE IMAGING (MRI)       0.000000         58.00       05800 MAGNETIC RESONANCE IMAGING (MRI)       0.000000         59.00       05900 CARDIAC CATHETERIZATION       0.000000         60.00       06000 LABORATORY       0.000000         63.00       06300 BLODD STORING, PROCESSING & TRANS.       0.000000         64.00       OHTRAVENOUS THERAPY       0.000000         64.00       OHTRAVENOUS THERAPY       0.0000000         67	
31.00       03100       INTENSIVE CARE UNIT         40.00       04000       SUBPROVIDER - IPF         41.00       04100       SUBPROVIDER - IRF         42.00       04200       SUBPROVIDER         43.00       04400       SKILLED NURSING FACILITY         ANCILLARY SERVICE COST CENTERS	30.00
40.00       04000       SUBPROVI DER - 1 PF         41.00       04100       SUBPROVI DER - 1 RF         42.00       04200       SUBPROVI DER         43.00       04300       NURSERY         44.00       O4400       SKI LLED         ANCI LLARY SERVI CE COST CENTERS       ANCI LLARY SERVI CE COST CENTERS         50.00       05000       OPERATI NG ROOM       0.000000         54.00       05400       RADI OLGY-DI AGNOSTI C       0.000000         55.01       05500       RADI OLGY-THERAPEUTI C       0.000000         55.01       05500       CT SCAN       0.000000         57.00       05700       CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         58.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       064000       INTRAVENOUS THERAPY       0.000000         64.00       INTRAVENOUS THERAPY       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0.000000	31.00
41.00       04100       SUBPROVI DER - 1 RF         42.00       04200       SUBPROVI DER         43.00       04300       NURSERY         44.00       04400       SKI LLED NURSI NG FACI LI TY         ANCI LLARY SERVI CE COST CENTERS	40.00
42.00       04200       SUBPROVI DER         43.00       04300       NURSERY         44.00       04400       SKI LLED       NURSI NG         ANCI LLARY       SERVI CE       COST         ANCI LLARY       SERVI CE       COST         50.00       05000       OPERATI NG       O.         54.00       05500       OPERATI NG ROOM       O.         55.00       05500       RADI OLOGY - DI AGNOSTI C       O.       0.000000         55.01       05501       ULTRA SOUND       O.       0.000000         55.01       05501       ULTRA SOUND       O.       0.000000         57.00       05700       CT       SCAN       O.       0.000000         58.00       05800       MAGNETI C       RESONANCE I MAGI NG (MRI )       O.       0.000000         58.00       05900       CARDI AC       CATHETERI ZATI ON       O.       0.000000         64.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       O.       0.000000         63.00       064001       NTRAVENOUS THERAPY       O.       0.000000         64.00       064001       NTRAVENOUS THERAPY       O.       0.000000         66.00       066000	41.00
43.00       04300       NURSERY         44.00       04400       SKI LLED NURSI NG FACI LI TY         ANCI LLARY SERVI CE COST CENTERS         50.00       05000       OPERATI NG ROOM         51.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000         55.01       05501       ULTRA SOUND       0.000000         55.01       05500       CT SCAN       0.000000         57.00       05700       CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         58.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       06000       LABORATORY       0.000000         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000         64.00       064001       NTRAVENOUS THERAPY       0.000000         66.00       066000       PHYSI CAL THERAPY       0.000000         67.00       0CUPATI ONAL THERAPY       0.000000	42.00
44.00       04400       SKI LLED NURSI NG FACI LI TY         ANCI LLARY SERVI CE COST CENTERS         50.00       05000       OPERATI NG ROOM       0.000000         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000         55.01       05500       RADI OLOGY-THERAPEUTI C       0.000000         57.00       05500       CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         58.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       06000       LABORATORY       0.000000         63.00       06400 I NTRAVENOUS THERAPY       0.000000         64.00       06400 I NTRAVENOUS THERAPY       0.000000         67.00       06700 OCUPATI ONAL THERAPY       0.000000	43.00
ANCILLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0.000000           54.00         05400         RADIOLOGY-DIAGNOSTIC         0.000000           55.00         05500         RADIOLOGY-THERAPEUTIC         0.000000           55.01         05500         RADIOLOGY-THERAPEUTIC         0.000000           57.00         05700         CT SCAN         0.000000           58.00         05800         MAGNETIC RESONANCE I MAGI NG (MRI)         0.000000           59.00         05900         CARDIAC CATHETERIZATION         0.000000           60.00         06000         LABORATORY         0.000000           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0.000000           64.00         06400 I NTRAVENOUS THERAPY         0.000000           67.00         06700         OCCUPATIONAL THERAPY         0.000000	44.00
50.00       05000       OPERATING ROOM       0.000000         54.00       05400       RADI 0L0GY-DI AGNOSTI C       0.000000         55.00       OS500       RADI 0L0GY-THERAPEUTI C       0.000000         55.01       05501       ULTRA SOUND       0.000000         57.00       05700 CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       06000       LABORATORY       0.000000         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000         64.00       06400 I NTRAVENOUS THERAPY       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0.000000	
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0.000000         55. 00       05500       RADI OLOGY-THERAPEUTI C       0.000000         55. 01       05501       ULTRA SOUND       0.000000         57. 00       05700       CT SCAN       0.000000         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60. 00       06000       LABORATORY       0.000000         63. 00       06400       I NTRAVENOUS THERAPY       0.000000         64. 00       06600       PHYSI CAL THERAPY       0.000000         67. 00       06700       OCCUPATI ONAL THERAPY       0.000000	50.00
55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000         55.01       05501       ULTRA SOUND       0.000000         57.00       05700       CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       06000       LABORATORY       0.000000         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0.000000	54.00
55. 01       05501       ULTRA SOUND       0.000000         57. 00       05700       CT SCAN       0.000000         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         59. 00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60. 00       06000       LABORATORY       0.000000         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000         64. 00       06400       INTRAVENOUS THERAPY       0.000000         66. 00       06600       PHYSI CAL THERAPY       0.000000         67. 00       06700       OCUPATI ONAL THERAPY       0.000000	55.00
57.00       05700       CT SCAN       0.000000         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0.000000         60.00       06000       LABORATORY       0.000000         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         66.00       06600       PHYSI CAL THERAPY       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0.000000	55.01
59. 00       05900       CARDI AC CATHETERI ZATI ON       0. 000000         60. 00       06000       LABORATORY       0. 000000         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0. 000000         64. 00       06400       I NTRAVENOUS THERAPY       0. 000000         66. 00       06600       PHYSI CAL THERAPY       0. 000000         67. 00       06700       OCUPATI ONAL THERAPY       0. 000000	57.00
59. 00       05900       CARDI AC CATHETERI ZATI ON       0. 000000         60. 00       06000       LABORATORY       0. 000000         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0. 000000         64. 00       06400       I NTRAVENOUS THERAPY       0. 000000         66. 00       06600       PHYSI CAL THERAPY       0. 000000         67. 00       06700       OCUPATI ONAL THERAPY       0. 000000	58.00
60.00         06000         LABORATORY         0.000000           63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0.000000           64.00         06400         INTRAVENOUS THERAPY         0.000000           66.00         06600         PHYSICAL THERAPY         0.000000           67.00         06700         OCCUPATI ONAL THERAPY         0.000000	59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000         64.00       06400       INTRAVENOUS THERAPY       0.000000         66.00       06600       PHYSICAL THERAPY       0.000000         67.00       06700       OCCUPATI ONAL THERAPY       0.000000	60.00
64.00         06400         INTRAVENOUS THERAPY         0.000000           66.00         06600         PHYSI CAL THERAPY         0.000000           67.00         06700         OCCUPATI ONAL THERAPY         0.000000	63.00
66.00         06600         PHYSI CAL THERAPY         0.000000           67.00         06700         OCCUPATI ONAL THERAPY         0.000000	64.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000	66.00
	67.00
	67.01
68. 00 06800 SPEECH PATHOLOGY 0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000	69.00
69. 01 06901 CARDI 0L0GY 0. 000000	69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000	73.00
OUTPATI ENT SERVI CE COST CENTERS	
90. 00 09000 CLINIC 0. 000000	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER 0. 000000	90.01
90. 02 09002 CLINIC 0. 000000	90.02
90. 03 09003 DERMATOLOGY CLINIC 0. 000000	90.03
90. 04 09004 ENT CLINIC 0. 000000	90.04
90. 05 09005 SURGERY CLINIC 0. 000000	90.05
90. 07 09007 UROLOGY CLINIC 0. 000000	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC 0. 000000	90.09
90. 11 09011 NEUROLOGY CLINIC 0. 000000	90.11
90. 12 09012 OPTHAMOLOGY CLINIC 0. 000000	90.12
90. 13 09013 ALLERGY CLINIC 0. 000000	90.13
90. 14 09014 WOUND CARE 0. 000000	90.14
91. 00 09100 EMERGENCY 0. 000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 0. 000000	95.00
200.00 Subtotal (see instructions)	200.00
201.00 Less Observation Beds	201.00
202.00 Total (see instructions)	202.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	-	Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	957, 083	0	957, 08	3 6, 258	152.94	30.00
31.00 INTENSIVE CARE UNIT	267, 626		267, 62		159.02	31.00
40.00 SUBPROVIDER - IPF	319, 264	0	319, 26	4 2,755	115.89	40.00
41.00 SUBPROVIDER – IRF	0	0		0 0	0.00	41.00
42.00 SUBPROVI DER	0	0		0 0	0.00	42.00
43.00 NURSERY	449		44	9 993	0.45	43.00
44.00 SKILLED NURSING FACILITY	269, 550		269, 55	0 4, 390	61.40	44.00
200.00 Total (lines 30-199)	1, 813, 972		1, 813, 97	2 16, 079		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 274					30.00
31.00 INTENSIVE CARE UNIT	847					31.00
40. 00 SUBPROVIDER - IPF	2, 338	270, 951				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	3, 286					44.00
200.00 Total (lines 30-199)	8, 745	955, 187				200.00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0104	Period: From 01/01/2016 To 12/31/2016		
		Title	e XVIII	Hospi tal	PPS	44 dili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center beschiption	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)	ondi goo		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	646, 149	42, 525, 174	0. 01519	95 4, 266, 166	64, 824	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	807, 761	18, 821, 312	0. 0429	17 780, 457	33, 495	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.00
55. 01 05501 ULTRA SOUND	7,666	8, 162, 342	0.00093	39 244, 077	229	55.01
57. 00 05700 CT SCAN	10, 221	36, 413, 892	0.00028	2, 057, 312	578	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	73, 575	14, 602, 598	0.00503	38 316, 286	1, 593	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	57, 247			98 419, 102	7, 208	59.00
60. 00 06000 LABORATORY	398, 132	50, 070, 265	0.00795	51 4, 395, 475	34, 948	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	529	796, 586			90	63.00
64.00 06400 INTRAVENOUS THERAPY	18	2, 633, 685	0.0000	503, 413		64.00
66. 00 06600 PHYSI CAL THERAPY	359, 554	7, 621, 615	0.0471	76 309, 455	14, 599	66.00
67.00 06700 OCCUPATI ONAL THERAPY	6, 789				425	67.00
67. 01 06701 AUDI OLOGY	1, 991	1, 044, 246	0. 00190		-	67.01
68.00 06800 SPEECH PATHOLOGY	1, 457					68.00
69. 00 06900 ELECTROCARDI OLOGY	0	-			0	69.00
69. 01 06901 CARDI OLOGY	53, 024					•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 282				3, 293	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	26, 459				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 413	13, 730, 248	0.0010	50 2, 922, 645	3, 069	73.00
OUTPATIENT SERVICE COST CENTERS	1 .		1			
90. 00 09000 CLINIC	0	-			-	
90. 01 09001 OTHER OUTPATI ENT SERVICE COST CENTER	164, 840					
90. 02 09002 CLINIC	7, 792				-	90.02
90. 03 09003 DERMATOLOGY CLINIC	0					90.03
90. 04 09004 ENT CLINIC	0	-	0.0000			90.04
90. 05 09005 SURGERY CLINIC	1	0				90.05
90. 07 09007 UROLOGY CLINIC	114				-	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	64		0.0000.		-	90.09
90. 11 09011 NEUROLOGY CLINIC	2				-	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	37		0.0000.		-	90.12
90. 13 09013 ALLERGY CLINIC	1, 199					90.13
90. 14 09014 WOUND CARE	135, 889					90.14
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	950, 690				57, 154 0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	176, 491	2,607,754	0.0676	79 0	0	92.00
95. 00 09500 AMBULANCE SERVICES			1			95.00
200.00 Total (lines 50-199)	3, 919, 386	266, 200, 387		21, 947, 859	232, 676	•
	5, 717, 300	200, 200, 307	I	21, 747, 007	232,070	1200.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 10:	pared: 44 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Education	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	·		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	0		o o	0	40.00
41. 00 04100 SUBPROVI DER – I RF	0	0		o o	0	41.00
42. 00 04200 SUBPROVI DER	0	0		o o	0	42.00
43. 00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		-	0	44.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	Inpati ent	I npati ent	-	
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
		0011 0)		Cost (col. 7		
				x col. 8)		
	6, 00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 258	0.00	2, 27	4 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 683	0.00				31.00
40. 00 04000 SUBPROVI DER - I PF	2, 755	0.00				40.00
41. 00 04100 SUBPROVIDER - IRF	2,700	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0 0		42.00
43. 00 04300 NURSERY	993	0.00				43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	4, 390			6 0		44.00
200.00 Total (lines 30-199)	16, 079	0.00	8, 74			200.00
	10,073		1 0,74	J 0		200.00

	nancial Systems	WI THAM MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0104	Period:	Worksheet D	
THROUGH (	COSTS				From 01/01/2016	Part IV	
					To 12/31/2016	Date/Time Pre 5/26/2017 10:	apared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing	Allied Healt		Total Cost	
	boot bontor bootription	Anestheti st	School		Medi cal	(sum of col 1	
		Cost	0011001		Education	through col.	
		0001			Cost	4)	
		1.00	2.00	3.00	4.00	5.00	
AN	CILLARY SERVICE COST CENTERS						
50.00 05	000 OPERATING ROOM	0	0		0 (	0 0	50.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	ol o	54.00
	500 RADI OLOGY-THERAPEUTI C	0	0		0 0	ol o	55.00
	501 ULTRA SOUND	0	0		0 0	ol o	55.01
	700 CT SCAN	0	0		0 0	ol o	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		
	900 CARDI AC CATHETERI ZATI ON	0	0		0 0		
	000 LABORATORY	0	0		0 0		
	300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	-	
	400 I NTRAVENOUS THERAPY	0	0		0 0		
	600 PHYSI CAL THERAPY	0	0		0 0	-	
	700 OCCUPATI ONAL THERAPY	0	0		0 0		
	701 AUDI OLOGY	0	0		0 0	°	01100
	800 SPEECH PATHOLOGY	0	0				
	900 ELECTROCARDI OLOGY	0	0		0 0	-	
	901 CARDI OLOGY	0	0		0 0		
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	-	
	200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	-	
	300 DRUGS CHARGED TO PATIENTS	0	0		0 0		
	TPATIENT SERVICE COST CENTERS	•	0	I		<u>,                                     </u>	/0.00
		0	0		0 (	0 0	90.00
	001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		0 0		
	002 CLINIC	0	0		0 0		
	003 DERMATOLOGY CLINIC	0	0		0 0		
	004 ENT CLINIC	0	0		0 0	-	
	005 SURGERY CLINIC	0	0		0 0		
	007 UROLOGY CLINIC	0	0		0 0		
	009 GASTROENTEROLOGY CLINIC	0	0		0 0		
	011 NEUROLOGY CLINIC	0	0		0 0		
	012 OPTHAMOLOGY CLINIC	0	0		0 0		
	013 ALLERGY CLINIC	0	0		0 0		90.12
	014 WOUND CARE	0	0		0 0	-	
	100 EMERGENCY	0	0		0 0	-	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0		
	HER REIMBURSABLE COST CENTERS		0	1			,2.00
	500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0		0 0	n n	200.00
	1	9	0	I	-1		

Health Financial Systems	WI THAM MEMORI			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	SS Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016	Part IV	norod
				10 12/31/2010	Date/Time Pre 5/26/2017 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges		0utpatient	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col . 6 ÷	goo	
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	42, 525, 174	0.00000	0 0.000000	4, 266, 166	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
55. 01 05501 ULTRA SOUND	0					55.01
57.00 05700 CT SCAN	0					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				316, 286	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					
60. 00 06000 LABORATORY	0				4, 395, 475	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				135, 097	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0					
66. 00 06600 PHYSI CAL THERAPY	0	_,,				
67. 00 06700 OCCUPATI ONAL THERAPY	0	.,				
67. 01 06701 AUDI OLOGY	0					67.01
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
69. 01 06901 CARDI OLOGY	0					•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0					•
OUTPATIENT SERVICE COST CENTERS		10,700,210	0.00000	0.000000	2,722,010	/0.00
90. 00 09000 CLINIC	0	0	0.00000	0 0.000000	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0					90.01
90. 02 09002 CLINIC	0	-				90.02
90. 03 09003 DERMATOLOGY CLINIC	0	-				90.03
90. 04 09004 ENT CLINIC	0	-			0	90.04
90. 05 09005 SURGERY CLINIC	0	-			0	90.05
90. 07 09007 UROLOGY CLINIC	0	-			0	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0				0	90.09
90. 11 09011 NEUROLOGY CLINIC	0				0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC		00,00,			0	90.12
90. 13 09013 ALLERGY CLINIC					0	90.13
90. 14 09014 WOUND CARE	0				-	90.14
91. 00 09100 EMERGENCY	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS		2,007,704	0.0000	0.00000	0	12.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	266, 200, 387			21, 947, 859	
			1	1		

Heal th Financi		WI THAM MEMORIA			In Lie	u of Form CMS-	2552-10
APPORTI ONMENT THROUGH COSTS	OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016		
				XVIII	Hospi tal	PPS	
Ci	ost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h		
		11.00	12.00	13.00			
	RY SERVICE COST CENTERS			1			
50.00         05000 01           54.00         05400 R           55.01         05501 U           57.00         05501 U           57.00         05700 C           58.00         05800 M           59.00         05900 C           60.00         06000 L           63.00         06300 B           64.00         06400 L           65.00         06600 P           67.00         06701 A           68.00         06800 S           69.00         06900 E           69.01         06901 C           71.00         07100 M           72.00         07200 I           73.00         07300 D	PERATI NG ROOM ADI OLOGY-DI AGNOSTI C ADI OLOGY-THERAPEUTI C LTRA SOUND T SCAN AGNETI C RESONANCE I MAGI NG (MRI) ARDI AC CATHETERI ZATI ON ABORATORY LOOD STORI NG, PROCESSI NG & TRANS. NTRAVENOUS THERAPY HYSI CAL THERAPY CCUPATI ONAL THERAPY UDI OLOGY PEECH PATHOLOGY LECTROCARDI OLOGY ARDI OLOGY PEL DEV. CHARGED TO PATI ENTS MPL. DEV. CHARGED TO PATI ENT RUGS CHARGED TO PATI ENTS		10, 608, 077 4, 261, 846 0 1, 470, 853 8, 343, 211 4, 681, 564 915, 606 4, 314, 443 150, 345 296, 551 19, 822 7, 514 138, 837 225 0 0 2, 655, 126 793, 550 68, 448 1, 708, 131		0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 50.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 01\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 63.\ 00\\ 64.\ 00\\ 64.\ 00\\ 67.\ 01\\ 68.\ 00\\ 67.\ 01\\ 68.\ 00\\ 69.\ 01\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
90.00         09000         CI           90.01         09001         0'           90.02         09002         CI           90.03         09003         DI           90.04         09004         EI           90.05         09005         SI           90.07         09007         UI           90.08         09009         G/           90.11         09011         NI           90.12         09012         OI           90.13         09013         AI           90.14         09014         WI           91.00         09100         EI           92.00         09200         00	THER OUTPATIENT SERVICE COST CENTER		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 90.07 90.07 90.11 90.12 90.13 90.14 91.00 92.00
95.00 09500 AI	MBULANCE SERVICES otal (lines 50-199)	0	47, 160, 536		0		95.00 200.00

Health Financial Systems	WI THAM MEMORI				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2016 To 12/31/2016		epared:
		Title	e XVIII	Hospi tal	PPS	<u>44 alli</u>
			Charges	illoopi tui	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		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. 111742		6, 6	'1 8	1, 185, 368	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 283622			4 0	1, 208, 753	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
55.01 05501 ULTRA SOUND	0. 082586			0 0	121, 472	•
57.00 05700 CT SCAN	0. 027757	8, 343, 211		0 5,830	231, 583	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 086947	4, 681, 564		4 0	407, 048	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 193627	915, 606			177, 286	59.00
60. 00 06000 LABORATORY	0. 158526	4, 314, 443	27	2 0	683, 951	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 115439			0 0	17, 356	
64.00 06400 INTRAVENOUS THERAPY	0. 001252	296, 551		0 0	371	64.00
66. 00 06600 PHYSI CAL THERAPY	0. 407977	19, 822		0 0	8, 087	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 226852			0 0	1, 705	67.00
67. 01 06701 AUDI OLOGY	0. 235328	138, 837		0 0	32, 672	67.01
68.00 06800 SPEECH PATHOLOGY	0. 268092			0 0	60	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	•
69. 01 06901 CARDI OLOGY	0. 151074	2, 655, 126	89	09 0	401, 121	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 482969	793, 550	5, 22	.7 0	383, 260	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 540024	68, 448		0 0	36, 964	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 156694	1, 708, 131		0 19, 908	267, 654	73.00
OUTPATIENT SERVICE COST CENTERS	1	1				
90. 00 09000 CLINIC	0. 000000			0 0	-	
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000			0 0	0	90.01
90. 02 09002 CLI NI C	0. 000000			0 0	0	90.02
90. 03 09003 DERMATOLOGY CLINIC	0. 000000			0 0	0	90.03
90. 04 09004 ENT CLINIC	0. 000000			0 0	0	90.04
90. 05 09005 SURGERY CLINIC	0. 000000			0 0	0	90.05
90. 07 09007 UROLOGY CLINIC	0. 016141	0		0 0	0	90.07
90. 09 09009 GASTROENTEROLOGY CLINIC	0. 000000			0 0	0	90.09
90. 11 09011 NEUROLOGY CLINIC	0. 001986			0 0	0	90.11
90. 12 09012 OPTHAMOLOGY CLINIC	0. 000000			0 0	0	90.12
90. 13 09013 ALLERGY CLINIC	0. 294056			0 0	0	90.13
90.14 09014 WOUND CARE	0. 297707				96, 505	•
91. 00 09100 EMERGENCY	0. 182331			6 0	968, 274	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 563181	1, 091, 695		0 0	614, 822	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1		Γ	
95.00 09500 AMBULANCE SERVICES	0. 448038			0		95.00
200.00 Subtotal (see instructions)		47, 160, 536	14, 53		6, 844, 312	•
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		47 1/0 50/	1	07 404	/ 044 040	202.02
202.00  Net Charges (line 200 +/- line 201)	I	47, 160, 536	14, 53	27, 436	6, 844, 312	202.00

APPORTI C	inancial Systems DNMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	WITHAM MEMORIA D VACCINE COST		CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016		epared:
			Titl	e XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost Reimbursed Services	Cost Reimbursed Services Not				
		(see inst.)	Subject To Ded. & Coins. (see inst.)	_			
0.0	NCI LLARY SERVI CE COST CENTERS	6.00	7.00				
	5000 OPERATING ROOM	745		1			50.00
							54.00
	5400 RADI OLOGY-DI AGNOSTI C	21					
	5500 RADI OLOGY-THERAPEUTI C 5501 ULTRA SOUND	0					55.00 55.01
	5700 CT SCAN	0					57.00
		0	16:	2			58.00
	5800 MAGNETIC RESONANCE IMAGING (MRI) 5900 CARDIAC CATHETERIZATION	192	64				59.00
	6000 LABORATORY	43		5			60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	43					63.00
	6400 I NTRAVENOUS THERAPY	0					64.00
	6600 PHYSI CAL THERAPY	0					66.00
	6700 OCCUPATI ONAL THERAPY	0					67.00
	6701 AUDI OLOGY	0					67.01
	6800 SPEECH PATHOLOGY	0					68.00
	6900 ELECTROCARDI OLOGY	0					69.00
	6901 CARDI OLOGY	136					69.01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 524					71.00
	7200 I MPL. DEV. CHARGED TO PATIENT	0					72.00
	7300 DRUGS CHARGED TO PATIENTS	0	3, 11	-			73.00
	UTPATIENT SERVICE COST CENTERS			1			
	9000 CLINIC	0	(	D			90.00
90.01 09	9001 OTHER OUTPATIENT SERVICE COST CENTER	0	(	b			90.01
90.02 09	9002 CLINIC	0	(	b			90.02
90.03 09	9003 DERMATOLOGY CLINIC	0	(	b			90.03
90.04 09	9004 ENT CLINIC	0	(	b			90.04
90.05 09	9005 SURGERY CLINIC	0	(	c			90.05
90.07 09	9007 UROLOGY CLINIC	0	(	c			90.07
90.09 09	9009 GASTROENTEROLOGY CLINIC	0	(	c			90.09
90.11 09	9011 NEUROLOGY CLINIC	0	(	C			90.11
90.12 09	9012 OPTHAMOLOGY CLINIC	0	(	C			90.12
	9013 ALLERGY CLINIC	0		C			90.13
	9014 WOUND CARE	93	40	5			90.14
	9100 EMERGENCY	16		2			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(				92.00
	THER REIMBURSABLE COST CENTERS	т т		T			
	9500 AMBULANCE SERVI CES	0					95.00
200.00	Subtotal (see instructions)	3, 770	3, 75	1			200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	3, 770	3, 75	11			202.00

DODTLONMENT OF LNDATLENT ANGLELADY CEDVICE CADLTA		AL HOSPITAL	CNL 15 0104			2552-10
PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L CUSIS	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part II	
		Component	CCN: 15-S104	To 12/31/2016	Date/Time Pre	
		Title	xvi i	Subprovider -	5/26/2017 10: PPS	44 am
		intre		IPF	115	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	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	
ANCI LLARY SERVICE COST CENTERS	(4( 440	40 505 474	0.0151		0	-
0.00 05000 OPERATING ROOM	646, 149	42, 525, 174			0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	807, 761	18, 821, 312			1, 293	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0	
5. 01 05501 ULTRA SOUND	7,666	8, 162, 342			4	
7.00 05700 CT SCAN	10, 221	36, 413, 892			14	
88.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	73, 575	14, 602, 598			0	
9.00 05900 CARDI AC CATHETERI ZATI ON	57, 247	3, 328, 626			0	
0.00 06000 LABORATORY	398, 132	50, 070, 265			3, 962	
3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	529	796, 586			1	63.00
4.00 06400 I NTRAVENOUS THERAPY	18	2, 633, 685			0	
6.00 06600 PHYSI CAL THERAPY	359, 554	7, 621, 615			1, 197	
57.00 06700 OCCUPATI ONAL THERAPY	6, 789	2, 676, 279			2	
57. 01 06701 AUDI 0L0GY	1, 991	1,044,246			0	
8.00 06800 SPEECH PATHOLOGY	1, 457	703, 482			10	
9.00 06900 ELECTROCARDI OLOGY	0	0			0	
9. 01 06901 CARDI OLOGY	53, 024	11, 358, 937	0.00466		365	
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	17, 282	6, 208, 014			194	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	26, 459	8, 523, 813			0	
3.00 07300 DRUGS CHARGED TO PATIENTS	14, 413	13, 730, 248	0.00105	614, 964	646	73.00
OUTPATIENT SERVICE COST CENTERS	0	0	0.0000	0 00	0	90.00
	-					
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	164, 840 7, 792	0			0	
0. 02 09002 CEINIC 0. 03 09003 DERMATOLOGY CLINIC	1, 192	0			0	
0. 03 09003 DERMATOLOGY CLINIC 0. 04 09004 ENT CLINIC	0	0				
0. 05 09004 ENT CLINIC 0. 05 09005 SURGERY CLINIC	1	0				
0. 03 09005 SURGERT CETNIC 0. 07 09007 UROLOGY CLINIC	114	-			0	
0. 07 09007 0K0E0G1 CETNIC 0. 09 09009 GASTROENTEROLOGY CLINIC	64	141, 010	0.00080		0	
0. 11 09011 NEUROLOGY CLINIC	2	86, 589			0	
0. 12 09012 OPTHAMOLOGY CLINIC	37	00, 369			0	1
0. 12 09012 0PTHAMOLOGY CLINIC 0. 13 09013 ALLERGY CLINIC	37 1, 199	650, 461	0.00000		0	
0. 13 09013 ALLERGY CLINIC 0. 14 09014 WOUND CARE	135, 889	3, 052, 674			0	
0. 14 09014 WOOND CARE 1. 00 09100 EMERGENCY	950, 690	30, 440, 785			324	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	950, 890	2, 607, 754				
2. 00 07200 003LKVATION DEDS (NON-DISTINCT PART)	U U	2,007,734	0.0000		0	72.00
OTHER REI MBURSABLE COST CENTERS						95.00

lealth Financial Systems	WI THAM MEMORIAL				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part IV	
FHROUGH COSTS		Component	CCN: 15-S104	To 12/31/2016		
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Healt		Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
	1.00	2.00	2.00	Cost	4) 5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	(		0 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	0	
55. 01 05501 ULTRA SOUND	0	(		0 0	0	55.01
57. 00 05700 CT SCAN	0	(		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	(		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(		0 0	0	59.00
50. 00 06000 LABORATORY	0	(		0 0	0	60.00
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(		0 0	0	63.00
54.00 06400 INTRAVENOUS THERAPY	0	(		0 0	0	64.00
56. 00 06600 PHYSI CAL THERAPY	0	(		0 0	0	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	(		0 0	0	67.00
57. 01 06701 AUDI OLOGY	0	(	D	0 0	0	
58.00 06800 SPEECH PATHOLOGY	0	(	D	0 0	0	
59. 00 06900 ELECTROCARDI OLOGY	0	(	D	0 0	0	
59. 01 06901 CARDI OLOGY	0	(	D	0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1 1	(	0	0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	(		0 0		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0	(		0 0	0	90.00
20. 00 09000 CETNIC 20. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		(		0 0		
20. 02 09002 CLINIC		(		0 0	-	
20. 03 09003 DERMATOLOGY CLINIC	0	(	-	0 0	-	
20. 04 09004 ENT CLINIC	0	(		0 0	-	
20. 05 09005 SURGERY CLINIC	0	(		0 0	-	
20. 07 09007 UROLOGY CLINIC	o	(		0 0	-	
90. 09 09009 GASTROENTEROLOGY CLINIC	0	(		0 0	0	90.09
PO. 11 09011 NEUROLOGY CLINIC	0	(		0 0	0	90.11
PO. 12 09012 OPTHAMOLOGY CLINIC	0	(	b	0 0	0	90.12
PO. 13 09013 ALLERGY CLINIC	0	(	D	0 0	0	90.13
20. 14 09014 WOUND CARE	0	(		0 0	0	90.14
91.00 09100 EMERGENCY	0	(		0 0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	) 0	(	0	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1		1	
95. 00 09500 AMBULANCE SERVICES				_		95.00
200.00  Total (lines 50-199)	0	(		0 0	0	200.00

leal th Financial Systems	WI THAM MEMORI		01 15 0101		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period: From 01/01/2016	Worksheet D Part IV	
THROUGH COSTS		Component		To 12/31/2016		
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS	-		1	-		
50. 00 05000 OPERATING ROOM	0					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 821, 312			30, 137	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0	
55.01 05501 ULTRA SOUND	0	8, 162, 342			4, 455	
57.00 05700 CT SCAN	0	36, 413, 892			48, 335	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14, 602, 598			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	3, 328, 626			0	
60. 00 06000 LABORATORY	0	50, 070, 265			498, 354	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	796, 586			1, 572	
64.00 06400 INTRAVENOUS THERAPY	0	2, 633, 685			0	
66. 00 06600 PHYSI CAL THERAPY	0	7, 621, 615			25, 372	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	2, 676, 279			844	67.00
67. 01 06701 AUDI OLOGY	0	1, 044, 246	0.00000	0. 000000	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	703, 482	0.00000	0. 000000	4, 844	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69.00
69. 01 06901 CARDI OLOGY	0	11, 358, 937	0.00000	0. 000000	78, 246	69. 0 ⁻
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6, 208, 014			69, 726	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 523, 813			0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 730, 248	0.00000	0.000000	614, 964	73.00
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLINIC	0	0			0	
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0			0	
90. 02 09002 CLINIC	0	0			0	
PO. 03 09003 DERMATOLOGY CLINIC	0	0			0	
90.04 09004 ENT CLINIC	0	0	0.00000		0	
90. 05 09005 SURGERY CLINIC	0	0			0	
PO. 07 09007 UROLOGY CLINIC	0	141, 010			0	
90. 09 09009 GASTROENTEROLOGY CLINIC	0	0	0.00000		0	
PO. 11 09011 NEUROLOGY CLINIC	0	86, 589			0	
20. 12 09012 OPTHAMOLOGY CLINIC	0	0	0.00000		0	
PO. 13 09013 ALLERGY CLINIC	0	650, 461	0.00000		0	90.1
90.14 09014 WOUND CARE	0	3, 052, 674			0	
91.00 09100 EMERGENCY	0	30, 440, 785			10, 380	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 607, 754	0.00000	0.00000	0	92.0
OTHER REIMBURSABLE COST CENTERS	-		1	-		
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50-199)	0	266, 200, 387	1		1, 387, 229	200.00

eal th Financial Systems	WI THAM MEMORI A		01 45 0404		u of Form CMS-	-2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PASS	S Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part IV	
nkuugn cusis		Component	CCN: 15-S104	To 12/31/2016		
		Titl€	e XVIII	Subprovider -	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent	I PF		
cost center bescription	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	ondi geo	Costs (col.			
	x col. 10)		x col. 12)	,		
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS				I		
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	)	0		55.00
55. 01 05501 ULTRA SOUND	0	C		0		55. O
57.00 05700 CT SCAN	0	C		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
50. 00 06000 LABORATORY	0	C		0		60.00
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0		63.00
54.00 06400 INTRAVENOUS THERAPY	0	C		0		64.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
57. 01 06701 AUDI OLOGY	0	C		0		67.0
58.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
59. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
59. 01 06901 CARDI OLOGY	0	C		0		69. 0 ⁻
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
OUTPATIENT SERVICE COST CENTERS						
20. 00 09000 CLINIC	0	C		0		90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0		90.0
20. 02 09002 CLINIC	0	C		0		90.02
20. 03 09003 DERMATOLOGY CLINIC	0	C		0		90.03
20. 04 09004 ENT CLINIC	0	C		0		90.04
20. 05 09005 SURGERY CLINIC	0	C		0		90.05
20. 07 09007 UROLOGY CLINIC	0	C		0		90.0
20. 09 09009 GASTROENTEROLOGY CLINIC	0	C		0		90.09
20. 11 09011 NEUROLOGY CLINIC	0	C		0		90.1
20. 12 09012 OPTHAMOLOGY CLINIC	0	C		0		90.12
20. 13 09013 ALLERGY CLINIC	0	C		0		90.13
20. 14 09014 WOUND CARE	0	0		0		90.14
91.00 09100 EMERGENCY	0	2, 160	1	0		91.00
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	1	0		92.00
OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00 09500 AMBULANCE SERVICES			1			95.00
200.00 Total (lines 50-199)	0	2, 160		0		200.0

	uncial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104	Peri od:	Worksheet D	
			Component	CCN: 15-S104	From 01/01/2016 To 12/31/2016	Date/Time Pre	epared:
			•			5/26/2017 10:	44 am
			Titl€	e XVIII	Subprovider - IPF	PPS	
				Charges	IPF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(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	
	LLARY SERVICE COST CENTERS		-	1	-		
	O OPERATING ROOM	0. 111742	0		0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 283622	0		0 0	-	
	0 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
	1 ULTRA SOUND	0. 082586	0		0 0	0	
	0 CT SCAN	0. 027757	0		0 0	0	
	O MAGNETIC RESONANCE IMAGING (MRI)	0. 086947	0		0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 193627	0		0 0	0	
	O LABORATORY	0. 158526	0		0 0	0	
	O BLOOD STORING, PROCESSING & TRANS.	0. 115439	0		0 0	0	
	O I NTRAVENOUS THERAPY	0. 001252	0		0 0	0	
	O PHYSI CAL THERAPY	0. 407977	0		0 0	0	
	O OCCUPATI ONAL THERAPY	0. 226852	0		0 0	0	
	1 AUDI OLOGY	0. 235328	0		0 0	0	
	O SPEECH PATHOLOGY	0. 268092	0		0 0	0	
		0. 000000	0		0 0	0	
	1 CARDI OLOGY	0. 151074	0		0 0	0	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 IMPL. DEV. CHARGED TO PATIENT	0. 482969	0		0 0	0	
	O DRUGS CHARGED TO PATIENTS	0. 540024 0. 156694			0 4,791	0	
	ATIENT SERVICE COST CENTERS	0. 150094	0	/	4, 791	0	73.00
	O CLINIC	0. 000000	0	1	0 0	0	90.00
	1 OTHER OUTPATIENT SERVICE COST CENTER	0. 000000	0		0 0	0	
	2 CLINIC	0. 000000	0		0 0	0	
	3 DERMATOLOGY CLINIC	0. 000000	0		0 0	0	
	4 ENT CLINIC	0. 000000	0		0 0	0	
	5 SURGERY CLINIC	0. 000000	0		0 0	0	
	7 UROLOGY CLINIC	0. 016141	0		0 0	0	
	9 GASTROENTEROLOGY CLINIC	0. 000000	0		0 0	0	90.09
90.11 0901	1 NEUROLOGY CLINIC	0. 001986	C		0 0	0	90.11
90.12 09012	2 OPTHAMOLOGY CLINIC	0. 000000	o		0 0	0	90.12
	3 ALLERGY CLINIC	0. 294056	0		0 0	0	90.13
	4 WOUND CARE	0. 297707	C		0 0	0	90.14
	0 EMERGENCY	0. 182331	2, 160		0 0	394	91.00
92.00 09200	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 563181	0		0 0	0	
92.00 09200	R REIMBURSABLE COST CENTERS						
					0		95.00
OTHER	O AMBULANCE SERVI CES	0. 448038			0	1	95.00
OTHER	0 AMBULANCE SERVICES Subtotal (see instructions)	0. 448038	2, 160		0 4, 791	394	200.00
95.00 09500	Subtotal (see instructions) Less PBP Clinic Lab. Services-Program	0. 448038				394	
0THEF 95.00 09500 200.00	Subtotal (see instructions)	0. 448038			0 4, 791		200.00

	al Systems	WI THAM MEMORI		CN 15 0104		u of Form CMS-2552-	
APPORTIONMENT (	OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part V	
			Component	CCN: 15-S104	To 12/31/2016		repared:
			Title	e XVIII	Subprovider -	PPS	). 44 dili
		Cos	sts				
Cos	st Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.) 6.00	<u>(see inst.)</u> 7.00	-			
ANCILLAR	Y SERVICE COST CENTERS	0.00	7.00				
	ERATING ROOM	0	0				50.00
54. 00 05400 RAI	DI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RAI	DI OLOGY-THERAPEUTI C	0	0				55.00
5.01 05501 UL	TRA SOUND	0	0				55. O
7.00 05700 CT	SCAN	0	0				57.00
8.00 05800 MA	GNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	RDI AC CATHETERI ZATI ON	0	0	•			59.0
0. 00 06000 LA		0	0				60.0
	OOD STORING, PROCESSING & TRANS.	0	0				63.0
	TRAVENOUS THERAPY	0	0				64.0
	YSI CAL THERAPY	0	0	1			66.0
	CUPATIONAL THERAPY	0	0				67.0
7.01 06701 AU		0	0				67.0
	EECH PATHOLOGY ECTROCARDI OLOGY	0	0				68.00 69.00
9.00 06900 EL		0	0				69.0
	DICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
	PL. DEV. CHARGED TO PATIENT	0	0				72.0
	UGS CHARGED TO PATIENTS	0	751				73.0
	NT SERVICE COST CENTERS			1			
0.00 09000 CLI		0	0				90.0
0. 01 09001 0TH	HER OUTPATIENT SERVICE COST CENTER	0	0				90.0
0. 02 09002 CLI	INIC	0	0				90.0
	RMATOLOGY CLINIC	0	0				90.0
0.04 09004 EN		0	0				90.0
	RGERY CLINIC	0	0				90.0
	OLOGY CLINIC	0	0				90.0
	STROENTEROLOGY CLINIC	0	0				90.0
		0	0				90.1
	THAMOLOGY CLINIC	0	0	1			90.1
0.13 09013 ALI 0.14 09014 WO		0	0				90.13
0. 14 09014 WO		0	0				90.12
	SERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	IMBURSABLE COST CENTERS		0	1			
	BULANCE SERVICES	0					95.00
	btotal (see instructions)	0	751				200.00
	ss PBP Clinic Lab. Services-Program	0					201.00
	ly Charges						
202.00 Ne ⁻	t Charges (line 200 +/- line 201)	0	751				202.00

ealth Financial Systems	WITHAM MEMORIAL				u of Form CMS-2	2552-1
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part IV	
HROUGH COSTS		Component	CCN: 15-5832	To 12/31/2016		
		Title	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Heal		Total Cost	
	Anestheti st	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
io. 00 05000 OPERATI NG ROOM	0	(		0 0	0	50.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(		0 0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(		0 0	0	
55.01 05501 ULTRA SOUND	0	(		0 0	0	55.0
7. 00 05700 CT SCAN	0	(		0 0	0	57.00
88.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(		0 0	0	58.00
9.00 05900 CARDI AC CATHETERI ZATI ON	0	(		0 0	0	59.0
0. 00 06000 LABORATORY	0	(		0 0	0	60.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(		0 0	0	63.0
4.00 06400 INTRAVENOUS THERAPY	0	(		0 0	0	64.0
6. 00 06600 PHYSI CAL THERAPY	0	(		0 0	0	66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0	(	D	0 0	0	67.0
57. 01 06701 AUDI OLOGY	0	(	D	0 0	0	67.0
8.00 06800 SPEECH PATHOLOGY	0	(		0 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	(	D	0 0	0	69.0
9. 01 06901 CARDI OLOGY	0	(	D	0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(	D	0 0	0	
2.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	(		0 0		
3.00 07300 DRUGS CHARGED TO PATIENTS	0	(		0 0	0	73.0
OUTPATIENT SERVICE COST CENTERS				0		
0.00 09000 CLINIC 0.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	(		0 0		
0. 01 090010THER OUTPATIENT SERVICE COST CENTER	0	(		0 0	-	
0. 03 09003 DERMATOLOGY CLINIC	0	(	-	0 0	-	
0. 04 09004 ENT CLINIC	0	(		0 0	-	
0. 05 09005 SURGERY CLINIC	0	(		0 0	-	
0. 07 09007 UROLOGY CLINIC	0	(		0 0	-	
0. 09 09009 GASTROENTEROLOGY CLINIC	0	(		0 0	-	
0. 11 09011 NEUROLOGY CLINIC	0	(		0 0	-	
0. 12 09012 OPTHAMOLOGY CLINIC	0	(		0 0	-	
0. 13 09013 ALLERGY CLINIC	0	(		0 0	0	
0. 14 09014 WOUND CARE	0	(	b	0 0	0	
1.00 09100 EMERGENCY	0	(	D	0 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(		0 0	0	92.0
OTHER REIMBURSABLE COST CENTERS						
5. 00 09500 AMBULANCE SERVICES						95.0
200.00 Total (lines 50-199)	0	(		0 0	0	200.0

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PAS	S Provider C	CN: 15-0104	Period:	Worksheet D	
HROUGH COSTS				From 01/01/2016		
		Component		To 12/31/2016	Date/Time Pre 5/26/2017 10:	
		Title	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost		I npati ent	
· ·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	-	
	4)			col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0	42, 525, 174	0.00000	0.000000	2, 406	50.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 821, 312	0.00000	0. 000000	29, 621	54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0. 000000	0	55.00
5.01 05501 ULTRA SOUND	0	8, 162, 342	0. 00000	0. 000000	17, 282	55.0 ⁴
7.00 05700 CT SCAN	0	36, 413, 892	0. 00000	0.000000	0	57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	14, 602, 598	0.00000	0. 000000	0	58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	59.00
0. 00 06000 LABORATORY	0	50, 070, 265	0. 00000	0. 000000	250, 425	60.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0. 000000	0	63.0
4.00 06400 INTRAVENOUS THERAPY	0				0	64.0
6.00 06600 PHYSI CAL THERAPY	0	7, 621, 615			1, 212, 881	66.0
7.00 06700 OCCUPATI ONAL THERAPY	0	2, 676, 279			1, 341, 806	
7. 01 06701 AUDI OLOGY	0				0	67.0
8.00 06800 SPEECH PATHOLOGY	0	703, 482			38, 298	
9. 00 06900 ELECTROCARDI OLOGY	0				0	69.0
9. 01 06901 CARDI OLOGY	0				541, 912	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-				248, 383	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0				210,000	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0				881, 907	73.0
OUTPATIENT SERVICE COST CENTERS		10,700,210	0.00000	0.00000	001,707	/0.0
0. 00 09000 CLINIC	0	0	0.00000	0.00000	0	90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		-			0	90.0
0. 02 09002 CLINIC	0	0			0	90.0
0. 03 09003 DERMATOLOGY CLINIC	0	0			0	90.0
0. 04 09004 ENT CLINIC	0	0			0	90.0
0. 05 09005 SURGERY CLINIC	0	-			0	90.0
0. 07 09007 UROLOGY CLINIC	0	141,010			0	90.0
0. 09 09009 GASTROENTEROLOGY CLINIC	0				0	90.0
0. 11 09011 NEUROLOGY CLINIC	0	-			0	90.1
0. 12 09012 OPTHAMOLOGY CLINIC	0	00, 309	0.00000		0	90.1
0. 12 09012 0PTHAMOLOGY CLINIC	0	650, 461	0.00000		0	90.1
0. 13 09013 ALLERGT CLINIC 0. 14 09014 WOUND CARE	0				0	90.1
1. 00 09100 EMERGENCY	0				0	90.1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	91.0
OTHER REIMBURSABLE COST CENTERS	0	2,007,754	0.0000	0.00000	0	92.0
5. 00 09500 AMBULANCE SERVICES						95.0

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ERVICE OTHER PASS	6 Provider C	CN: 15-0104	Peri od:	Worksheet D	
HROUGH COSTS				From 01/01/2016	Part IV	
		Component	CCN: 15-5832	To 12/31/2016	Date/Time Pr 5/26/2017 10	epared :44 am
		Title	e XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	charges	Costs (col.			
	x col. 10)		x col. 12)	/		
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS	11100	12100	10100			
0.00 05000 OPERATING ROOM	0	C	)	0		50.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0		55.0
5.01 05501 ULTRA SOUND	0	C		0		55.0
7.00 05700 CT SCAN	0	C		0		57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.0
0. 00 06000 LABORATORY	0	C		0		60.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0		63.0
4.00 06400 INTRAVENOUS THERAPY	0	C		0		64.0
6. 00 06600 PHYSI CAL THERAPY	0	C		0		66.0
7.00 06700 OCCUPATI ONAL THERAPY	0	C	)	0		67.0
7. 01 06701 AUDI OLOGY	0	C		0		67.0
8.00 06800 SPEECH PATHOLOGY	0	C		0		68.0
9. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.0
9. 01 06901 CARDI OLOGY	0	C		0		69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73.0
OUTPATIENT SERVICE COST CENTERS						
	0	C		0		90.0
0. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	C		0		90.0
	0	C		0		90.0
0. 03 09003 DERMATOLOGY CLINIC	0	C		0		90.0
	0			0		90.0
0. 05 09005 SURGERY CLINIC 0. 07 09007 UROLOGY CLINIC	0	C		0		90.0
0. 07 09007 0R0L0GY CLINIC 0. 09 09009 GASTROENTEROLOGY CLINIC	0	C		0		90.0
0. 09 09009 GASTROENTEROLOGY CLINIC	0	0		0		90.
0. 12 09012 OPTHAMOLOGY CLINIC	0	0		0		90.
0. 12 09012 0PTHAMOLOGY CLINIC	0			0		90.
0. 14 09014 WOUND CARE	0	0		0		90.
1. 00 09100 EMERGENCY	0	C		0		91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.0
OTHER REIMBURSABLE COST CENTERS		C	·I	~I		
5. 00 09500 AMBULANCE SERVICES						95.0
00.00 Total (lines 50-199)	0	C		0		200.0

Health Financial Systems		I THAM MEMORI				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND V	ACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D Part V	
			Component	CCN: 15-5832	To 12/31/2016		epared: 44 am
			Title	e XVIII	Skilled Nursing Facility		
				Charges	- address g	Costs	
Cost Center Description		Cost to	PPS	Cost	Cost	PPS Services	
	CI	harge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		orksheet C,	inst.)	Subject To	Subject To		
	Pa	art I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		0 111740				0	50.00
50. 00 05000 OPERATING ROOM		0. 111742	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 283622	0		0 0		
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 ULTRA SOUND		0. 000000 0. 082586	0		0 0	0	
						0	
57.00 05700 CT SCAN		0. 027757	0		0 0	0	
58. 00 05800 MAGNETI C RESONANCE I MAGI NG 59. 00 05900 CARDI AC CATHETERI ZATI ON	(MRT)	0. 086947 0. 193627	0		0 0	-	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY			0		0 0	0	
	TDANC	0. 158526	0			0	
63.00 06300 BLOOD STORING, PROCESSING &	TRANS.	0. 115439	0		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY 66. 00 06600 PHYSI CAL THERAPY		0.001252	0		0 0	0	
		0. 407977 0. 226852	0		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY 67. 01 06701 AUDI OLOGY		0. 226852	0			0	
68. 00 06800 SPEECH PATHOLOGY		0. 268092	0		0 0 0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY		0. 208092	0		0 0		69.00
69. 01 06901 CARDI 0LOGY		0. 151074	0		0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO	DATIENTS	0. 482969	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIE		0. 540024	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 156694	0		0 629	0	
OUTPATIENT SERVICE COST CENTERS		0. 130094	0	1	0 027	0	/ /3.00
90. 00 09000 CLINIC		0. 000000	0		0 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE CO	ST CENTER	0. 000000	0		0 0		1
90. 02 09002 CLINIC		0. 000000	0		0 0	0	
90. 03 09003 DERMATOLOGY CLINIC		0. 000000	0		0 0	0	
90. 04 09004 ENT CLINIC		0. 000000	0		0 0	0	1
90. 05 09005 SURGERY CLINIC		0. 000000	Ő		0 0	0	
90. 07 09007 UROLOGY CLINIC		0. 016141	Ő		0 0	0	
90. 09 09009 GASTROENTEROLOGY CLINIC		0. 000000	0		0 0	0	
90. 11 09011 NEUROLOGY CLINIC		0.001986	0		0 0	0	1
90. 12 09012 OPTHAMOLOGY CLINIC		0. 000000	0		0 0	0	1
90. 13 09013 ALLERGY CLINIC		0. 294056	0		0 0	0	
90. 14 09014 WOUND CARE		0. 297707	0		0 0	0	
91.00 09100 EMERGENCY		0. 182331	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART)	0. 563181	0		0 0	0	
OTHER REIMBURSABLE COST CENTERS	, ,				·		1
95.00 09500 AMBULANCE SERVICES		0. 448038			0		95.00
200.00 Subtotal (see instructions)			0		0 629	0	200.00
201.00 Less PBP Clinic Lab. Servic	es-Program				0 0		201.00
Only Charges	Ŭ						
202.00 Net Charges (line 200 +/- I	ne 201)		0	1	0 629	0	202.00

Health Fina	ncial Systems	WI THAM MEMORI	AL_HOSPITAL		In Lieu	of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0104	Period: From 01/01/2016	Worksheet D	
			Component (	CCN: 15-5832	To 12/31/2016	Part V Date/Time Pre 5/26/2017 10:	epared: 44 am
			Title	e XVIII	Skilled Nursing Facility	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To Ded. & Coins.	Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	-			
ANCI	LLARY SERVICE COST CENTERS	0.00	7.00	1			
	O OPERATING ROOM	0	0				50.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0	0				55.00
55.01 0550	1 ULTRA SOUND	0	0				55.01
57.00 0570	O CT SCAN	0	0				57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0	0				59.00
	0 LABORATORY	0	0				60.00
	OBLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	O INTRAVENOUS THERAPY	0	0				64.00
	0 PHYSI CAL THERAPY	0	0				66.00
	0 OCCUPATIONAL THERAPY	0	0				67.00
	1 AUDI OLOGY	0	0				67.01
	O SPEECH PATHOLOGY	0	0				68.00
		0	0				69.00
	1 CARDI OLOGY 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				69.01
	OIMPL. DEV. CHARGED TO PATIENTS	0	0	•			71.00
	O DRUGS CHARGED TO PATIENTS	0					73.00
	ATIENT SERVICE COST CENTERS	0	,,	1			/ 0.00
		0	0				90.00
	1 OTHER OUTPATIENT SERVICE COST CENTER	0	0				90.01
90.02 0900	2 CLINIC	0	0				90.02
90.03 0900	3 DERMATOLOGY CLINIC	0	0				90.03
90.04 0900	4 ENT CLINIC	0	0				90.04
	5 SURGERY CLINIC	0	0				90.05
	7 UROLOGY CLINIC	0	0	•			90.07
	9 GASTROENTEROLOGY CLINIC	0	0				90.09
	1 NEUROLOGY CLINIC	0	0				90.11
	2 OPTHAMOLOGY CLINIC	0	0				90.12
	3 ALLERGY CLINIC	0	0				90.13
	4 WOUND CARE	0	0				90.14
	O EMERGENCY	0					91.00
	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS	0	0	1			92.00
	O AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	0					200.00
	Less PBP Clinic Lab. Services-Program	0	,,				
201.00		0					201.00
201.00	Only Charges	0					201.00

	Financial Systems WITHAM MEMORIAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/26/2017 10:	pared:
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
. 00	Inpatient days (including private room days and swing-bed day			6, 258	1.0
. 00 . 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed days)		vivato room dove	6, 258 0	
. 00	do not complete this line.	ays). If you have only p	in vate room days,	0	3.0
. 00 . 00	Semi-private room days (excluding swing-bed and observation l Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	5, 104 0	
. 00	reporting period	com days) thi odgi becenic		0	5.0
. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.0
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.0
00	reporting period	om dava) ofter December	21 of the post	0	
. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) arter December	31 of the cost	0	8.0
. 00	Total inpatient days including private room days applicable	to the Program (excludin	ig swing-bed and	2, 274	9.0
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.0
1 00	through December 31 of the cost reporting period (see instruc				11 0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of		room days) arter	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12.0
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13.0
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Prog Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	16.0
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	   17.0
	reporting period	C		0.00	10.0
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces arter becember 31 or	the cost	0.00	18.0
9. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 c	of the cost	0.00	19.0
D. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.0
1.00	reporting period Total general inpatient routine service cost (see instruction	nc)		7, 964, 220	21.0
2.00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line A	0	23.0
3.00	x line 18)	a si di the cost reporti	ng period (inte o	0	23.0
4. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24.0
5. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.0
6.00	x line 20) Total swing-bed cost (see instructions)			0	26.0
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 964, 220	
8.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	od and obsorvation had a	(hargos)	0	28.0
9.00	Private room charges (excluding swing-bed charges)		inal ges)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TINE 28)		0. 000000 0. 00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi		icti ons)	0.00	
5.00	Average per diem private room cost differential (line 34 x li	, ,	-	0.00	
6. 00	Private room cost differential adjustment (line 3 x line 35)			0	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	lifferential (line	7, 964, 220	37.0
7.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
7.00					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			4 070	1
8. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 272. 65	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	e instructions) e 38)		1, 272. 65 2, 894, 006 0	39.0

	ATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider C	CN: 15-0104	Peri od:	Worksheet D-	- <u>2552-</u> 1
5 017					From 01/01/2016		
					To 12/31/2016	Date/Time Pro	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	С	0. (	0 00	(	) 42.
	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	2, 637, 728	1 403	1 547 1	047	1, 327, 486	4.12
	CORONARY CARE UNIT	2,037,728	1, 683	1, 567. 2	28 847	1, 327, 480	5 43. 44.
	BURN INTENSIVE CARE UNIT						45.
6.00	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (V	Wkst. D-3, col. 3	, line 200)			3, 495, 073	3 48.
	Total Program inpatient costs (sum of lines			ons)		7, 716, 565	
	PASS THROUGH COST ADJUSTMENTS						
0.00	Pass through costs applicable to Program in	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	482, 476	5 50.
1.00	III) Pass through costs applicable to Program in	nnatient ancillar	v services (f	rom Wkst D	sum of Parts II	232, 676	5 51.
1.00	and IV)	ipatront anorra	y services (i			202, 070	
	Total Program excludable cost (sum of lines					715, 152	
3.00	Total Program inpatient operating cost excl		lated, non-ph	ysician anest	hetist, and	7,001,413	3 53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					-
	Program di scharges					(	54.
5.00	Target amount per discharge					0.00	55.
	Target amount (line 54 x line 55)					(	
	Difference between adjusted inpatient opera	ating cost and ta	rget amount (	line 56 minus	line 53)	0	
8.00 9.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	reporting period	ending 1996	undated and c	ompounded by the	0.00	
7.00	market basket	reporting period	churng 1770,		ompounded by the	0.00	J 37.
	Lesser of lines 53/54 or 55 from prior year					0.00	
1.00	If line 53/54 is less than the lower of lin					C	) 61.
	which operating costs (line 53) are less thamount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% c	r the target		
2.00	Relief payment (see instructions)					(	62.
	Allowable Inpatient cost plus incentive pay	yment (see instru	ctions)			(	) 63.
	PROGRAM INPATIENT ROUTINE SWING BED COST				· · · · · · · · · · · · · · · · · · ·	-	
4.00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts through Dece	mber 31 of th	e cost report	ing period (See	C	64.
5.00	Medicare swing-bed SNF inpatient routine co	osts after Decemb	er 31 of the	cost reportin	g period (See	(	65.
	instructions)(title XVIII only)						
6.00	Total Medicare swing-bed SNF inpatient rout	tine costs (line	64 plus line	65)(title XVI	II only). For	C	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	ing costs through	December 31	of the cost r	enorting period	C	67.
7.00	(line 12 x line 19)	The costs through	December 31	or the cost r	cporting period		07.
8.00	Title V or XIX swing-bed NF inpatient routi	ine costs after D	ecember 31 of	the cost rep	orting period	C	68.
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER	,				(	) 69.
	Skilled nursing facility/other nursing faci				)		70.
1.00	Adjusted general inpatient routine service	cost per diem (I					71.
	Program routine service cost (line 9 x line						72.
	Medically necessary private room cost appli	, e	•				73.
4.00 5.00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Part II. column		74.
	26, line 45)		20010 (110				/ 0.
	Per diem capital-related costs (line 75 ÷ l						76.
	Program capital -related costs (line 9 x lin						77.
	Inpatient routine service cost (line 74 mir Aggregate charges to beneficiaries for exce	,	rovider recor	ds)			78.
	Total Program routine service costs for cor	• •			nus line 79)		80.
1.00	Inpatient routine service cost per diem lir	mitation			,		81.
	Inpatient routine service cost limitation	•	· .				82.
	Reasonable inpatient routine service costs		S)				83.
	Program inpatient ancillary services (see i Utilization review - physician compensation		ns)				84. 85.
	Total Program inpatient operating costs (su	•					86.
	PART IV - COMPUTATION OF OBSERVATION BED PA	ASS THROUGH COST	_ /				
7.00	Total observation bed days (see instruction					1, 154	
	Adjusted general inpatient routine cost per	n diam (li 07	11 00 00			1, 272. 65	5 88.

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 44 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	957, 083	7, 964, 220	0. 12017	3 1, 468, 638	176, 491	90.00
91.00 Nursing School cost	0	7, 964, 220	0.00000	0 1, 468, 638	0	91.00
92.00 Allied health cost	0	7, 964, 220	0.00000	0 1, 468, 638	0	92.00
93.00 All other Medical Education	0	7, 964, 220	0.00000	0 1, 468, 638	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Peri od:	Worksheet D-1	
		Component CCN: 15-S104	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 10:	
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	INPATIENT DAYS			0.755	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2, 755 2, 755	1
00	Private room days (excluding swing-bed and observation bed da		rivate room davs	2,733	3
00	do not complete this line.	ays). If you have only p	in vare room days,	0	
00	Semi-private room days (excluding swing-bed and observation k	5 /		2, 755	4
00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	nom dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	bolli days) al ter becenber	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
	reporting period	<i></i>			
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (evoludin	n swing_bed and	2, 338	9
00	newborn days)			2, 330	ĺ
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period			0	
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	14 15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		I		
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	and after December 21 of	the cost	0.00	10
5.00	reporting period	ces al tel becember 31 01	the cost	0.00	
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period	-			
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
1.00	reporting period Total general inpatient routine service cost (see instruction	ne)		2, 809, 673	21
2.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		22
	5 x line 17)		5 j		
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
1 00	x line 18) Swing had cast applicable to NE type carvices through December	or 21 of the cost report	ing pariod (line	0	24
4.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
	x line 20)				
6.00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		2,809,673	27
3. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
9.00	Private room charges (excluding swing-bed charges)		5 /	0	29
0. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
. 00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li		/	0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	2, 809, 673	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
3. 00	Adjusted general inpatient routine service cost per diem (see			1, 019. 85	38
9.00	Program general inpatient routine service cost (line 9 x line			2, 384, 409	
	Medically necessary private room cost applicable to the Progr			0	40
	Total Program general inpatient routine service cost (line 39	9 + IINE 4U)		2, 384, 409	41

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	WI THAM MEMORI A		CN: 15-0104	Period:	worksheet D-1	
			CCN: 15-S104	From 01/01/2016 To 12/31/2016	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	5/26/2017 10: PPS	44 a
				I PF		_
Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.
Intensive Care Type Inpatient Hospital Ur			<u> </u>	0 0		42
0. 00 INTENSIVE CARE UNIT	0	(	0.0	0 00	0	
. OO CORONARY CARE UNIT . OO BURN INTENSIVE CARE UNIT						44
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
· .					1.00	
.00 Program inpatient ancillary service cost			272)		245, 032	
.00 Total Program inpatient costs (sum of lin PASS THROUGH COST ADJUSTMENTS	ies 41 through 48)(	see mstructi	UNS)		2, 629, 441	49
.00 Pass through costs applicable to Program	inpatient routine	services (fro	om Wkst. D, su	m of Parts I and	270, 951	50
) 00  Pass through costs applicable to Program.	inpatient ancillar	v services (f	rom Wkst. D.	sum of Parts II	8, 012	2 51
and IV)	·	,				
2.00  Total Program excludable cost (sum of lin 3.00  Total Program inpatient operating cost e:		lated non-ph	weician anost	batist and	278, 963 2, 350, 478	
medical education costs (line 49 minus l					2, 330, 470	<u> </u> 33
TARGET AMOUNT AND LIMIT COMPUTATION .00 Program discharges					0	54
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
.00 Difference between adjusted inpatient op .00 Bonus payment (see instructions)	erating cost and ta	rget amount (	line 56 minus	line 53)		
.00 Lesser of lines 53/54 or 55 from the cos	t reporting period	endi ng 1996,	updated and c	ompounded by the	-	
.00 Lesser of lines 53/54 or 55 from prior ye	par cost roport up	dated by the	markat backat		0.00	60
1.00 If line 53/54 is less than the lower of					0.00	
which operating costs (line 53) are less		s (lines 54 x	: 60), or 1% o	f the target		
amount (line 56), otherwise enter zero ( 2.00 Relief payment (see instructions)	see instructions)				0	62
8.00 Allowable Inpatient cost plus incentive	payment (see instru	ctions)			0	63
. 00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of th	e cost report	ing period (See	0	64
instructions)(title XVIII only)						
.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decemb	er 31 of the	cost reportin	g period (See	0	) 65
.00 Total Medicare swing-bed SNF inpatient re	outine costs (line	64 plus line	65)(title XVI	II only). For	0	66
CAH (see instructions) .00 Title V or XIX swing-bed NF inpatient ro	iting costs through	December 31	of the cost r	enorting period		67
(line 12 x line 19)	atime costs through	December 31	of the cost i	eporting period		"
00 Title V or XIX swing-bed NF inpatient ro	utine costs after D	ecember 31 of	the cost rep	orting period	0	68
line 13 x line 20) 0.00 Total title V or XIX swing-bed NF inpatio	ent routine costs (	line 67 + lir	ie 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHE				、 、		
.00  Skilled nursing facility/other nursing fa .00  Adjusted general inpatient routine servio				)		70
.00 Program routine service cost (line 9 x li						72
.00 Medically necessary private room cost ap .00 Total Program general inpatient routine :	0	•				73
.00 Capital -related cost allocated to inpatio				Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 -	÷line 2)					76
.00 Program capital-related costs (line 9 x						77
.00 Inpatient routine service cost (line 74 i	,	rovidor roca	ide)			78
.00 Aggregate charges to beneficiaries for e: .00 Total Program routine service costs for e				nus line 79)		80
.00 Inpatient routine service cost per diem	imitation			,		81
<ul> <li>.00 Inpatient routine service cost limitation</li> <li>.00 Reasonable inpatient routine service cost</li> </ul>	•					82
. 00 Program inpatient ancillary services (see	•	<i></i>				84
.00 Utilization review - physician compensat	on (see instructio					85
0.00 Total Program inpatient operating costs PART IV - COMPUTATION OF OBSERVATION BED		rougn 85)				86
7.00 Total observation bed days (see instruct	ons)				0	
8.00 Adjusted general inpatient routine cost 9.00 Observation bed cost (line 87 x line 88)	•	line 2)			0.00	) 88 ) 89
. oo jobservation bed cost (The of A The oo)	(See This in uctions)				1 0	1 09

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
		Component (	CCN: 15-S104	To 12/31/2016		pared: 44 am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST		_			
90.00 Capital-related cost	319, 264	2, 809, 673	0. 11363	30 0	0	90.00
91.00 Nursing School cost	0	2, 809, 673	0.0000	0 0	0	91.00
92.00 Allied health cost	0	2, 809, 673	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	2, 809, 673	0. 00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/26/2017 10:	epare
		Title XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		4, 390	1 1
00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			4, 390	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.		-		
00	Semi-private room days (excluding swing-bed and observation b		01 6 11	4, 390	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7
~	reporting period		01 - E +b +	0	
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	3, 286	9
	newborn days)	0			
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room dave) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		room days) arter	0	' '
00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	/ear, enter 0 on this li	ne)	0	14
	Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period	a ofter December 21 of	the east	0.00	1
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 01	the cost	0.00	20
00	Total general inpatient routine service cost (see instruction	าร)		2, 363, 237	21
00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
~~	5 x line 17)				
00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 of the cost reporti	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ina period (line	0	24
	7 x line 19)		5 1 2 2 2		
00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 363, 237	
00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			2,000,207	1 - '
00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	· Lino 28)		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IIIC 20)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) Constal inpatient routing service cost not of swing bod cost	and privato room cost d	ifforantial (line	0	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	iiierential (line	2, 363, 237	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	-			38
	Program general inpatient routine service cost (line 9 x line	38)			39
	Medically necessary private room cost applicable to the Progr	com (lino 14 v !! 25)			40

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	WI THAM MEMORI		CN: 15-0104	In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPORTATION OF INPATIENT OPERATING COST			CCN: 15-5832	From 01/01/2016 To 12/31/2016	Date/Time Pre	epared:
		Title	e XVIII	Skilled Nursing	5/26/2017 10: PPS	44 dili
Cost Center Description	Total I npati ent Cost	Total I npati ent Days	Average Pe Diem (col. ÷ col. 2)	0 5	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	te					42.00
43.00 INTENSIVE CARE UNIT	15					43.00
44. 00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.00
47. 00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (					1.00	48.00
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	s 41 through 48)	(see instructi	ons)			49.00
50.00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, s	um of Parts I and		50.00
51.00 Pass through costs applicable to Program i	nnationt ancilla	ry services (f	rom Wkst D	sum of Parts II		51.00
and IV)		Ty services (1	Tom WKSt. D,	3011 01 1 01 1 3 11		51.00
52.00 Total Program excludable cost (sum of line 53.00 Total Program inpatient operating cost exc	luding capital r	elated, non-ph	ysi ci an anes	thetist, and		52.00 53.00
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	e 52)					
54.00 Program di scharges						54.00
55.00   Target amount per discharge 56.00   Target amount (line 54 x line 55)						55.00 56.00
57.00 Difference between adjusted inpatient oper-	ating cost and t	arget amount (	line 56 minu	s line 53)		57.00
58.00 Bonus payment (see instructions)	reporting pariod	anding 1004	undeted and	compounded by the		58.00
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period	ending 1996,	updated and	compounded by the	2	59.00
60.00 Lesser of lines 53/54 or 55 from prior yea						60.00
61.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t						61.00
amount (line 56), otherwise enter zero (se			00), 01 1%	on the target		
<ul><li>62.00 Relief payment (see instructions)</li><li>63.00 Allowable Inpatient cost plus incentive pay</li></ul>	vmont (coo instr	uctions)				62.00 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see mstr					_ 03.00
64.00 Medicare swing-bed SNF inpatient routine c	osts through Dec	ember 31 of th	e cost repor	ting period (See		64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine c	osts after Decem	ber 31 of the	cost reporti	ng period (See		65.00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient rou	tino costs (lino	64 plus lino	65) (+i +l o XV			66.00
CAH (see instructions)	time costs (inne	o4 prus rrne	05)(11110 XV	ini oniy). Toi		00.00
67.00 Title V or XIX swing-bed NF inpatient rout	ine costs throug	h December 31	of the cost	reporting period		67.00
<pre>68.00 (line 12 x line 19) Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)</pre>	ine costs after	December 31 of	the cost re	porting period		68.00
69.00 Total title V or XIX swing-bed NF inpatien						69.00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fac				7)	2 262 227	70.00
70.00 Skilled nursing facility/other nursing fac 71.00 Adjusted general inpatient routine service	5		•	')	2, 363, 237 538. 32	
72.00 Program routine service cost (line 9 x line	e 71)				1, 768, 920	72.00
73.00 Medically necessary private room cost appl 74.00 Total Program general inpatient routine se					0 1, 768, 920	
75.00 Capital -related cost allocated to inpatien 26, line 45)				Part II, column	1, 768, 920 0	1
76.00 Per diem capital-related costs (line 75 ÷					0.00	
77.00 Program capital-related costs (line 9 x li 78.00 Inpatient routine service cost (line 74 mi					0	
79.00 Aggregate charges to beneficiaries for exc		provider recor	ds)		0	
80.00 Total Program routine service costs for co	•	cost limitatio	n (line 78 m	inus line 79)	0	
81.00 Inpatient routine service cost per diem li 82.00 Inpatient routine service cost limitation		1)			0.00 0	
83.00 Reasonable inpatient routine service costs	(see instructio				1, 768, 920	83.00
84.00 Program inpatient ancillary services (see		onc)			1, 199, 302	
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (s					0 2, 968, 222	
PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROUGH COST					
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost pe		÷line 2)			0	87.00 88.00
						1 00.00

Health Financial Systems	WI THAM MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (	CCN: 15-5832	From 01/01/2016 To 12/31/2016		pared: 44 am
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0.0000	0 0	0	90.00
91.00 Nursing School cost	0	0	0.0000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	0	0.00000	0 00	0	93.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/26/2017 10:	pare
		Title XIX	Hospi tal	Cost	44 0
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding nowborn)		6, 258	1 1
00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			6, 258	
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		5, 104	4
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5			
00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through Decembe	er 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	n days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	, the Program (excludin	bac bed_park	171	9
	newborn days)	0			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruction)		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		te room days)	0	12
. 00	through December 31 of the cost reporting period	5 . 6 .	5 1		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ve			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)			993	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		I	0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0.00	] 17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 c	of the cost	0.00	19
	reporting period	J. J		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of	the cost	0.00	20
	Total general inpatient routine service cost (see instructions			7, 964, 220	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	- 31 of the cost report	ing period (line	0	24
00	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reportin	ig period (Tine 8	0	25
. 00	Total swing-bed cost (see instructions)	(1)		0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7, 964, 220	21
	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 -	⊧line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instru	icti ons)	0.00	
	Average per diem private room cost differential (line 34 x lin Drivate room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost d	lifferential (line	0 7, 964, 220	36 37
-	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			-
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 272. 65	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			217, 623 0	39 40
	Total Program general inpatient routine service cost (line 39	. ,		217, 623	

46. 00       SURGE CALL INTERSIVE CARE UNIT       46. 00         70. 00       THER SPECIAL CARE (SPECIPY)       1         47. 00       Cost Center Description       1.00         70. 00       The SPECIAL CARE (SPECIPY)       1         48. 00       Program inpatient costs: (sum of Times 41 through 48) (see instructions)       31, 101       49. 00         70. 00       PASS Through costs applicable to Program Inpatient routine services (from Wkst. D. sum of Parts I and III)       0       50. 00         71. 00       Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts I and III)       0       50. 00         71. 00       Pass through costs applicable cost (sum usi into 52)       0       0       50. 00       50. 00         71. 00       Program excludable cost (sum usi into 52)       0       6       6. 4. 00       50. 00         71. 00       Target amount (into 54 × line 52)       0       6       6. 4. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50. 00       50.		Financial Systems	WITHAM MEMORI				u of Form CMS-2	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	COMPUT	ATTON OF INPATIENT OPERATING COST		Provider C	F	rom 01/01/2016	Date/Time Pre	pared:
Impart leftImpart leftUser (col. 1(col. 4)42. ORNURSERY (11 to V & XIX only)1.002.003.0047.001.001.002.003.001.0047.0043. OUINTERSIVE CARE UNIT2.637,7281.6621.567.28043. OUINTERSIVE CARE UNIT2.637,7281.6621.567.28047.0045. OUCOMMANT CARE UNIT2.637,7281.6621.567.28047.0046. OUCOMMANT CARE UNIT2.637,7281.6621.567.28047.0047. OUCOST Center Description1.001.0047.0047.0048. OUCOMMANT Description1.001.0047.0049. OUCost Center Description1.001.0047.0049. OUCost Center Description1.001.0047.0040. OUCost Center Description1.001.001.0040. OUCost Center Description1.001.001.0040. OUCost Center Description1.001.001.0040. OUCost Center Description1.001.001.0041.				Ti tl	e XIX	Hospi tal		44 011
1.00         2.00         3.00         4.00         5.00           1.00         1.00         2.00         3.00         4.00         0.00         4.00           3.00         Intermitive Care Dypering at ant Magnitud Units         2.637,728         1.667,28         0         4.00           4.00         CORMANC ARE UNIT         2.637,728         1.682         1.667,28         0         4.00           4.00         CORMANC ARE UNIT         2.637,728         1.682         1.667,28         0         4.00           4.00         CORMANC ARE UNIT         2.637,728         1.682         1.687,728         0         4.00           4.00         CORMANC ARE UNIT         2.637,728         1.682         1.682         4.00         4.00           4.00         Context Exercises         Context Exercises         1.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00		Cost Center Description	I npati ent	Inpati ent	Diem (col. 1	Program Days	(col. 3 x	
Intensive Care Type Impatient Respirat Units         4.50           00         INTERSIVE CARE UNIT         2,637,728         1,632         1,557,28         0         0         4.50           01         INTERSIVE CARE UNIT         2,637,728         1,632         1,557,28         0         0         4.50           00         INTERSIVE CARE UNIT         2,637,728         1,632         0         4.50           00         OPER SPECIAL CARE (SPECIFY)         1         0         4.50         0         4.50         4.50           00         OPER SPECIAL CARE (SPECIFY)         1         1         1.00         4.50           00         OPER SPECIAL CARE (SPECIFY)         1         1.00         4.50         4.50           01         OPER SPECIAL CARE (SPECIFY)         1         1.00         4.50         4.50           01         PARE through costs applicable to Program Inpatient ancillary services (From Wist, D, sum of Parts I and UNI)         5.100         5.100         5.100           02         OPER SPECIAL CARE (SPECIFY)         0         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5.100         5			1.00	2.00	3.00		5.00	
43.00       INTERSIVE CARE UNIT       2.637.728       1.683       1.567.28       0       0.4.00         44.00       CORMARY CARE UNIT       2.637.728       1.683       1.567.28       0       0.4.00         45.00       BURN INTERSIVE CARE UNIT       2.637.728       1.683       1.567.28       0       0       44.00         45.00       BURN INTERSIVE CARE UNIT       2.637.728       1.683       1.567.28       0       0.4.00         45.00       BURN INTERSIVE CARE UNIT       2.637.728       1.682       4.700       4.700         700       OTESE PERCIAL CARE (EXPERI)       1.00       1.00       4.700       7.710       7.700       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710       7.710 <t< td=""><td>42.00</td><td></td><td>12, 941</td><td>993</td><td>13.03</td><td>0</td><td>0</td><td>42.00</td></t<>	42.00		12, 941	993	13.03	0	0	42.00
44 col       CORONARY CARE UNIT       44 col         65 col       BURK ICAL INTERSIVE CARE UNIT       44 col         65 col       BURK ICAL INTERSIVE CARE UNIT       45 col         65 col       BURK ICAL INTERSIVE CARE UNIT       47 col         66 col       BURK ICAL INTERSIVE CARE UNIT       47 col         67 col       DTRESTIVE CARE UNIT       47 col         68 col       Program Inpatient and Ilary service cost (Wist. D-3. col. 3. line 200)       94.237 ft.8 col         69 col       Program Inpatient and Ilary services (From Wist. D. sum of Parts I and Ilar)       51.00         60 col       Program Incalcel cost Analysicable cost (call of lines 50 and 51)       51.00         61 col       Program Incalcel cost Analysicable cost cost cost cost cost cost cost cost	43 00		2 637 728	1 683	1 567 28	0	0	13 00
45. CO BURCH INTERSIVE CABE UNIT       45. CO BURCH INTERSIVE CABE UNIT       45. CO BURCH INTERSIVE CABE UNIT         47. OU OTHER SPECIAL CABE (SPECIP)       1.00       77. OUTHER SPECIAL CABE (SPECIP)         41. CO TORER SPECIAL CABE (SPECIP)       1.00       78. OUTHER SPECIAL CABE (SPECIP)         41. CO TORER SPECIAL CABE (SPECIP)       1.00       78. OUTHER SPECIAL CABE (SPECIP)       78. OUTHER SPECIAL CABE (SPECIP)         52. CO TORER SPECIAL CABE (SPECIP)       1.00       79. OUTHER SPECIAL CABE (SPECIP)       98. OUTHER SPECIAL CABE (SPECIP)       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00			2,037,720	1,003	1, 507. 20	0	0	
47.00       OTHER SPECIAL CARE (SPECIPY)       47.00         0       Cost Center Description       1.00         18.00       Program Inpatient ancillary service cost (West: D-3, col. 3, line 200)       94, 287       48.00         10.00       Cost Cost: ADJESTMENT (sum of lines 41 through 40) (see instructions)       94, 287       48.00         10.00       Program Inpatient ancillary services (from West: D, sum of Parts I and II)       05.00       90.00         10.00       Program excludable cost: (sum of lines 50 and 51)       05.00       10.00       05.00         10.01       Program excludable cost: (sum of lines 50 and 51)       05.00       05.00       05.00         10.01       Program excludable cost: (sum of lines 50 and 51)       05.00       05.00       05.00         10.01       Program excludable cost: (sum of lines 50 and 51)       05.00       05.00       05.00         10.02       Program excludable cost: (sum of lines 50 and 51)       05.00       05.00       05.00         10.01       Program excludable cost: (sum of lines 52)       0.00       05.00       0.00       0.00         10.02       Program discharges       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00       0.00								45.00
Cost Centre Description         1.00           48.00         Program inpatient ancillary service cost (Wst. D.3, col. 3, line 200)         94,28           48.01         Cost Applicable to Program inpatient costs (sum of lines 41 through 48) (see instructions)         91,00           90.01         Cost Applicable to Program inpatient routine services (from Wst. D, sum of Parts I and Introductors (see the program inpatient ancillary services (from Wst. D, sum of Parts I and Introductors (line 40 and 19)         05,00           91.00         Program inpatient operating cost excluding capital related, non-physician anesthetist, and Integram inpatient operating cost excluding capital related, non-physician anesthetist, and Integram inpatient operating cost and target amount (line 54 k line 53)         0,00           91.00         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0,00           90.00         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0,00           90.01         Lesser of Lines 53/24 or 55 from the cost report, updated by the market backet         0.00           0.00         Lesser of Lines 53/24 or 55 from program repatient cost situations)         0.410           0.01         Lesser and Lines S3/24 or 55 from program repatient costs through Decomber 31 of the cost reporting period (see Instructions)         0.400           0.00         Lesser of Lines 53/24 or 55 from phymer (see Instructions)         0.400								46.00
1.00         1.00           48:00         Program inpatient ancillary service cost (Wst. D-3, col. 3, line 200)         94,287         48:00           49:00         Ital Program inpatient costs (sum of lines 41 through 48)(see instructions)         94,287         48:00           49:00         PASS Through costs applicable to Program inpatient nuclinary services (from Wst. D, sum of Parts I and other and V)         50:00         51:00           10:00         Pass through costs applicable to Program inpatient calliary services (from Wst. D, sum of Parts I and other and V)         52:00         52:00           20:00         Total Program excluduble cost (sum of lines 50)         53:00         50:00         50:00           54:00         Program discharge         0.00         50:00         50:00           50:00         Target amount (line 54 x line 55)         0.00         50:00         50:00           50:00         Target amount (line 54 x line 55)         0.00         60:00         50:00         50:00           50:00         Instruct (see instructions)         0.00         60:00         50:00         50:00           60:00         Instructions)         0.00         60:00         50:00         60:00         50:00           60:00         Instructions)         0.00         50:00         50:00         60:00 <td>47.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>47.00</td>	47.00							47.00
48.00       Program Inpatient ancillery service cost (West D-3, col. 3, line 200)       94,283       48.00         94.00       Total Program Inpatient costs (sum of lines 41 through 49)(see Instructions)       311,011       49.00         94.00       Total Program Inpatient costs (sum of lines 41 through 49)(see Instructions)       311,011       49.00         94.00       Total Program Inpatient costs (sum of lines 41 through 49)(see Instructions)       311,011       49.00         91.00       Total Program excludable cost (sum of lines 50 and 51)       51.00       51.00         51.00       Total Program inpatient oparating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52)       64.00         51.00       Total Program anget costs (sum of lines 50 and 51)       55.00       55.00         50.00       Target amount (line 54 x line 55)       50.00       57.00       57.00         51.00       Difference between adjusted inpatient oparating cost and target amount (line 56 minus line 53)       59.00       50.00         52.00       Difference between adjusted inpatient cost secord regort secord regor		Cost Center Description					1 00	
49.00       Total Program inputient costs (sum of lines 41 through 48) (see instructions)       311,901       49.00         ABSS THROUGH COST ADJUSTNEMTS       Fragment inputient costs applicable to Program inputient nucline services (from NKst. D. sum of Parts I and 111)       50.00       50.00         10.10       Pass through costs applicable to Program inputient ancillary services (from NKst. D. sum of Parts II of S1.00       51.00         20.00       Total Program excludable cost (sum of lines 50.00       51.00       52.00         51.00       Degram excludable cost (sum of lines 52.00       54.00       55.00       55.00         52.00       Target amount per discharge       0.54.00       55.00       56.00       56.00         52.00       Dest test frampatient operating cost and target amount (line 56 minus line 53)       67.00       67.00         53.00       Degram excludable cost (sum of lines 55.95 or 00 enter the lesser of 50.00 the amount by anich operating cost and target amount (line 56 minus line 53)       67.00       67.00         53.00       Dest test fram prior year cost report updated by the market basket       0.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00	48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)				48.00
50.00       Pass through costs applicable to Program inpatient routine services (from West. D, sum of Parts I and III)       0         51.00       Pass through costs applicable to Program inpatient ancillary services (from West. D, sum of Parts II and III)       0         52.00       Total Program applicable to Program inpatient ancillary services (from West. D, sum of Parts II and IV)       0         52.00       Total Program and the toperating cost excluding capital related, non-physician anesthetist, and 0       0         53.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0       0         64.00       Program instances       0         55.00       Target amount (Ine 54 x line 55)       0         57.00       Difference between adjusted inpatient operating cost and target amount (Ine 56 minus line 53)       0         58.00       Difference between adjusted inpatient cost reporting period ending 1996, updated and compounded by the market basket       0.00         60.01       Lesser of lines 53/54 or 55 from prior year cost reporting between 55/50 or 16 enter the lesser of 55/50 or 16 he amount by amount (line 50, otherwise enter zoro (see instructions)       0         61.00       If line 51/54 is tass than the lower of lines 55, 59 or 60 enter the lesser of 55/50 or 16 enter the larget amount (line 50, otherwise enter zoro (see instructions)       0         63.00       Medicare swing-bed SF inpatient routine costs through becember 31 of the					ons)			
111)       the intervent of the program inpatient ancillary services (from Wkst. D, sum of Parts II on the program inpatient operating cost excluding capital related, non-physician anesthetist, and the program inpatient operating cost excluding capital related, non-physician anesthetist, and the program inpatient operating cost excluding capital related, non-physician anesthetist, and the program inpatient operating cost excluding capital related, non-physician anesthetist, and the program discharges       0       51.00         54.00       Program discharges       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       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							L	
51:00       Pass's through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II       0       51:00         20:00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and       0       53:00         20:00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and       0       54:00         20:00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and       0       54:00         20:00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and       0       54:00         20:00       Target amount (line 54 x line 55)       0       0       56:00       0         20:00       Difference bateen adjusted inpatient operating cost and target amount (line 53/5 di cf 55 from the cost reporting period ending 19%, updated and compounded by the market basket       0.00       60:00         60:00       Lesser of Line 53/5 di cf 55 from the cost reporting period costs (lines 54 x 60), or 1% of the amount by which apprating costs (line 53) are less than the patient costs further costs (lines 54 x 60), or 1% of the amount by 0       61:00         61:00       The first addition 0       See instructions)       0       62:00         62:00       Del first addition 20       See instructions)       0       62:00         63:00       Maintam	50.00	5 11 5 1	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
and iv)       and iv)       and iv)       and iv)       and iv)         25.00       Total Program excludible cost (sum of lines 50 and 51)       and iv)       bit of the standard s	51 00		ationt ancillar	ny services (f	rom Wkst D si	um of Parts II	0	51 00
52.00       Total Program excludable cost (sum of lines 50 and 51)       0       53.00         53.00       Total Program ingetient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)       53.00         77.80EFT AdMURT AND LIMIT COMPUTATION       0       53.00         54.00       Program discharges       0         50.00       Target amount per discharge       0         50.00       Difference batewan djusted inpatient operating cost and target amount (line 56 minus line 53)       0         50.00       Difference batewan djusted inpatient operating cost and target amount (line 56 minus line 53)       0         51.00       Difference batewan djusted inpatient operating cost science of the sol (line 53)       0         52.00       Difference batewan djusted inpatient operating cost and target amount (line 56) (line 53) and less than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 33) are less than expected costs (lines 54 x 60), or 1% of the amount by main (line 56) (line 30) are less than expected costs (lines 54 x 60), or 1% of the amount by main (line 56) (line 30) are less than the cost report and sched line cost report (line 56) (line 50) (line 100) (line 50) (l	51.00			y services (i	TOIL WKST. D, S			51.00
medical education costs (line 47 minus line 52)         0.0           TARSET MAUNT AND LIMIT COMPUTATION         0.0           54.00 Program discharges         0.00           55.00 Target amount per discharge         0.00           56.00 Target amount per discharge         0.00           57.00 Difference between adjusted inpotient operating cost and target amount (line 56 minus line 53)         0.00           58.00 Bonus payment (see instructions)         0.00           59.00 Lesser of lines 53/54 or 55 from ptior year cost report, updated by the market basket         0.00           61.00 IF ine 53/54 is 155 from ptior year cost report, updated by the market basket         0.00           62.00 Relief payment (see instructions)         0           62.00 Relief payment (see instructions)         0           63.00 All invalue languating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target         0           64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)         0           65.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tite XVIII only)         0           66.00 Total function sing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)         0           67.00 Total medicare swing-bed SF inpatient routine costs after December 31 of the c	52.00	Total Program excludable cost (sum of lines					0	52.00
TARGET AMOUNT AND LIMIT COMPUTATION           14.00         Program discharges         0           55.00         Target amount (ine 54 x line 55)         0           57.00         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0           58.00         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0           59.00         Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket         0.00           60.00         Rel lef payment (see lines than the lower of lines 55, 59 or 40 enter the lesser of 50% of the amount by 0         0           61.00         If line 53/54 is line 53) are less than expected costs (lines 54 x 60), or 18 of the target amount (line 56), otherwise enter zero (see instructions)         0           62.00         Market less line through the cost reporting period (See instructions)         0           63.00         Market less line for the solution costs through December 31 of the cost reporting period (See instructions)         0           64.00         Net left will in only in         0         66.00           64.00         Net left will in only in         0         66.00           65.00         Total Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions)         0           66.00         Title V or	53.00			elated, non-ph	ysician anesth	etist, and	0	53.00
54.00       Program discharges       0       54.00       0       76.00       0       56.00       76.00       0       56.00       76.00       0       56.00       76.00       0       56.00       76.00       0       56.00       76.00       0       56.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       0       0       55.00       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			52)					
55.00       Target amount (ine 54 x line 55)       0.00       55.00         56.00       Target amount (ine 54 x line 55)       0.00       55.00         57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55.00         59.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       59.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       If lines 53/54 ir 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       If lines 53/54 ir 55 from prior year cost report, updated py the market basket       0.00       61.00         62.00       Medicare string-bed SWF inpatient routine costs through December 31 of the cost reporting period (See       0       64.00         64.00       Medicare sming-bed SWF inpatient routine costs (line 64 plus line 65) (tite XVIII only). For       0       64.00         65.00       Tite V or XIX swing-bed FF inpatient routine costs (line 67 + line 63)       0       67.00         66.00       Tite V or XIX swing-bed FF inpatient routine costs (line 67 + line 63)       0       67.00         67.00       Tite V or XIX swing-bed FF inpatient routine costs (line 71 + line 63)       0       67.00 <td>54 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>54 00</td>	54 00						0	54 00
56.00       Target amount (line 54 x line 55)       0       56.00       57.00       0       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       56.00       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       57.00       0       0       57.00       0       0       57.00       0       0       57.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
58.00       Bonus payment (see instructions)       0       58.00       59.00         59.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       59.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       I'resser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       I'resser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       I'resser of lines 53/54 or 55 from the cost report is post of the target amount (line 56), otherwise enter zero (see instructions)       0       61.00         63.00       All owable inpatient could is costs through December 31 of the cost reporting period (See instructions)       0       62.00         64.00       Medicare swing-bed SF inpatient routine costs fire December 31 of the cost reporting period (See instructions)       0       66.00         65.00       Tit e Y or XIX swing-bed NF inpatient routine costs for line 67 + line 68)       0       67.00         66.00       Tit e Y or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         67.00       Tit e Y or XIX swing-bed NF inpatient routine costs (line 7 + line 68)       0       69.00         67.00	56.00	Target amount (line 54 x line 55)					0	56.00
59.00       Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the mount by the basket basket       0.00       59.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         61.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         62.00       Relief payment (see instructions)       0       63.00         62.00       Relief payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         65.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)       0       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 67 + line 68)       0       0       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       0       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       0       0         70.00			ing cost and ta	arget amount (	line 56 minus	line 53)		
market basket       0.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       0.00         61:00       If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)       0       61.00         63:00       All owable inpatient cost plus incentive payment (see instructions)       0       62.00         64:00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite XVIII only). For Cost (lite XVIII only)       64.00         65:00       Total Modicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For Cost (see instructions)       0       66.00         66:00       Total Modicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see Instructions)       0       67.00         67:00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (lite 12 × line 19)       0       68.00         68:00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         69:00       Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 68)       0       69.00         70:00       Skilled nursing facillty/Other nursing facility/ICF/ID routine			porting poriod	onding 1004	undated and co	mounded by the	-	
60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00       61.00       61.00       files 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       61.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       62.00       63.00       62.00       63.00       62.00       63.00       64.00       64.00       64.00       64.00       64.00       64.00       66.00       65.00       65.00       65.00       65.00       65.00       66.00       65.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00 <t< td=""><td>59.00</td><td></td><td>porting period</td><td>ending 1996,</td><td>updated and co</td><td>ipounded by the</td><td>0.00</td><td>59.00</td></t<>	59.00		porting period	ending 1996,	updated and co	ipounded by the	0.00	59.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)       0         62:00       Relief payment (see instructions)       0         63:00       Allowable inpatient cost plus incentive payment (see instructions)       0         64:00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)       0         65:00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tite XVIII only). For CAH (see instructions)       0         66:00       Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         67:00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         68:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         69:00       Total title V or XIX swing-bed NF inpatient routine scruce cost (line 71 + line 70)       70.00         70:00       Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 72 + line 73)       71.00         70:00       Title Sort applicable to Program (line 14 x line 35)       72.00         70:00       Forgram routine service cost (line 75 + line 2)       72.00         70:00       Pogram capital -relate	60.00		cost report, up	odated by the	market basket		0.00	60.00
amount (line 5b), otherwise enter zero (see instructions)       0         62.00       Relief payment (see instructions)       0         63.00       Allowable Inpatient cost plus Incentive payment (see instructions)       0         64.00       Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0         65.00       Medicare swing-bed SNF Inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0         66.00       Total Medicare swing-bed SNF Inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)       0       66.00         66.00       Total Medicare swing-bed SNF Inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0       67.00         68.00       Title V or XIX swing-bed NF Inpatient routine costs (line 67 + line 68)       0       0       0         70.00       Skilled nursing facility/Yother nursing facility/IC/FID routine service cost (line 37)       70.00       71.00         71.00       Adjusted general inpatient routine service costs (line 70 + line 2)       72.00       73.00         73.00       Medical ynecesary private room cost applicable to Program (line 14 x line 35)       74.00       74.00         74.00       Total Program coalital-related costs (line 75 + line 2)       74.00       78.00<	61.00						0	61.00
62:00       Relief payment (see instructions)       0       62:00         63:00       Allowable inpatient cost plus incentive payment (see instructions)       0       63:00         64:00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (til te XVIII only)       64:00         65:00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (til te XVIII only).       66:00         66:00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)       66:00         67:00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       67:00         68:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         69:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 63)       0         69:00       Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)       70:00         70:00       Skilled nursing facility/other nursing facility/OF/ID routine service cost (line 37 + line 73)       71:00         71:00       Adjusted general inpatient routine service costs (from 70 + line 2)       72:00         70:00       Capital -related costs (line 75 + line 2)       72:00         70:00       Capi				ts (lines 54 x	60), or 1% of	the target		
63.00       Allowabie' npatient cost plus incentive payment (see instructions)       0       63.00         PROGRAM INPATIENT ROUTINE SWING BED COST       0       64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0       64.00         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)       0       0       0         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0       68.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       0       69.00         70.00       Title V or XIX swing-bed NF inpatient routine costs (line 70 + line 20)       70.00       68.00         71.00       Allowabie degrad inpatient routine service cost per diem (line 70 + line 35)       70.00       70.00         70.00       Skilled nursing facility/Other nursing facility/ICF/ID routine service cost (from Worksheet B, Part II, column 26, line 45)       70.00         70.00       Capital -related costs (line 75 + line 2)       70.00       70.00         70.00 <t< td=""><td>62 00</td><td></td><td>risti uctions)</td><td></td><td></td><td></td><td>0</td><td>62 00</td></t<>	62 00		risti uctions)				0	62 00
PROGRAM INPATLENT ROUTINE SWING BED COST         64.00         del care swing-bed SKF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)         65.00         ded care swing-bed SKF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)         66.00         65.00           66.00         Total Medicare swing-bed SKF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Cost (see instructions)         66.00         66.00           67.00         Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)         67.00         67.00           68.00         Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)         68.00           69.00         Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)         0           70.00         Skilled nursing facility/Other nursing facility/ICF/ID routine service cost (line 37)         70.00           71.10         Adjusted general inpatient routine service cost per diem (line 70 + line 2)         70.00           70.00         Skilled nursing facility/Other oursing facility/ICF/ID routine service cost (line 74 + line 35)         70.00           71.01         Porgram outine service cost (line 74 + line 73)         70.00           73.00         Period costs (line 75 + line 2)         70.00			ent (see instru	uctions)				
instructions)(title XVIII only)65:0065:00Nedicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only).66:0070:0170:0270:0270:0270:0270:0370:0470:0470:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0570:0571:0572:0673:0574:0775:0576:0576:0577:0576:0577:0677:0677:0778:0679:0670:0770:0870:0970:0970:0970:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:0070:00								
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Instructions)Čitite XVIII only)66.0067.0066.00CAH (see instructions)066.00CAH (see instructions)066.00CAH (see instructions)067.00Citle V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)068.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)069.00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY070.00Skilled nursing facility/CFT/ID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)72.0072.00Total Program general inpatient routine service costs (line 72 + line 73)73.0073.00Total -related costs (line 75 + line 2)74.0074.00Program capital -related costs (line 75 + line 2)78.0074.00Program capital -related costs (line 74 minus line 77)79.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0079.00Inpatient routine service cost (see instructions)80.0080.00Inpatient routine service costs (see instructions)80.0080.00Inpatient routine service costs (see instructions)83.0080.00Inpatient routine servic	65 00		ts after Decemb	per 31 of the	cost reporting	neriod (See	0	65 00
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70.00Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)71.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital-related costs (line 75 + line 2)76.0077.00Program capital-related costs (line 74 ninus line 77)70.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Reasonable inpatient noutine service (see instructions)83.0082.00Total Program inpatient operating costs (sum of lines 83 through 85)84.0082.00Adjusted general inpatient outions bed days (see instructions)83.0083.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1.15487.00Adjusted general inpatient operating costs (sum of lines 74 + line 20)1.272.65	69.00	<u> </u>					0	69.00
71.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)71.0072.00Program routine service cost (line 9 x line 71)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column75.0076.00Per diem capital -related costs (line 75 ÷ line 2)76.0077.00Program capital -related costs (line 74 minus line 77)76.0078.00Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)78.0080.00Inpatient routine service cost (see instructions)81.0082.00Reasonable inpatient routine services (see instructions)82.0083.00Reasonable inpatient operating costs (sum of lines 83 through 85)84.0097.00Adjusted general inpatient operating costs (sum of lines 27 + line 2)1,15487.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1,272.65	70.00							70,00
73.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital -related costs (line 75 ÷ line 2)76.0077.00Program capital -related costs (line 74 minus line 77)77.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0080.00Total Program routine service cost per diem limitation79.0081.00Inpatient routine service cost (see instructions)81.0082.00Program inpatient noutine services (see instructions)82.0084.00Program inpatient operating costs (sue of lines 83 through 85)82.0085.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65			2		• •			71.00
74.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Per diem capital -related costs (line 75 ÷ line 2)76.0077.00Program capital -related costs (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost per diem limitation79.0081.00Inpatient routine service cost s (see instructions)80.0082.00Inpatient routine service costs (see instructions)81.0083.00Reasonable inpatient ancillary services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.0087.00Total observation bed days (see instructions)1, 15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 272.65								72.00
75.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service cost per diem limitation81.0081.00Inpatient routine service cost s (see instructions)81.0082.00Reasonable inpatient ancillary services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.0087.00Total observation bed days (see instructions)1, 15487.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1, 272.6588.00Adjusted general inpatient routine cost per diem (line 27 + line 2)1, 272.65			, U	•				
26, line 45)76.0076.00Per diem capital -related costs (line 75 ÷ line 2)76.00Program capital -related costs (line 9 x line 76)77.00Program capital -related costs (line 7 x line 76)78.00Inpatient routine service cost (line 74 minus line 77)79.00Aggregate charges to beneficiaries for excess costs (from provider records)80.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)81.00Inpatient routine service cost per diem limitation82.00Inpatient routine service costs (see instructions)83.00Reasonable inpatient routine services (see instructions)84.00Program inpatient ancillary services (see instructions)85.00Utilization review - physician compensation (see instructions)86.00Total Program inpatient operating costs (sum of lines 83 through 85)PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 15488.00			•			art II. column		
77.00Program capital -related costs (line 9 x line 76)77.0078.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation80.0082.00Inpatient routine service cost (see instructions)81.0083.00Reasonable inpatient routine services (see instructions)82.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.6588.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)88.00	/0/00							/ 01 00
78.00Inpatient routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65								76.00
79.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine services (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.6588.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65			,					
80.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0081.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65				orovi der recor	(sh			
81.00Inpatient routine service cost per diem limitation81.0082.00Inpatient routine service cost limitation (line 9 x line 81)82.0083.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65		55 5 5	· · ·		,	us line 79)		80.00
83.00Reasonable inpatient routine service costs (see instructions)83.0084.00Program inpatient ancillary services (see instructions)84.0085.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)85.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Total observation bed days (see instructions)1,15488.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65						,		81.00
84.00       Program inpatient ancillary services (see instructions)       84.00         85.00       Utilization review - physician compensation (see instructions)       85.00         86.00       Total Program inpatient operating costs (sum of lines 83 through 85)       86.00         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST       1,154         87.00       Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)       1,272.65								82.00
85.00Utilization review - physician compensation (see instructions)85.0086.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Total observation bed days (see instructions)1,15488.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65				าร)				1
86.00Total Program inpatient operating costs (sum of lines 83 through 85)86.00PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST1,15487.00Total observation bed days (see instructions)1,15488.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.65				ons)				1
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST87.00Total observation bed days (see instructions)1,15487.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,272.6588.00			•					86.00
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1, 272.6588.00								1
		<b>J</b>	·					
	57.00			,			1 1, 100, 030	1 0 7. 00

Health Financial Systems	WI THAM MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 44 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	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	957, 083	7, 964, 220	0. 12017	3 1, 468, 638	176, 491	90.00
91.00 Nursing School cost	0	7, 964, 220	0.00000	0 1, 468, 638	0	91.00
92.00 Allied health cost	0	7, 964, 220	0.00000	0 1, 468, 638	0	92.00
93.00 All other Medical Education	0	7, 964, 220	0.00000	0 1, 468, 638	0	93.00

Health Financial Systems WITHAM MEMORIAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0104	Period:	Worksheet D-3	3
			From 01/01/2016 To 12/31/2016		enared.
			10 12/01/2010	5/26/2017 10:	
	Title	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			1, 997, 669		30.00
31. 00 03100 I NTENSI VE CARE UNI T			1, 817, 408		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 1117	42 4, 266, 166	476, 710	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2836		221, 355	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
55. 01 05501 ULTRA SOUND		0. 0825		20, 157	
57.00 05700 CT SCAN		0.0277		57, 105	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0869		27, 500	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1936	27 419, 102	81, 149	59.00
60. 00 06000 LABORATORY		0. 1585	26 4, 395, 475	696, 797	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1154		15, 595	
64. 00 06400 I NTRAVENOUS THERAPY		0.0012		630	
66. 00 06600 PHYSI CAL THERAPY		0. 4079		126, 251	
67. 00 06700 OCCUPATIONAL THERAPY		0. 2268		38, 001	
67. 01 06701 AUDI OLOGY 68. 00 06800 SPEECH PATHOLOGY		0. 2353		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 2680		12, 831 0	
69. 01   06901 CARDI OLOGY		0. 1510		358, 044	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4829		571, 281	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5400		0,1,201	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1566		457, 961	
OUTPATIENT SERVICE COST CENTERS				,	
90. 00 09000 CLINIC		0.0000	00 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000			
90. 02 09002 CLINIC		0.0000			
90. 03 09003 DERMATOLOGY CLINIC		0.0000			
90. 04 09004 ENT CLINIC		0.0000		0	
90. 05 09005 SURGERY CLINIC		0.0000		0	
90. 07 09007 UROLOGY CLINIC 90. 09 09009 GASTROENTEROLOGY CLINIC		0.0161		0	
90. 11 09009 GASTROENTEROLOGY CLINIC		0.0000		0	
90. 12 09012 OPTHAMOLOGY CLINIC		0.0000		0	
90. 13 09013 ALLERGY CLINIC		0. 2940		0	
90. 14 09014 WOUND CARE		0. 2977			•
91.00 09100 EMERGENCY		0. 1823		333, 674	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5631		0	
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			21, 947, 859	3, 495, 073	200.00
			-		0.04 0.0
201.00 Less PBP Clinic Laboratory Services-Program only charge 202.00 Net Charges (line 200 minus line 201)	es (line 61)		0 21, 947, 859		201.00 202.00

NPATIENT A	ncial Systems WITHA NCILLARY SERVICE COST APPORTIONMENT	Provider (	CCN: 15-0104	Peri od:	Worksheet D-3	<u>2552-10</u> 3
				From 01/01/2016		
		Component	CCN: 15-S104	To 12/31/2016	Date/Time Pre 5/26/2017 10:	
		Title	e XVIII	Subprovider -	PPS	TT dim
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	col. 2) 3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			0		30.00
1.00 03100	INTENSIVE CARE UNIT			0		31.00
	SUBPROVIDER - IPF			2, 529, 358		40.00
	SUBPROVI DER – I RF			0		41.00
	SUBPROVI DER			0		42.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS		0 4417	40		50.00
	OPERATING ROOM		0. 1117			
	RADI OLOGY-DI AGNOSTI C		0. 2836		8, 548	
	RADI OLOGY-THERAPEUTI C ULTRA SOUND		0.0000		0	
	CT SCAN		0. 0825			
	MAGNETIC RESONANCE IMAGING (MRI)		0. 02/7			
	CARDI AC CATHETERI ZATI ON		0. 1936			
	LABORATORY		0. 1585		-	
	BLOOD STORING, PROCESSING & TRANS.		0. 1154		181	
	INTRAVENOUS THERAPY		0.0012			
	PHYSI CAL THERAPY		0. 4079		10, 351	66.00
7.00 06700	OCCUPATIONAL THERAPY		0. 2268	52 844	191	67.00
7.01 06701	AUDI OLOGY		0. 2353	28 0		
	SPEECH PATHOLOGY		0. 2680		1, 299	
	ELECTROCARDI OLOGY		0.0000		0	
	CARDI OLOGY		0. 1510			
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4829			
	IMPL. DEV. CHARGED TO PATIENT		0.5400			
	DRUGS CHARGED TO PATIENTS		0. 1566	94 614, 964	96, 361	73.00
	TIENT SERVICE COST CENTERS		0.0000	00 0	0	90.00
	OTHER OUTPATIENT SERVICE COST CENTER		0.0000			
			0.0000			
	DERMATOLOGY CLINIC		0.0000			
	ENT CLINIC		0.0000			
	SURGERY CLINIC		0.0000		0	90.05
	UROLOGY CLINIC		0.0161		0	
0. 09 09009	GASTROENTEROLOGY CLINIC		0.0000	00 0	0	90.09
0.11 09011	NEUROLOGY CLINIC		0.0019	86 0	0	90.11
	OPTHAMOLOGY CLINIC		0.0000		0	
	ALLERGY CLINIC		0. 2940			
	WOUND CARE		0. 2977			
	EMERGENCY		0. 1823			
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 5631	81 0	0	92.00
	REIMBURSABLE COST CENTERS					05.00
200.00	Total (sum of lines 50-94 and 96-98)			1, 387, 229	245, 032	95.00
200.00	Less PBP Clinic Laboratory Services-Program of	only charges (line 61)		1, 387, 229	240,032	200.00

Cost Center Description Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS O30.00 O3000 ADULTS & PEDIATRICS O31.00 O3100 INTENSIVE CARE UNIT O.00 O4000 SUBPROVIDER - IPF	Component	CN: 15-0104 CCN: 15-5832 EXVIII Ratio of Cos To Charges		Date/Time Pre 5/26/2017 10:	epared:
30. 00 31. 00 OJADULTS & PEDIATRICS 31. 00 OJADULTS LOCATE UNIT		Ratio of Cos	To 12/31/2016 Skilled Nursing Facility st Inpatient Program	Date/Time Pre 5/26/2017 10: PPS	
30. 00 31. 00 OJADULTS & PEDIATRICS 31. 00 OJADULTS LOCATE UNIT	Ti tl e	Ratio of Cos	Facility St Inpatient Program	PPS I npati ent	
30. 00 31. 00 OJADULTS & PEDIATRICS 31. 00 OJADULTS LOCATE UNIT			t Inpatient Program		
30. 00 31. 00 OJADULTS & PEDIATRICS 31. 00 OJADULTS LOCATE UNIT			Program		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT				(col. 1 x	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			J	col. 2)	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT		1.00	2.00	3.00	
31. 00 03100 I NTENSI VE CARE UNI T		1			
			0		30.00
IU. UU  U4UUU SUBPRUVIDER - IPF			0		31.00
41.00 04100 SUBPROVI DER – I RF			0		40.00
42. 00 04200 SUBPROVIDER - TRF			0		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		1			10100
50. 00 05000 OPERATI NG ROOM		0. 1117	42 2, 406	269	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2836		8, 401	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			
55. 01 05501 ULTRA SOUND		0.0825			
57.00 05700 CT SCAN		0.0277			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0869			
59. 00 05900 CARDI AC CATHETERI ZATI ON 50. 00 06000 LABORATORY		0. 1936 0. 1585		-	
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1585			
54. 00 06400 I NTRAVENOUS THERAPY		0.0012			
66.00 06600 PHYSI CAL THERAPY		0. 4079			
57.00 06700 OCCUPATI ONAL THERAPY		0. 2268			
57. 01 06701 AUDI OLOGY		0. 2353	28 0	0	67.01
58.00 06800 SPEECH PATHOLOGY		0. 2680		10, 267	
59.00 06900 ELECTROCARDI OLOGY		0.0000		0	
59. 01 06901 CARDI OLOGY		0. 1510			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.4829			
72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS		0. 5400 0. 1566			
OUTPATIENT SERVICE COST CENTERS		0.1500	74 001, 907	130, 190	/ 3.00
20. 00 09000 CLINIC		0.0000	00 0	0	90.00
90. 01 09001 OTHER OUTPATIENT SERVICE COST CENTER		0.0000	00 0	0	90.01
90. 02 09002 CLINIC		0.0000	00 0	0	90.02
PO. 03 09003 DERMATOLOGY CLINIC		0.0000			
90. 04 09004 ENT CLINIC		0.0000			
90. 05 09005 SURGERY CLINIC		0.0000			
90.07 09007 UROLOGY CLINIC		0.0161			
70. 09 09009 GASTROENTEROLOGY CLINIC 70. 11 09011 NEUROLOGY CLINIC		0.0000			
90. 12 09012 OPTHAMOLOGY CLINIC		0.0019			
PO. 13 09013 ALLERGY CLINIC		0. 2940			
70. 14 09014 WOUND CARE		0. 2977			
91.00 09100 EMERGENCY		0. 1823			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5631		0	92.00
OTHER REIMBURSABLE COST CENTERS					4
95.00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)	- (11		4, 564, 921		
201.00 Less PBP Clinic Laboratory Services-Program only charge 202.00 Net Charges (line 200 minus line 201)	s (II ne 61)		0 4, 564, 921		201.00

INPATIENT AN	ncial Systems WITHAM MEMORIAL NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN· 15-0104	Peri od:	u of Form CMS-: Worksheet D-3	
			011. 15 0104	From 01/01/2016	WorkSheet D a	,
				To 12/31/2016		
		Ti +1	e XIX	Hospi tal	5/26/2017 10: Cost	44 am
	Cost Center Description	11.0	Ratio of Cos		Inpatient	
			To Charges		Program Costs	
			5	Charges	(col. 1 x	
					col. 2)	
	LENT DOUTLNE SEDVICE COST CENTEDS		1.00	2.00	3.00	
	I ENT ROUTI NE SERVI CE COST CENTERS		1	366, 347		30.00
	I NTENSI VE CARE UNI T			45, 202		31.00
	SUBPROVI DER – I PF			0,202		40.00
	SUBPROVIDER - IRF			0		41.00
	SUBPROVI DER			0		42.00
43.00 04300	NURSERY			89, 668		43.00
	LARY SERVICE COST CENTERS		1			
	OPERATING ROOM		0. 1117		14, 859	
	RADI OLOGY-DI AGNOSTI C		0. 2836		3, 384	
	RADI OLOGY-THERAPEUTI C		0.0000		0	
	ULTRA SOUND		0.0825		565	
	CT SCAN		0.0277		1, 208	
58.00 05800	MAGNETIC RESONANCE I MAGI NG (MRI)		0.0869		437	
	CARDIAC CATHETERIZATION		0. 1936 0. 1585		576 19, 317	
	BLOOD STORING, PROCESSING & TRANS.		0. 1585		786	
	INTRAVENOUS THERAPY		0. 0012		0	
	PHYSI CAL THERAPY		0.4079		1, 650	
	OCCUPATI ONAL THERAPY		0. 2268		463	
	AUDI OLOGY		0. 2353		0	
	SPEECH PATHOLOGY		0. 2680		88	68.00
69.00 06900	ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
69.01 06901	CARDI OLOGY		0. 1510	74 39, 588	5, 981	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4829	69 51, 758	24, 998	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT		0. 5400	24 0	0	72.00
	DRUGS CHARGED TO PATIENTS		0. 1566	94 85, 323	13, 370	73.00
	TI ENT SERVICE COST CENTERS		0.0000			
	CLINIC		0.0000		0	
90.01 09001	OTHER OUTPATIENT SERVICE COST CENTER		0.0000		0	
90.02 09002 90.03 09003	CLINIC DERMATOLOGY CLINIC		0.0000		0	
	ENT CLINIC		0.0000		0	
	SURGERY CLINIC		0.0000		0	
	UROLOGY CLINIC		0.0161		0	
	GASTROENTEROLOGY CLINIC		0.0000		0	
	NEUROLOGY CLINIC		0.0019		0	
	OPTHAMOLOGY CLINIC		0.0000		0	
	ALLERGY CLINIC		0. 2940		0	
	WOUND CARE		0. 2977		94	90.14
	EMERGENCY		0. 1823		6, 511	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 5631	81 0	0	92.00
	REIMBURSABLE COST CENTERS		1			
	AMBULANCE SERVICES					95.00
200.00	Total (sum of lines 50-94 and 96-98)			551, 035	94, 287	200.00
201.00 202.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0 EE1 02E		201.00
	Net Charges (line 200 minus line 201)		1	551, 035		202.00

	ATION OF REIMBURSEMENT SETTLEMENT WI THAM MEMORIAL HOSPITAL Provider	r CCN: 15-0104	Peri od: From 01/01/2016 To 12/31/2016		pared:
	Ti	tle XVIII	Hospi tal	PPS	uiii
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments			0	1.00
. 01	DRG amounts other than outlier payments for discharges occurring prior	- to October 1	(see	4, 329, 133	1.01
. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or	c after October	1 (see	1, 443, 044	1.02
. 02	instructions)		1 (300	1, 443, 044	1.02
. 03	DRG for federal specific operating payment for Model 4 BPCI for discharge	arges occurring	prior to October	0	1.03
. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discha	argos occurring	on or after	0	1.04
. 04	October 1 (see instructions)	inges occurring		0	1.0-
. 00	Outlier payments for discharges. (see instructions)			36, 656	2.00
. 01	Outlier reconciliation amount			0	2.01
. 02 . 00	Outlier payment for discharges for Model 4 BPCI (see instructions) Managed Care Simulated Payments			0	2.02 3.00
. 00	Bed days available divided by number of days in the cost reporting per	riod (see instr	ructions)	64.85	4.00
	Indirect Medical Education Adjustment	·			
. 00	FTE count for allopathic and osteopathic programs for the most recent	cost reporting	period ending on	0.00	5.00
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet the crite	eria for an add	l-on to the can	0.00	6.00
. 00	for new programs in accordance with 42 CFR 413.79(e)		i on to the cup	0.00	0.00
. 00	MMA Section 422 reduction amount to the IME cap as specified under 42			0.00	7.00
. 01	ACA Section 5503 reduction amount to the IME cap as specified under 42 If the cost report straddles July 1, 2011 then see instructions.	2 CFR §412.105(	(f)(1)(iv)(B)(2)	0.00	7.0
. 00	Adjustment (increase or decrease) to the FTE count for allopathic and	osteopathic pr	ograms for	0.00	8.00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)	(iv), 64 FR 263	340 (May 12,	01.00	0.0
	1998), and 67 FR 50069 (August 1, 2002).				
. 01	The amount of increase if the hospital was awarded FTE cap slots under the cost report straddles July 1, 2011, see instructions.	- section 5503	of the ACA. If	0.00	8. 0 ⁻
. 02	The amount of increase if the hospital was awarded FTE cap slots from	a closed teach	ning hospital	0.00	8.0
	under section 5506 of ACA. (see instructions)		0		
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,	01 and 8,02)	(see	0.00	9.00
0. 00	instructions) FTE count for allopathic and osteopathic programs in the current year	from your reco	ords	0.00	10.00
1.00	FTE count for residents in dental and podiatric programs.	Jour Jour 1000		0.00	
2.00	Current year allowable FTE (see instructions)			0.00	
3.00	Total allowable FTE count for the prior year.	on or ofter Co	ntombox 20 1007	0.00	
4.00	Total allowable FTE count for the penultimate year if that year ended otherwise enter zero.	on or after se	eptember 30, 1997,	0.00	14.00
5.00				0.00	15.00
6.00					16.00
7.00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count				17.00 18.00
9.00				0.000000	•
0.00	Prior year resident to bed ratio (see instructions)			0.000000	•
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000	
				0	
2.01	Indirect Medical Education Adjustment for the Add-on for Section 422 of	of the MMA	l	0	22.0
3.00	Number of additional allopathic and osteopathic IME FTE resident cap s		Sec. 412.105	0.00	23.00
4 00	(f)(1)(iv)(C).			0.00	
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lower of	line 23 or lir	ne 24 (see	0.00 0.00	
0.00	instructions)	20 01 111	10 21 (300	0.00	20.00
6.00	Resident to bed ratio (divide line 25 by line 4)			0.00000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00 8.01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	
9.00				0	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.0 ⁴
0 00	Disproportionate Share Adjustment	ave (see instru	ictions)	2.05	20 0
0.00		iys (see instru	ictions)	3. 05 25. 51	
2.00				28.56	
3.00				12.00	
4 00	Disproportionate share adjustment (see instructions)			173, 165	34.0

Heal th	Financial Systems WITHAM MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period:	Worksheet E	
			From 01/01/2016 To 12/31/2016		pared:
				5/26/2017 10:	
		Title XVIII	Hospital	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			5, 977, 483, 147	35.00
35. 01 35. 02	Factor 3 (see instructions)	tor zoro on this line)	0.000055964		35. 01 35. 02
33. UZ	Hospital uncompensated care payment (If line 34 is zero, en (see instructions)		358, 513	338, 490	30. UZ
35.03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	268, 395	85, 318	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.)		353, 713		36.00
40.00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		jh 46) 0		40.00
40.00	652, 682, 683, 684 and 685 (see instructions)	discharges for M3-DRGS	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS an 685. (see instructions)	-DRGs 652, 682, 683, 684	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not gual	ify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6	J J /	0		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
45.00	days) Average weekly cost for dialysis treatments (see instruction:	s)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 4		0		46.00
47.00	Subtotal (see instructions)		6, 335, 711		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instruction			6, 335, 711	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			464, 362	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt Direct graduate medical education payment (from Wkst. E-4, I			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			1, 588	
54.01	Islet isolation add-on payment	(0)		0	54.01
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int			0	55.00 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		nrouah 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		5 ,	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			6, 801, 661	
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu:	s line 60)		6, 968 6, 794, 693	
62.00	Deductibles billed to program beneficiaries	s The boy		873, 096	
63.00	Coinsurance billed to program beneficiaries			1, 288	
64.00	Allowable bad debts (see instructions)			101, 771	
65.00	Adjusted reimbursable bad debts (see instructions)	tructione)		66, 151	
66.00 67.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructions)		78, 265 5, 986, 460	
68.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	e instructions)	0, 700, 400	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50 70. 88	RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment			0	70. 50 70. 88
70.88 70.89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		0	70.88 70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			20, 249 -3, 832	
	Recovery of accel erated depreciation				70.95

Health Financial Systems	WI THAM MEMORI AL HOSPI TAL		104		u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provide	r CCN: 15-0		Period: From 01/01/2016 To 12/31/2016		
	Ti	tle XVIII		Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1.00	
70.96 Low volume adjustment for federal fisht the corresponding federal year for t		0	2	2016	488, 558	70.96
70.97 Low volume adjustment for federal fis the corresponding federal year for th	scal year (yyyy) (Enter in column		2	2017	137, 906	70.97
70.98 Low Volume Payment-3	he period charny on or arter 10/1				0	70.98
70.99 HAC adjustment amount (see instructio	ons)				0	
71.00 Amount due provider (line 67 minus l					6, 629, 341	
71.01 Sequestration adjustment (see instru					132, 587	
72.00 Interim payments					6, 453, 740	
73.00 Tentative settlement (for contractor	use only)				0	
74.00 Balance due provider (Program) (line					43, 014	74.00
75.00 Protested amounts (nonallowable cost					0	75.00
CMS Pub. 15-2, chapter 1, §115.2	•					
TO BE COMPLETED BY CONTRACTOR (lines						
90.00 Operating outlier amount from Wkst.		s)			0	
91.00 Capital outlier from Wkst. L, Pt. I,					0	,
92.00 Operating outlier reconciliation adj					0	
93.00 Capital outlier reconciliation adjus	tment amount (see instructions)				0	
94.00 The rate used to calculate the time					0.00	
95.00 Time value of money for operating ex					0	
96.00 Time value of money for capital rela	ted expenses (see instructions)			D.1	0	96.00
				Prior to 10/1 1.00	2.00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100.00
HVBP Adjustment for HSP Bonus Payment	t					1
101.00 HVBP adjustment factor (see instruct	i ons)			0. 000000000	0. 000000000	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 instructio				0. 0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus	payment (see instructions)			0	0	104.00

LOW VC	DLUME CALCULATION EXHIBIT 4			Provider C		eriod: rom 01/01/2016 o 12/31/2016		pared
				Title	xviii	Hospi tal	572672017 TU: PPS	44 dill
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
. 00	DRG amounts other than outlier	1.00	0	0	0	0	0	1.0
. 01	payments DRG amounts other than outlier payments for discharges	1.01	4, 329, 133	0	4, 329, 133		4, 329, 133	1.0
. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 443, 044	0		1, 443, 044	1, 443, 044	1.C
. 03	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1.03	O	0	0		0	1.0
. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1.04	0	0		0	0	1. C
. 00	October 1 Outlier payments for discharges (see instructions)	2.00	36, 656	0	27, 491	9, 165	36, 656	2.0
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	_	0	-	
3.00 4.00	Operating outlier reconciliation Managed care simulated	2. 01 3. 00	0	0		0	0	
	payments							
00	Indirect Medical Education Adju		0,000000	0,00000	0,000000	0,000000		
. 00 . 00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 000000	0. 000000		0. 000000	0	5. 0 6. 0
. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. (
	managed care (see instructions)							
	Indirect Medical Education Adju					0.00000		_ <i>,</i>
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000				7.0
. 00 . 01	IME adjustment (see instructions) IME payment adjustment add on	28. 00 28. 01	0	0	0	0	0	
. 01	for managed care (see instructions)	28.01	0	0		0	0	0.1
. 00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.(
. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. (
0 00	Disproportionate Share Adjustme		0.1000	0 1200	0 1000	0. 1200		1 10 /
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1200	0. 1200	0. 1200	0. 1200		10. (
1. 00	Disproportionate share adjustment (see instructions)	34.00	173, 165	0	129, 874	43, 291	173, 165	11.(
1. 01	Uncompensated care payments	36.00	353, 713	0	268, 395	85, 318	353, 713	11. (
2.00	Additional payment for high per Total ESRD additional payment	<u>centage of ES</u> 46.00	KD beneficiary	di scharges 0	0	0	0	12.0
3.00	(see instructions) Subtotal (see instructions)	47.00	6, 335, 711	0	4, 754, 893	1, 580, 818	6, 335, 711	12 (
4.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0, 333, 711	0	4, 754, 895	1, 560, 818 0	0, 555, 711 0	
5. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	6, 335, 711	0	4, 754, 893	1, 580, 818	6, 335, 711	15. (
	Payment for inpatient program capital	50.00	464, 362	0				
	Special add-on payments for new technologies Net organ aquisition cost	54.00	1, 588	0	1, 191	397	1, 588	
7. 01 7. 02		68.00	0	0	0	0	0	17.0 17.0

	Financial Systems		WI THAM MEMORI			In Lie	u of Form CMS-2	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
					XVIII	Hospi tal	PPS	
			Amounts (from		Period Prio		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C		0 0	0	18.00
19.00	SUBTOTAL			0	5, 104, 35	56 1, 697, 305	6, 801, 661	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	464, 120	0	348, 04	90 116, 030	464, 120	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0	C		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	242	0	18	32 60	242	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2.01	0	C		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0. 0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6.00	0	O		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	C		0 0	0	25.00
26.00		12.00	464, 362	C	348, 2	72 116, 090	464, 362	26.00
	······	W/S E, Part A						
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 0957 488, 55		488, 558	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				137, 906	137, 906	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

OSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	5 Provider CC	CN: 15-0104	Period:	Worksheet E	
					From 01/01/2016 To 12/31/2016		pared
			Title	XVIII	Hospi tal	PPS	_
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1.00	1.0
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4, 329, 133		0	0	
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 443, 044		5, 772, 177	5, 772, 177	1.0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.(
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1.
. 00	Outlier payments for discharges (see instructions)	2.00	36, 656		0 36, 656	36, 656	2.
. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.
. 00	Operating outlier reconciliation	2. 01	0		0 0	0	3.
. 00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0		0 0	0	4.
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0. 000000		5.
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	0	6. 6.
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	he MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0. 000000		7.
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0 0 0	0	8. 8.
00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29. 01	0		0 0	0	9.
	Al I owable disproportionate share percentage	33.00	0 1200	0. 120	0 1200		10
	(see instructions) Disproportionate share adjustment (see	33.00	0. 1200 173, 165	0. 120	0 0. 1200 0 173, 165	173, 165	10.
	(astructions) Uncompensated care payments	36.00	353, 713	268, 39	-	353, 713	
	Additional payment for high percentage of ES			,			1
. 00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.
	Subtotal (see instructions)	47.00	6, 335, 711	268, 39	95 6, 067, 316	6, 335, 711	13.
. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.
. 00		49.00	6, 335, 711	268, 39	6, 067, 316	6, 335, 711	15.
. 00	Payment for inpatient program capital	50.00	464, 362		0 464, 362	464, 362	16.
	Special add-on payments for new technologies		1, 588		0 1, 588	1, 588	
	Net organ acquisition cost		., 500		., 500	., 200	17.
	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
00	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18.
3. 00	amount (see instructions)						

	Financial Systems	WI THAM MEMORI				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 10:	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	464, 120		0 464, 120	464, 120	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	242		0 242	242	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.000	0. 0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	464, 362		0 464, 362	464, 362	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	488, 558			488, 558	1
29.00	Low volume adjustment on or after October 1	70. 97	137, 906		137, 906		
	HVBP payment adjustment (see instructions)	70. 93	20, 249		0 20, 249		
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0		0 0	0	30.01
	payment (see instructions)						
	HRR adjustment (see instructions)	70. 94	-3, 832		0 -3, 832		
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99	1.00	2.00	0 0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems WITHAM MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0104	Period:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2016 To 12/31/2016	Part B	narod
			10 12/31/2010	5/26/2017 10:	
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			7 501	1 1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		7, 521 6, 844, 312	1.00
3.00	PPS payments			7, 339, 744	3.00
4.00	Outlier payment (see instructions)			1, 325	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	uctions)		0.000	5.00 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 7, 521	10.00 11.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,021	11.00
10.00	Reasonabl e charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		41, 970 0	12.00
14.00	Total reasonable charges (sum of lines 12 and 13)	The 09)		41, 970	
	Customary charges				
	Aggregate amount actually collected from patients liable for			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
	Total customary charges (see instructions)			41, 970	
19.00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds l	ine 11) (see	34, 449	19.00
20.00	Excess of reasonable cost over customary charges (complete or	nlvifline 11 exceeds l	ine 18) (see	0	20.00
	instructions)	5		-	
	Lesser of cost or charges (line 11 minus line 20) (for CAH se	ee instructions)		7, 521	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	22.00 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			7, 341, 069	
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	or CAH see instructions	)	0 1, 495, 317	25.00 26.00
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			5, 853, 273	
~~ ~~	instructions)			0	
	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28.00 29.00
	Subtotal (sum of lines 27 through 29)	)		5, 853, 273	
	Primary payer payments			1, 283	
32.00	Subtotal (line 30 minus line 31)	(())		5, 851, 990	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. 1-5, line 11)	CES)		0	33.00
	Allowable bad debts (see instructions)			127, 464	
	Adjusted reimbursable bad debts (see instructions)			82, 852	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	tructions)		115, 762 5, 934, 842	36.00 37.00
	MSP-LCC reconciliation amount from PS&R			248	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction		-+:)	0	39.50
39.98 39.99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	39.98 39.99
	Subtotal (see instructions)			5, 934, 594	40.00
	Sequestration adjustment (see instructions)			118, 692	40.01
	Interim payments Tentative settlement (for contractors use only)			5, 733, 614 0	41.00 42.00
42.00	Balance due provider/program (see instructions)			82, 288	
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	02,200	44.00
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104 Component CCN: 15-S104	Period: From 01/01/2016 To 12/31/2016		
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			751	1 1 (
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru	ctions)		394	1.0
00	PPS payments			552	
00	Outlier payment (see instructions)			0	4.0
00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
00	Line 2 times line 5			0	6.0
00 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV. col. 13. line 200		0	9.0
. 00	Organ acquisitions			0	10.0
. 00	Total cost (sum of lines 1 and 10) (see instructions)			751	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable charges			4, 791	1 1 2 1
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		4, 791	12.0
. 00	Total reasonable charges (sum of lines 12 and 13)			4, 791	
	Customary charges				
6.00	Aggregate amount actually collected from patients liable for			0	
. 00	Amounts that would have been realized from patients liable for	1 5	on a chargebasis	0	16.
. 00	had such payment been made in accordance with 42 CFR §413.13 Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17.
3.00	Total customary charges (see instructions)			4, 791	
. 00	Excess of customary charges over reasonable cost (complete o	nly if line 18 exceeds l	ne 11) (see	4,040	
	instructions)	-			
0. 00	Excess of reasonable cost over customary charges (complete of	nly if line 11 exceeds l	ne 18) (see	0	20.
. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH s	oo instructions)		751	21.
	Interns and residents (see instructions)			0	21.
8.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	23.
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			552	24.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 05
5.00 5.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	or CAH see instructions		0	25. 26.
. 00 . 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			1, 303	
	instructions)			,	
8.00	Direct graduate medical education payments (from Wkst. E-4,			0	28.
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36	)		0	
0. 00 . 00	Subtotal (sum of lines 27 through 29)			1, 303 0	30. 31.
2.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 303	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	ICES)		1,000	021
8.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.
. 00	Allowable bad debts (see instructions)			0	34.
	Adjusted reimbursable bad debts (see instructions)	tructions)		0	
b. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	tructrons)		0 1, 303	
. 00 3. 00	MSP-LCC reconciliation amount from PS&R			1, 303	38.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	-		0	39.
. 98	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	0	39.
. 99 . 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 1, 303	39. 40.
. 00	Sequestration adjustment (see instructions)			26	
. 00	Interim payments			1, 480	
. 00	Tentative settlement (for contractors use only)			0	
. 00	Balance due provider/program (see instructions)			-203	
. 00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	44.
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
. 00	Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)			0	
. 00					
. 00 2. 00 3. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.

	Financial Systems WITHAM MEMORIAL H		In Lie	u of Form CMS-2	2552-10
CALCUL		Provider CCN: 15-0104 Component CCN: 15-5832	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	
		Title XVIII	Skilled Nursing Facility	5/26/2017 10: 4 PPS	<u>44 am</u>
			- I delifit y	1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES				1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	ions)		99 0	1.00 2.00
3.00	PPS payments			5	3.00
4.00	Outlier payment (see instructions)				4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	tions)		0	5.00 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	V		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	V, COL. 13, LINE 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			99	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			629	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			629	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e	)	-	0,000000	47 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17.00 18.00
19.00	Excess of customary charges over reasonable cost (complete onl)	y if line 18 exceeds li	ne 11) (see		19.00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete onl instructions)	y if line 11 exceeds li	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		99	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		0	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			00	26.00 27.00
27.00	instructions)	rus the sum of filles 2.		77	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 99	29.00 30.00
30.00 31.00	Primary payer payments			99	30.00
32.00	Subtotal (line 30 minus line 31)				32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	36.00
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			99	37.00 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions			0	39.50
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instru	ctions)	0	39.98 39.99
40.00	Subtotal (see instructions)			99	40.00
40.01	Sequestration adjustment (see instructions)			2	40.01
41.00 42.00	Interim payments Tentative settlement (for contractors use only)			123 0	41.00 42.00
43.00	Balance due provider/program (see instructions)				43.00
44.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	chapter 1,	0	44.00
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)				90.00
91.00	Outlier reconciliation adjustment amount (see instructions)				91.00
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				92.00 93.00
	Total (sum of lines 91 and 93)				93.00 94.00
			I	'	

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Worksheet E-1 Part I Date/Time Pre 5/26/2017 10:	pared:
		Title	XVIII	Hospi tal	PPS	_
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		6, 453, 74	10 0	5, 733, 614 0	
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					-
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
3. 02				0	0	
3.03				0	0	
3.04 3.05				0	0	
5.05	Provider to Program			0	0	3.0
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3.51				0	0	3.5
3.52				0	0	
3.53				0	0	
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
5.99	3. 50-3. 98)			0	0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 453, 74	10	5, 733, 614	4.0
	TO BE COMPLETED BY CONTRACTOR					
6. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. C
	Program to Provider			-		
5. 01 5. 02	TENTATI VE TO PROVIDER			0	0	
5.02				0	0	
	Provider to Program			<u> </u>		1
5. 50	TENTATI VE TO PROGRAM			0	0	
5. 51				0	0	
. 52 . 99	Subtatal (sum of lines 5 01 5 40 minus sum of lines			0	0	
. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			U	0	5.9
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. (
. 01	SETTLEMENT TO PROVIDER		43, 01	4	82, 288	
. 02	SETTLEMENT TO PROGRAM		,	0	0	6.0
7.00	Total Medicare program liability (see instructions)		6, 496, 75		5,815,902 NPR Date	7.(
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C	)	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0104 CCN: 15-S104	Period: From 01/01/2016 To 12/31/2016	5 Date/Time Pre	pare
		Title	× XVIII	Subprovider -	5/26/2017 10: PPS	44 a
		Inpati en	it Part A	I PF Pa	rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	-	1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		2, 029, 7	59 0	1, 480 0	1. 2. 3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
)1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
)3 )4				0	0	3
)4 )5				0	0	
	Provider to Program					
0	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52 53				0	0	
53 54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 029, 7	59	1, 480	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider		1	-		
)1 )2	TENTATI VE TO PROVI DER			0	0	5
)2 )3				0	0	5
	Provider to Program					
0	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
7	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			2	0	6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		2, 029, 7	0	203 1, 277	6
50			2,029,7	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	2	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component	CN: 15-0104 CCN: 15-5832	Period: From 01/01/201 To 12/31/201		pared
		Title	xviii	Skilled Nursing		
		Inpatien	t Part A	Facility Pa	rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		1, 389, 2	76 0	123 0	1. ( 2. ( 3. (
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	3.
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	э.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 389, 2	76	123	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	5
03				0	0	5
- 0	Provider to Program			0		-
50 51	TENTATI VE TO PROGRAM			0	0	5 5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER			0	0	6
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 389, 2	0	26 97	6 7
			1, 307, 2	Contractor	NPR Date	/
				Number	(Mo/Day/Yr)	
	Name of Contractor	(	0	1.00	2.00	

Heal th	Financial Systems WITHAM MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0104	Peri od:	Worksheet E-1	
			From 01/01/2016 To 12/31/2016		narod
			10 12/31/2010	5/26/2017 10:	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		ie 14	2, 289	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		3, 121	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			482	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		6, 787	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			295, 532, 009	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		2, 278, 925	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	/Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ins)	0	32.00

	Financial Systems WITHAM MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period: From 01/01/2016	Worksheet E-3 Part II	
		Component CCN: 15-S104	To 12/31/2016		
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
I. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	dical education payments	)	2, 237, 974	1.0
. 00	Net IPF PPS Outlier Payments			9, 353	2.
. 00	Net IPF PPS ECT Payments			0	3.
. 00	Unweighted intern and resident FTE count in the most recent	cost report filed on or	pefore November	0.00	4.
0.1	15, 2004. (see instructions)			0.00	
. 01	Cap increases for the unweighted intern and resident FTE cou program or hospital closure, that would not be counted witho			0.00	4.
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		under 42		
5.00	New Teaching program adjustment. (see instructions)			0.00	5.
b. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0.00	6.
	teaching program" (see instuctions)	···· ··· ·· ··· ·· ··· ··· ··· ··· ···			
7.00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0.00	7.
	teaching program" (see instuctions)				
8.00	Intern and resident count for IPF PPS medical education adju	stment (see instructions	)	0.00	8.
9.00	Average Daily Census (see instructions)	the newsraph [150, 1]		7.527322	9.
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of $.5150 - 1$ .		0.000000	
1.00 2.00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0	11. 12.
3.00	Nursing and Allied Health Managed Care payment (see instruct	i op)		2, 247, 327 0	12.
4.00	Organ acquisition (DO NOT USE THIS LINE)			0	14.
5.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	15.
6.00	Subtotal (see instructions)			2, 247, 327	
7.00	Primary payer payments			15, 926	
8.00	Subtotal (line 16 less line 17).			2, 231, 401	18.
9.00	Deducti bl es			151, 844	19.
0.00	Subtotal (line 18 minus line 19)			2, 079, 557	20.
1.00	Coinsurance			8, 372	
2.00	Subtotal (line 20 minus line 21)			2, 071, 185	
3.00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		0	23.
4.00	Adjusted reimbursable bad debts (see instructions)			0	24.
5.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	25.
6.00	Subtotal (sum of lines 22 and 24)	Line (0)		2,071,185	
7.00	Direct graduate medical education payments (from Wkst. E-4, Other pass through costs (see instructions)	TThe 49)		0	27. 28.
9.00	Outlier payments reconciliation			0	20.
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.
0.50	Pioneer ACO demonstration payment adjustment (see instructio	ns)		0	30.
0.99	Recovery of Accelerated Depreciation			0	30.
1.00	Total amount payable to the provider (see instructions)			2, 071, 185	31.
1.01	Sequestration adjustment (see instructions)			41, 424	31.
2.00	Interim payments			2, 029, 759	32.
3.00	Tentative settlement (for contractor use only)			0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 32			2	34.
35.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	35.
	§115.2 TO BE COMPLETED BY CONTRACTOR				
0.00	Original outlier amount from Worksheet E-3, Part II, line 2			9, 353	50
51.00	Outlier reconciliation adjustment amount (see instructions)			¢, 333 0	51.
52.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				53.

	Financial Systems WITHAM MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period:	Worksheet E-3	
		Component CCN: 15-5832	From 01/01/2016 To 12/31/2016		nared
			10 12/31/2010	5/26/2017 10:	44 am
		Title XVIII	Skilled Nursing	PPS	
			Facility		
			-		
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTH	IER HEALTH SERVICES FOR	ITTLE XVIII PART	A PPS SNF	
	SERVICES PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				-
1.00	Resource Utilization Group Payment (RUGS)			1, 563, 768	1.00
2.00	Routine service other pass through costs			1, 303, 700	2.00
3.00	Ancillary service other pass through costs			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			1, 563, 768	4.00
1.00	COMPUTATION OF NET COST OF COVERED SERVICES			1,000,700	1.00
5.00	Medical and other services (Do not use this line as vaccine of	costs are included in li	ne 1 of W/S E.		5.00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6.00
7.00	Coinsurance			146, 139	7.00
8.00	Allowable bad debts (see instructions)			0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)		0	9.00
	Adjusted reimbursable bad debts (see instructions)			0	
	Utilization review			0	11.00
	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 1	0 and 11)(see instruction	ons)	1, 417, 629	•
	Inpatient primary payer payments			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
	Recovery of Accel erated Depreciation			0	
	Subtotal (see instructions			1, 417, 629	•
15.01	Sequestration adjustment (see instructions)			28, 353	
	Interim payments			1, 389, 276	
	Tentative settlement (for contractor use only) Balance due provider/program (line 15 minus lines 15.01, 16,	and 17)		0	17.00 18.00
			2 chaptor 1	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accorda §115.2	THE WILLI CHIS IN PUD. 15-	-z, chapter i,	0	19.00

CALCUL	Financial Systems WI THAM MEMORIAL H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0104	Period:	Worksheet E-3	2552-10 B
			From 01/01/2016 To 12/31/2016		epared: 44 am
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	TICES FOR TITLES V OR	XIX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		311, 910		1.00
2.00	Medical and other services		011, 710	0	
3.00	Organ acquisition (certified transplant centers only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		311, 910	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		311, 910	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				_
	Reasonabl e Charges		504.047		
8.00	Routine service charges		501, 217	0	8.00
9.00 10.00	Ancillary service charges		551, 035	0	9.00
11.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 052, 252	0	1
12.00	CUSTOMARY CHARGES		1,052,252	0	12.00
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s	5			
14.00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14.00
	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	1
16.00	Total customary charges (see instructions)		1, 052, 252	0	
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	740, 342	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete only	y IF IIne 4 exceeds II	ne u	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	(ctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 10		311, 910	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be of				21.00
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		311, 910	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 00 00
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00 32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		311, 910	0	
33.00			0	0	
	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	311, 910	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
38.00	Subtotal (line 36 ± line 37)		311, 910	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		311, 910	0	40.00
41.00	Interim payments		285, 224	0	
42.00	Balance due provider/program (line 40 minus line 41)		26, 686	0	
42.00	Protested amounts (nonallowable cost report items) in accordance		0	0	43.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2016 o 12/31/2016	Worksheet G Date/Time Pre 5/26/2017 10:	
		General Fund	Speci fi c Purpose Fund 2.00	Endowment Fund 3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	27, 623, 969	0	0	0	1.0
00	Temporary investments	12, 831, 683	0	0	0	
00	Notes receivable		0	0	0	3.0
00 00	Accounts receivable Other receivable	14, 059, 089 2, 156, 911	0	0	0	4.0
00	Allowances for uncollectible notes and accounts receivable	2, 150, 911	0	0	0	6.0
00	Inventory	2, 693, 483	-	0	0	
00	Prepai d'expenses	C	0	0	0	8.
00	Other current assets	977, 013		0	0	
). 00	Due from other funds	0	0	0	0	10.
. 00	Total current assets (sum of lines 1-10)	60, 342, 148	0	0	0	11.
2.00	FI XED ASSETS Land	0	0	0	0	12.
. 00 . 00	Land improvements	15, 269, 174	0	0	0	13.0
	Accumulated depreciation	0	0	0	0	
	Bui I di ngs	405, 853	0	0	0	15.
	Accumulated depreciation	0	0	0	0	16.
	Leasehold improvements	0	0	0	0	17.
	Accumulated depreciation	0	0	0	0	18.
	Fixed equipment	0	0	0	0	19. 20.
	Accumulated depreciation Automobiles and trucks	0	0	0	0	20.
	Accumulated depreciation	0	0	0	0	21.
	Major movable equipment	137, 747, 688	-	0	0	
	Accumulated depreciation	-66, 499, 751	0	0	0	24.
. 00	Minor equipment depreciable	0	0	0	0	25.
	Accumulated depreciation	0	0	0	0	26.
	HIT designated Assets	0	0	0	0	27.
	Accumulated depreciation	0	0	0	0	28.
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	86, 922, 964	0	0	0	29. 30.
. 00	OTHER ASSETS	00, 922, 904	0	0	0	30.
. 00	Investments	0	0	0	0	31.
2.00	Deposits on Leases	C	0	0	0	32.
	Due from owners/officers	0	0	0	0	33.
	Other assets	17, 585, 925		0	0	34.
	Total other assets (sum of lines 31-34)	17, 585, 925		0	0	35.
o. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	164, 851, 037	0	0	0	36.
00	Accounts payable	2, 340, 688	0	0	0	37.
	Salaries, wages, and fees payable	8, 202, 966		0	0	
	Payroll taxes payable	0		0	0	39.
. 00	Notes and Loans payable (short term)	0	0	0	0	40.
	Deferred income	0	0	0	0	
	Accel erated payments	0			0	42.
	Due to other funds Other current liabilities	3, 607, 774	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	14, 151, 428		0	0	
	LONG TERM LI ABI LI TI ES	11/101/120				1.01
. 00	Mortgage payable	0	0	0	0	46.
. 00	Notes payable	0	0	0	0	47.
	Unsecured Loans	0	0	0	0	
	Other long term liabilities	56, 819, 333		0	0	49.
	Total long term liabilities (sum of lines 46 thru 49)	56, 819, 333	0	0	0	
. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	70, 970, 761	0	0	0	51.
. 00	General fund balance	93, 880, 276				52
	Specific purpose fund	,0,000,2,0	0			53
	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58.
00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	02 000 27/	_	~	^	E0
. 00 . 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	93, 880, 276 164, 851, 037		0	0	
	TIOLOGI TTANITTLES AND TUNU NATANCES (SUM OF TIMES OF AND	104,001,037	0	0	0	1 00

Heal th	Financial Systems	WI THAM MEMORI AL	L HOSPI TAL			In Lie	u of Form CM	S-2	552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0104		i od: om 01/01/2016 12/31/2016	Worksheet C Date/Time F 5/26/2017 1	G-1 Prep	bared:
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	+	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		88, 385, 599 5, 494, 677 93, 880, 276 0 93, 880, 276 0 93, 880, 276		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	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 11.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
1.00	Fund halfsame at heritarian of mariad	6.00	7.00	8.00					1 00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

ATEMENT	OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0104		iod: m 01/01/2016 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 5/26/2017 10:4	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
PART	I – PATIENT REVENUES						
Gene	eral Inpatient Routine Services						
00 Hosp	pi tal		14, 166, 9	51		14, 166, 951	1.00
DO SUBF	PROVIDER – IPF		3, 008, 1	60		3, 008, 160	2.00
DO SUBF	PROVIDER – IRF			0		0	3.00
	PROVIDER			0		0	4.00
	ng bed - SNF			0		0	5.00
	ng bed - NF			0		0	6.00
	LLED NURSING FACILITY		2, 210, 2	15		2, 210, 215	7.00
	SING FACILITY						8.00
	ER LONG TERM CARE						9.00
	al general inpatient care services (sum of lines 1-9)		19, 385, 3	26		19, 385, 326	10.00
	ensive Care Type Inpatient Hospital Services		1				
	ENSIVE CARE UNIT		3, 671, 4	01		3, 671, 401	11.00
	ONARY CARE UNIT						12.00
	N INTENSIVE CARE UNIT						13.00
	GI CAL INTENSI VE CARE UNI T						14.00
	ER SPECIAL CARE (SPECIFY)						15.00
00 Tota	al intensive care type inpatient hospital services (sum o	of lines	3, 671, 4	01		3, 671, 401	16.00
	al inpatient routine care services (sum of lines 10 and ?	(6)	23, 056, 7	27		23, 056, 727	17.00
	illary services	10)	47, 433, 2		181, 787, 899	229, 221, 114	18.00
	patient services		3, 544, 1		33, 435, 123	36, 979, 273	
	AL HEALTH CLINIC		3, 344, 1	0	33, 435, 123	30, 979, 273	20.00
	ERALLY QUALIFIED HEALTH CENTER			0	0	0	20.00
	E HEALTH AGENCY			0	0	0	22.00
	ULANCE SERVICES		13, 8	58	6, 261, 037	6, 274, 895	23.00
00 CMH0			15,0	50	0,201,037	0, 274, 095	24.00
	ULATORY SURGI CAL CENTER (D. P. )						25.00
00 HOSE							26.00
	S, DIETARY, PHYSICIAN PRIVATE OFF		2,8	86	42, 880, 024	42, 882, 910	
	FESSIONAL FEE		2,0	0	3, 675, 813	3, 675, 813	
	F-INSURED		1,098,7	19	5, 714, 631	6, 813, 350	
	al patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	75, 149, 5		273, 754, 527	348, 904, 082	
	, line 1)				,		
	II - OPERATING EXPENSES						1
00 Oper	rating expenses (per Wkst. A, column 3, line 200)				119, 641, 030		29.00
00 ADD	(SPECI FY)			0			30.00
00				0			31.00
00				0			32.00
00				0			33.00
00				0			34.00
00				0			35.00
	al additions (sum of lines 30-35)				0		36.00
	UCT (SPECIFY)			0			37.00
00				0			38.00
00				0			39.00
00				0			40.00
00				0			41.00
	al deductions (sum of lines 37-41)				0		42.00
00 Tota	al operating expenses (sum of lines 29 and 36 minus line	42)(transfer	1		119, 641, 030		43.00

	Financial Systems	WI THAM MEMORIAL			u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0104	Period:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10 12/31/2010	5/26/2017 10:	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, P	art I, column 3, line	28)		348, 904, 082	1.00
2.00	Less contractual allowances and discounts		ts		230, 669, 234	2.00
3.00	Net patient revenues (line 1 minus line 2				118, 234, 848 119, 641, 030	
4.00	00 Less total operating expenses (from Wkst. G-2, Part II, line 43)					
5.00	Net income from service to patients (line	3 minus line 4)			-1, 406, 182	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscell		servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from laundry and linen service				0	13.00
	Revenue from meals sold to employees and	guests			0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical		nan patients		0	16.00
	Revenue from sale of drugs to other than				0	17.00
	Revenue from sale of medical records and				0	18.00
19.00	Tuition (fees, sale of textbooks, uniform				0	19.00
20.00	Revenue from gifts, flowers, coffee shops	, and canteen			0	20.00
	Rental of vending machines				0	21.00
	Rental of hospital space				0	22.00
	Governmental appropriations				0	23.00
	OTHER OPERATING INCOME				4, 083, 884	
	NON-OPERATING INCOME				2, 816, 975	
	Total other income (sum of lines 6-24)				6, 900, 859	
	Total (line 5 plus line 25)				5, 494, 677	26.00
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and				0	28.00
29.00	Net income (or loss) for the period (line	26 minus line 28)		l	5, 494, 677	29.00

Health Financial Systems WITHAM M CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0104	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre			
		Title XVIII	lloonital	5/26/2017 10: PPS	44 am		
			Hospi tal	PPJ			
				1.00			
PART I - FULLY PROSPECTIVE	METHOD						
CAPITAL FEDERAL AMOUNT				464, 120			
	Capital DRG other than outlier						
	Model 4 BPCI Capital DRG other than outlier						
2.00 Capital DRG outlier payment				242	2.00 2.01		
2.01   Model 4 BPCI Capital DRG ou 3.00   Total inpatient days divide	1 3	cost reporting period (see ins	tructions)	0 19. 15			
	Total inpatient days divided by number of days in the cost reporting period (see instructions) Number of interns & residents (see instructions)						
	percentage (see instructions)	s)		0. 00 0. 00	4.0 5.0		
1.01)(see instructions)	5	5					
7.00 Percentage of SSI recipien 30) (see instructions)	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line						
8.00 Percentage of Medicaid pati	Percentage of Medicaid patient days to total days (see instructions)						
0 Sum of lines 7 and 8					9.0		
00 Allowable disproportionate share percentage (see instructions)					10.0		
1.00 Disproportionate share adju				0			
2.00 Total prospective capital p	ayments (see instructions)			464, 362	12.0		
				1.00			
PART II - PAYMENT UNDER REA	SONABLE COST			1.00			
.00 Program inpatient routine of	capital cost (see instruction	ns)		0	1.0		
.00 Program inpatient ancillary	Program inpatient ancillary capital cost (see instructions)				2.0		
	Total inpatient program capital cost (line 1 plus line 2)				3.0		
					4.C		
5.00  Total_inpatient program cap	bital cost (line 3 x line 4)			0	5.0		
				1.00			
PART III - COMPUTATION OF E							
.00 Program inpatient capital ( .00 Program inpatient capital (		umetanese (sas instructions)		0	1.C		
5 1 1	tal costs (line 1 minus line	umstances (see instructions)		0	3.0		
00 Applicable exception percer		2)		0.00	4.0		
The second secon	to payments (line 3 x line	4)		0.00	5.0		
	extraordinary circumstances	<i>,</i>		0.00	6.0		
.00 Adjustment to capital minir	num payment level for extrao	rdinary circumstances (line 2	x line 6)	0	7.0		
00 Capital minimum payment lev				0	8. (		
, J I I J	nts (from Part I, line 12, as	11 2		0	9. (		
					10.0		
Worksheet L, Part III, line	e 14)		5	0	11.0		
		ital payments (line 10 plus li		0			
			rorrowing period	0	14.0		
4.00 Carryover of accumulated ca			0.1				
4.00 Carryover of accumulated ca (if line 12 is negative, en	iter the amount on this line)	)	0.	0	15 (		
4.00 Carryover of accumulated ca (if line 12 is negative, en 5.00 Current year allowable open		) see instructions)		0	15.0		