REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0048 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 6/8/2020 3:16 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 6/8/2020 Time: 3:16 pm use only]Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 [

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-439, 096	-14, 985	0	0	1.00
2.00	Subprovider - IPF	0	64, 418	528		0	2.00
3.00	Subprovider - IRF	0	-26, 504	6		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-401, 182	-14, 451	0	0	200.00

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

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	TA	Provid	ler CCI	N: 15-0048	Period:	01/2010		ieet S-2	2552 2
							From 01/ To 12/		Date/T	ime Pre	
	1.00	2.	00		3.00			4.00	6/8/20	20 3: 16	pm
	Hospital and Hospital Health Care Co										
)() ()()	Street: 1401 CHESTER BOULEVARD City: RICHMOND	PO Box: State: I	N	Zip Cod	0. 172	74 00	inty: WAYNE				1.
0		Component Na		CCN	CBS			Paym	ent Sys	tem (P,	<u> </u>
				Number	Numb			ed	T, 0, or	- N)	
		1.00		2.00	2.0	0 4.00	E 00	V	XVIII	-	-
	Hospital and Hospital-Based Componen			2.00	3.0	00 4.00	5.00	6.0	0 7.00	8.00	
0	Hospi tal	REID HOSPITAL &		150048	999	15 1	07/01/19	966 N	Р	0	3
0	Subprovider - IPF	CARE SERVI CES SUBPROVI DER		15S048	999	15 4	01/01/20	001 N	Р	0	4
0	Subprovider - IRF	REHAB UNIT		153048 15T048	999		01/01/20		P	0	5
0	Subprovider - (Other)										6
0	Swing Beds - SNF										7
0 0	Swing Beds - NF Hospital-Based SNF										8
00	Hospi tal -Based NF										10
00	Hospital-Based OLTC										11
00 00	Hospital-Based HHA Separately Certified ASC										12
00	Hospi tal -Based Hospi ce	HOSPI CE		151524	999	15	11/03/19	993			14
00	Hospital-Based Health Clinic - RHC										15
00 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
00	Renal Dialysis										18
00	Other										19
								om: 00	2.	00	1
00	Cost Reporting Period (mm/dd/yyyy)							/2019	12/31	/2019	20
00	Type of Control (see instructions)							2			21
						1.00	2.	00	3.	00	1
00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	(ing navm)	onte for	. 1	Y		N			22
00	disproportionate share hospital adju	2	0.5			1					22
	§412.106? In column 1, enter "Y" fo	r yes or "N" for	no. Is th	ni s							
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			dment							
01	Did this hospital receive interim un			for thi	s	Y		Y			22
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or aft	er October 1. (se	ee instruc	ctions)							
02	Is this a newly merged hospital that payments to be determined at cost re					N		N			22
	Enter in column 1, "Y" for yes or "N				15)						
	cost reporting period prior to Octob	er 1. Enter in co	olumn 2, '	'Y" for							
	or "N" for no, for the portion of the October 1.	e cost reporting	period or	n or aft	er						
03	Did this hospital receive a geograph					Ν		N		N	22
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for	no for the portio	on of the	cost	.						
	reporting period occurring on or aft Does this hospital contain at least										
	counted in accordance with 42 CFR 41.										
~~	yes or "N" for no.			1/ 05							
00	Which method is used to determine Me below? In column 1, enter 1 if date						3	N			23
	if date of discharge. Is the method	of identifying th	ne days ir	n this c							
	reporting period different from the reporting period? In column 2, ente										
			In-State		tate	Out-of	Out-of	Medi ca	aid (Other	
			Medicai d			State Modi opi d	State Madi agi d	HMO da	2	di cai d	
			paid day	s elig unp		Medicaid paid days	Medicaid eligible			days	
				da	I		unpai d				
20	If this provider is an LDDC bear's t	optor the	1.00	2.		3.00	4.00	5.00		6.00	
υU	If this provider is an IPPS hospital in-state Medicaid paid days in colum		1, 83	30	221	404	134	6	, 392	134	24
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai	u uavs in column					1	1			1
	4, Medicaid HMO paid and eligible bu										

Ith Financial Systems REID HOSPITA SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provider CC		Period:	1 /2010	Workshe	eet S-2	2
					1/2019	Part I Date/Ti 6/8/202		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Meo	ther di cai d days	
00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	267	5.00	25.
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	e			Urban/Ri			Geogr	
				1. 0		2.0		1
 Enter your standard geographic classification (not v cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not v reporting period. Enter in column 1, "1" for urban or 	or rural. wage) status or "2" for r	at the end ural. If ap	d of the cos		2 2			26. 27.
enter the effective date of the geographic reclassif 00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			CH status in		1			35.
				Begi nn		Endi		
00 Enter applicable beginning and ending dates of SCH s	status Subs	cript line	36 for numb	1.0 er 01/01/		2.0		36.
of periods in excess of one and enter subsequent dat 00 If this is a Medicare dependent hospital (MDH), enter	tes.				0			37.
 is in effect in the cost reporting period. 01 Is this hospital a former MDH that is eligible for a accordance with FY 2016 OPPS final rule? Enter "Y" a instructions) 								37.
00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.				Y/I	M	Y/	/NI	38.
				1.0		2.0		1
 00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "V" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octor no in column 2, for discharges on or after October " 	i), (ii), or the mileage iii)? Enter on adjustmen ober 1. Ente	(iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	er in colum nts in ? "Y" for ye (" for yes o	n s r N		N		39. 40.
					V 1.00	XVIII 2.00	XI X 3.00	
Prospective Payment System (PPS)-Capital					1			
 00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exc 					N N	N	N N	45.
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 00 Is this a new hospital under 42 CFR §412.300(b) PPS				0	N		N	47.
00 <u>Is the facility electing full federal capital paymen</u> Teaching Hospitals	nt? Enter "	Y" for yes	or "N" for	no.	N N	N N	N	47.
00 Is this a hospital involved in training residents in or "N" for no.	n approved G	ME programs	? Enter "Y	" for yes	Y			56.
00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is ' "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "N nth of this "Y", complet	" for no in cost report e Worksheet	n column 1. ing period?	If column 1 Enter "Y"				57.
00 If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §21487 If yes,	complete W	kst. D-5.		s as	N			58.
00 Are costs claimed on line 100 of Worksheet A? If ye	es, comprete	WKSL. D-2,	NAHE 413.8 Y/N	35 Worksho Line	e #	Pass-Ti Qualifi Criterio	cation	
			1.00	2.0	00	3.	00	
00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?01 If line 60 is yes, complete columns 2 and 3 for each	(see instru	ctions)	Y		23. 00	1		60. 60.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/8/2020 3:16	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 instructions) Enter the current year total unweighted primary care 	N			0. 00	. 0.00	61.0
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 	Dra	aron None	Drogrom Code	Unweighted IME	Unuci shtod	61.0
		ogram Name	Program code		Direct GME FTE	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 1, the program name. Enter in column 4, the direct GME FTE unweighted count. 				0.00) 61. 1 ⁰) 61. 2 ⁰
					1.00	
 ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction) 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 	trainec ctions) a Teachi gram. (s	l in this cost ng Health Cen see instruction	reporting peri ter (THC) into			62.0 62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c		uctions)	N	63. 0
			Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Spotion 5504 of the ACA Pass Year ETE Decidents in No	opprovid	dor Sottings	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. med residents y care provider imary care n 3 the ratio	This base year	-		64.0

	PLEX IDENTIFICATION DA	ATA Provi der	Fr	riod: om 01/01/2019	Worksheet S- Part I	
			To	12/31/2019	Date/Time Pr 6/8/2020 3:1	repared 16 pm
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 (col. 3 + col 4))	3/
	1.00	2.00	3.00	4.00	5.00	-
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0.00	0. 00000	00 65.0
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. (col. 1 + col	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settir	ngsEffective fo	r cost reporti	ing periods	
FTEs attributable to rotations (Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 -	unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name	ry care resident 3 the ratio of structions) Program 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 0.0000	
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		
				1.00	0 2.00 3.00	
Inpatient Psychiatric Facility						
00 Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or does it con	itain an IPF subp	rovider? Y		70.
00 If line 70 is yes: Column 1: Did recent cost report filed on or k 42 CFR 412.424(d)(1)(iii)(c)) Cd	d the facility have a before November 15, 2 blumn 2: Did this fac FR 412.424 (d)(1)(iii	004? Enter "Y" for ility train resident)(D)? Enter "Y" for	yes or "N" for no s in a new teach yes or "N" for no	o. (see i ng o.	0	71.
program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	ty DDS					
Column 3: If column 2 is Y, indi	ehabilitation Facilit	y (IRF), or does it	contain an IRF	Y		75.0

REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048 Period:

	Worksheet S-2
′01/2019	Part I

110.00 Did this hospital participate in the Rural Community Hospit			4104	1.00 N	110.00
for yes or "N" for no for each therapy.					
therapy services provided by outside supplier? Enter "Y"	IN IN	IN		111	109.00
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00 N	3.00 N	4.00 N	109.00
UFK Section 9412.113(C). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	I Speech	Respi ratory	
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.	CRNA fee sche	edul e? See 42	N		108.00
reimbursed. If yes complete Wkst. D-2, Pt. II.		0			
training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col			t		
107.00 If this facility qualifies as a CAH, is it eligible for cos			N		107.00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	noa or paymen	t N		106.00
105.00 Does this hospital qualify as a CAH?		bod of norm	+ N		105.00
Rural Providers				1	
Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.	n 1 for title	V, and in			
98.06 Does title V or XIX follow Medicare (title XVIII) when cost			Y	Y	98.06
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.	column I for t	ittev, and i			
98.05 Does title V or XIX follow Medicare (title XVIII) and add b				Y	98.05
in column 2 for title XIX.		titte v, and			
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			N	N	98.04
for title V, and in column 2 for title XIX.					
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y				N	98.03
for title V, and in column 2 for title XIX.					
98.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	Y	98.02
title XIX.					
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t				Y	98.01
column 1 for title V, and in column 2 for title XIX.	oporting of	AFACC CR WI-+	V	V V	00.01
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			T	T	70.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the i			0.00 Y	0.00 Y	97.00
applicable column.					
95.00 f line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye	0. 00 N	0.00 N	95.00		
applicable column.					
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	no in the	Ν	N	94.00
93.00 Does this facility operate an ICF/IID facility for purposes	of title V an	nd XIX? Enter	Ν	N	93.00
instructions) Enter "Y" for yes or "N" for no in the applic	able column.			111	
full or in part? Enter "Y" for yes or "N" for no in the app 92.00 Are title XIX NF patients occupying title XVIII SNF beds (d				N	92.00
91.00 Is this hospital reimbursed for title V and/or XIX through			N	Y	91.00
90.00 Does this facility have title V and/or XIX inpatient hospit yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
Title V and XIX Services					
			1.00	XI X 2.00	-
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	VIV	
87.00 Is this hospital an extended neoplastic disease care hospit	al classified	under section		N	87.00
86.00 Did this facility establish a new Other subprovider (exclud §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	led unit) under	42 CFR Secti	on		86.00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i		2		N	85.00
"Y" for yes and "N" for no. TEFRA Provi ders					-
81.00 Is this a LTCH co-located within another hospital for part	or all of the	cost reportin	g period? Enter	N	81.00
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye	s and "N" for	no.		N	80.00
Long Term Care Hospital PPS				1.00	-
				0/0/2020 3. 10	
			To 12/31/2019		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-0048	Period: From 01/01/2019	Worksheet S-2 Part I	2
Health Financial Systems REID HOSPITAL & HEA				u of Form CMS-	

complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES			n Lie	u of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:		Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 6/8/202	me Pre	epared:
		1.00		2. (20	_
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Commu Health Integration Project (FCHIP) demonstration for this cost reporting peri "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, ento integration prong of the FCHIP demo in which this CAH is participating in col Enter all that apply: "A" for Ambulance services; "B" for additional beds; an for tele-health services.	iod? Enter er the lumn 2.	N		2.0]	111.00
Wisseller and Cast Departing Information			1.00) 2.00	3.00	-
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in co is yes, enter the method used (A, B, or E only) in column 2. If column 2 is ' 3 either "93" percent for short term hospital or "98" percent for long term of psychiatric, rehabilitation and long term hospitals providers) based on the of Pub. 15-1, chapter 22, §2208.1.	"E", enter care (inclu definition	in column udes	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for 117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" in no.	for yes or		Y N			116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	1			118.00
	Premiums	Losse	S	Insur	ance	
	1.00	2.00		3. (_
118.01 List amounts of malpractice premiums and paid losses:		0	0			0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other that		1.00 N)	2. (00	118.02
Administrative and General? If yes, submit supporting schedule listing cost 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 Harmless provisi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" fo "N" for no. Is this a rural hospital with < 100 beds that qualifies for the (Hold Harmless provision in ACA §3121 and applicable amendments? (see instruct Enter in column 2, "Y" for yes or "N" for no.	ion in ACA `or yes or Outpatient	Y		N		119.00 120.00
121.00 Did this facility incur and report costs for high cost implantable devices cl	harged to	Y				121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w) Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in the Worksheet A line number where these taxes are included.		Y		5.0	06	122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for yes and "N" for	rno.lf	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2.	ation date					126.00
127.00 If this is a Medicare certified heart transplant center, enter the certifica in column 1 and termination date, if applicable, in column 2.						127.00
128.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification center.		ן ו				128.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certifi	ïcation					130. 00
date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certi date in column 1 and termination date, if applicable, in column 2.	i fi cati on					131.00
132.00 If this is a Medicare certified islet transplant center, enter the certification in column 1 and termination date, if applicable, in column 2.	tion date					132.00
133.00 If this is a Medicare certified other transplant center, enter the certification of th	tion date					133.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number in (and termination date, if applicable, in column 2. All Providers	column 1					134.00
All providers 140.00 Are there any related organization or home office costs as defined in CMS Pul chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home offi are claimed, enter in column 2 the home office chain number. (see instruction	fice costs	Y				140. 00

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provider CC	N: 15-004			/01/2019 /31/2019	Date/Time Pr	repared
1.00		2.00					3.00	6/8/2020 3: 1	16 pm
If this facility is part of a cha	in organization, enter		es 141 throu	uah 143 tl	ne nam	e and		of the	
home office and enter the home of									
41.00 Name: REID HOME OFFICE	Contractor's Name	e: WPS		Contr	actor'	s Num	ber: 0810)1	141. C
42.00 Street: 1100 REID PARKWAY	PO Box:								142. C
43.00 City: RICHMOND	State:	IN		ZipC	ode:		4737	4	143.0
								1.00	-
44.00 Are provider based physicians' co	sts included in Worksh	eet A?						Y	144. C
						1	. 00	2.00	
45.00 If costs for renal services are c							Y		145.0
inpatient services only? Enter "Y no, does the dialysis facility in									
period? Enter "Y" for yes or "N"			I this cost	reportinț	,				
46.00 Has the cost allocation methodolo		evi ousl	v filed cost	report?			N		146. (
Enter "Y" for yes or "N" for no i					lf				
yes, enter the approval date (mm/	dd/yyyy) in column 2.								_
								1.00	_
47.00Was there a change in the statist	cal basis? Enton "\/"	for yes	or "N" for	20				1.00 N	147. (
47.00 Was there a change in the statist 48.00 Was there a change in the order o								N N	147.0
49.00 Was there a change to the simplif					for n	D .		N	149. (
			Part A	Part			tle V	Title XIX	
			1.00	2.00		3	. 00	4.00	
Does this facility contain a prov									
or charges? Enter "Y" for yes or	"N" for no for each co	mponent			B. (S	ee 42			455
55.00Hospital			N	N			N	N	155.0
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N			N N	N N	156. (157. (
58. 00 SUBPROVI DER			IN .	IN				IN IN	158. 0
59. 00 SNF			N	Ν			Ν	N	159.0
50. 00 HOME HEALTH AGENCY			N	N			N	N	160.0
61.00 CMHC				Ν			Ν	N	161. C
								1.00	_
Multicampus 55.00 s this hospital part of a Multic	amplic becnited that ha	<u> </u>		coc in di	fforo	at CPS	Ac2	N	165. 0
Enter "Y" for yes or "N" for no.		s one o	i iiore caliipu	Ses III ui	Tiele	IL CDS	AS (IN	105.0
	Name		County	State	Zip(Code	CBSA	FTE/Campus	
	0		1.00	2.00	3. (00	4.00	5.00	
66.00 If line 165 is yes, for each								0.0	00 166. C
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)									
column 5 (see instructions)								1.00	
column 5 (see instructions) Health Information Technology (HI						Act		1	
column 5 (see instructions) Health Information Technology (HI 67.00Is this provider a meaningful use	r under §1886(n)? Ente	er "Y"	for yes or "	N" for no).			1.00 Y	
column 5 (see instructions) Health Information Technology (HI 67.001s this provider a meaningful use 68.001f this provider is a CAH (line 1	r under §1886(n)? Ente D5 is "Y") and is a mea	er "Y" ani ngfu	for yes or " I user (line	N" for no).		the	1	
column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instrue	er "Y" ani ngfu cti ons)	for yes or " I user (line	N" for no 167 is '). 'Y"), (enter		1	168. (
column 5 (see instructions) Health Information Technology (HI 67.001s this provider a meaningful use 68.001f this provider is a CAH (line 1 reasonable cost incurred for the 68.011f this provider is a CAH and is	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user,	er "Y" aningfu ctions) does t	for yes or " I user (line his provider	N" for no 167 is " qualify). 'Y"), (for a	enter		1	168. (
column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or	er "Y" aningfu ctions) does t "N" fo	for yes or " I user (line his provider r no. (see i	N" for no 167 is " qualify nstructio). 'Y"), (for a ons)	enter hards	hi p	Y	168. (168. (
column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	r under §1886(n)? Entr 25 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" aningfu ctions) does t "N" fo	for yes or " I user (line his provider r no. (see i	N" for no 167 is " qualify nstructio). 'Y"), (for a ons)	enter hards "), en	hip ter the	Y 9.1	168. (168. (
column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful	r under §1886(n)? Entr 25 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" aningfu ctions) does t "N" fo	for yes or " I user (line his provider r no. (see i	N" for no 167 is " qualify nstructio). 'Y"), (for a ons)	enter hards "), en Begi	hip ter the nning	Y 9. [.] Endi ng	168. (168. (
column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" aningfu ctions) does t "N" fo and is	for yes or " I user (line his provider r no. (see i not a CAH (N" for no 167 is ' qualify nstructio line 105). 'Y"), (for a ons)	enter hards "), en Begi	hip ter the	Y 9.1	168. (168. (99169. (
column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" aningfu ctions) does t "N" fo and is	for yes or " I user (line his provider r no. (see i not a CAH (N" for no 167 is ' qualify nstructio line 105). 'Y"), (for a ons)	enter hards "), en Begi	hip ter the nning	Y 9. [.] Endi ng	168. (168. (99169. (
column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" aningfu ctions) does t "N" fo and is	for yes or " I user (line his provider r no. (see i not a CAH (N" for no 167 is ' qualify nstructio line 105). 'Y"), (for a ons)	enter hards "), en Begi	hip ter the nning	Y 9. [.] Endi ng	168. (168. (99169. (
column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1 reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" aningfu ctions) does t "N" fo and is	for yes or " I user (line his provider r no. (see i not a CAH (N" for no 167 is ' qualify nstructio line 105). 'Y"), (for a ons)	enter hards "), en <u>Begi</u> 1	hip ter the nning .00	Y 9. 1 Endi ng 2. 00	168. (168. (99169. (
column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 1) reasonable cost incurred for the 58.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" aningfu ctions) does t "N" fo and is ing dat	for yes or " I user (line his provider not. (see i not a CAH (e for the re	N" for no 167 is ' qualify nstructic line 105 porting). 'Y"), (for a ons)	enter hards "), en <u>Begi</u> 1	hip ter the nning	Y 9. [.] Endi ng	0 171. C
column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	r under §1886(n)? Entr D5 is "Y") and is a mea HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) Deginning date and end vider have any days for	er "Y" aningfu ctions) does t "N" fo and is ing dat	for yes or " I user (line his provider r no. (see i not a CAH (e for the re iduals enrol	N" for no 167 is ' qualify nstructic line 105 porting led in	o. YY"), o for a ons) is "N'	enter hards "), en <u>Begi</u> 1	hip ter the nning .00	Y 9. 1 Endi ng 2. 00	168. (168. (99 169. (170. (

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part II Date/Time Pr	epared
				N/ /NI	6/8/2020 3:1	<u>6 pm</u>
				Y/N 1.00	 2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente			-
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c		instructions)		V/I	1.
			Y/N 1.00	Date 2.00	3.00	_
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum	Program? If n 3, "V" for	N	2.00	3.00	2.
00	voluntary or "I" for involuntary. 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 othe relationships? (see instructions)	offices, drug ler or its of the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A	04/28/2020	4
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		N			5
				Y/N	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	-
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	Y Y		7		
00 . 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c	IS.		Y		9
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
~~	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14
. 00	Did total beds available change from the prior cost reporti		<u>yes, see inst</u> "t A	ructions. Par	N t B	15
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	04/01/2020	Y	04/01/2020	17
. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19

Health Financial Systems

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			CN: 15-0048	Worksheet S		
				From 01/01/2019 To 12/31/2019	Part II Date/Time P 6/8/2020 3:	
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		-	N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made dur	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	porting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repo	rting period?	lf yes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	f yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during th copy.	yes, submit	Ν	27.00		
28.00	Interest Expense Were new loans, mortgage agreements or letters of credit e	reporting	N	28.00		
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	eserve Fund)	Y	29.00		
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	see	Y	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without i		Ν	31.00		
	i nstructi ons. Purchased Servi ces		, , , ,			_
32.00	Have changes or new agreements occurred in patient care se	ervi ces furni she	ed through co	ntractual	Y	32.00
33.00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive biddina? If	Y	33.00
	no, see instructions.		3	J		
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement with	h provider-ba	sed physi ci ans?	Ν	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based	Ν	35.00
				Y/N	Date	
				1.00	2.00	
o (o o	Home Office Costs			N		
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of					38.00
39.00	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth					39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lf ves, see			40.00
	instructions.					
	Cost Depart Dropaner Costant Information	1.	. 00	2.	00	
41 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	KEDDV				41 00
41.UU	held by the cost report preparer in columns 1, 2, and 3,	KERRY		BEJARANO		41.00
42.00	respectively. Enter the employer/company name of the cost report	BKD				42.00
43.00	preparer. Enter the telephone number and email address of the cost	3173834000		KBEJARANO@BKD. (СОМ	43.00
	report preparer in columns 1 and 2, respectively.			ļ		I

Heal th	Financial Systems	REID HOSPITAL & HEA	LTH CARE SE	ERVI CES		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE	Provi de	er CCN: 15-0048	Peri		Worksheet S-2	
					To	m 01/01/2019	Part II Date/Time Pre	nared
						12/ 31/ 2017	6/8/2020 3: 16	
				3.00				
	Cost Report Preparer Contact Informati	on						
41.00	Enter the first name, last name and th		SENIOR MANA	AGING CONSULTAN	Г			41.00
	held by the cost report preparer in co	lumns 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the	cost report						42.00
	preparer.							
43.00	Enter the telephone number and email a	ddress of the cost						43.00
	report preparer in columns 1 and 2, re	specti vel y.						

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019		
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e		I/P Days / O/P Visits / Trips 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 Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	133	48, 54			1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 5.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		133	48, 54	45 0.00	0 0 0	5.00 6.00 7.00
8.00 9.00 10.00 11.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00	30	10, 95	50 0. 00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	43.00	163	59, 49	95 0.00	0 0 0	12. 0 13. 0 14. 0 15. 0
6.00 7.00 8.00 9.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	40. 00 41. 00	38 20	13, 87 7, 30		0	16. 0 17. 0 18. 0 19. 0 20. 0
20.00 21.00 22.00 23.00 24.00 24.10 25.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	116. 00 30. 00	O		0		20.00 21.00 22.00 23.00 24.00 24.10 25.00
6.00 6.25 7.00 8.00 9.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	89. 00	221			0 0	26. 0 26. 2 27. 0 28. 0 29. 0
0. 00 1. 00 2. 00 2. 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		Ο		0		30. 0 31. 0 32. 0 32. 0
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33. 0 33. 0

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019		pare
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
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)	18, 784	1, 545	37, 78			1.
00	HMO and other (see instructions)	3, 919	7, 151				2
00	HMO IPF Subprovider	894	1, 296				3
00	HMO IRF Subprovider	288	299				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
00	Hospital Adults & Peds. Swing Bed NF		0		0		6
00	Total Adults and Peds. (exclude observation	18, 784	1, 545	37, 78	3		7
00	beds) (see instructions) INTENSIVE CARE UNIT	2, 708	213	5, 17	6		8
0	CORONARY CARE UNI T	2,700	213	5,17	0		
00	BURN INTENSIVE CARE UNIT						1
00	SURGI CAL I NTENSI VE CARE UNI T						1
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY		77	1, 88	9		13
00	Total (see instructions)	21, 492	1, 835	44, 84	8 15.47	1, 364. 57	14
00	CAH visits	0	0		0		1!
00	SUBPROVIDER - IPF	5, 589	102	8, 93	6 0.00	57.63	1
00	SUBPROVI DER – I RF	2, 744	0	4, 17	4 0.00	23.40	
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						10
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						2
00 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22
00	HOSPICE	917	50	1, 16	6 0.00	22. 21	
10	HOSPICE (non-distinct part)	, , , ,	50	1, 10	0 0.00	22.21	24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26
00	Total (sum of lines 14-26)				15.47	1, 467. 81	27
00	Observation Bed Days		315	4, 72	2		28
00	Ambulance Trips	0					29
00	Employee discount days (see instruction)			57			30
00	Employee discount days - IRF			8			31
00	Labor & delivery days (see instructions)	0	134	19			32
01	Total ancillary labor & delivery room				0		32
. 00	outpatient days (see instructions) LTCH non-covered days	0					33
	LTCH non-covered days LTCH site neutral days and discharges	0					33

HOSPITAL AND HOSPITAL HEALT	TH CARE COMPLEX STATISTICA	AL DATA	Provider C	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/8/2020 3:16	pared:
		Full Time Equivalents		Di s	scharges		
Component		Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers		10.00		Patients	<u> </u>
		11.00	12.00	13.00	14.00	15.00	1.00
8 exclude Swing Bed, Hospice days)(see in for the portion of L 100 HMO and other (see i HMO I PF Subprovider HMO I RF Subprovider 5.00 Hospital Adults & Pe 6.00 Hospital Adults & Pe	ds. Swing Bed SNF ds. Swing Bed NF s. (exclude observation ons) UNIT ARE UNIT SPECIFY) ons)	0. 00 0. 00 0. 00	C C C	9 5, 8 3	13 1, 787 132 20	11, 209 11, 209 647 281	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
23. 00 AMBULATORY SURGI CAL	CENTER (D. P.)						23.00
24.00 HOSPICE		0.00					24.00
24. 10 HOSPICE (non-disting	t part)						24.10
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC							25.00 26.00
26. 25 FEDERALLY QUALIFIED	HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines		0.00					27.00
28.00 Observation Bed Days							28.00
29.00 Ambul ance Trips							29.00
30.00 Employee discount da 31.00 Employee discount da							30.00 31.00
1 3	ys - TRF s (see instructions)						31.00
32.01 Total ancillary labo							32.00
outpatient days (see	instructions)						
33.00 LTCH non-covered day					0		33.00
33.01 LTCH site neutral da	ys and discharges			1	0		33. C

Health Financial Systems

REID H	HOSPI TAL	&	HEALTH	CARE	SERVI CES	

SPII	AL WAGE INDEX INFORMATION			Provider CC	Fi Ti		Date/Time Pre 6/8/2020 3:16	pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	(col.2 ± col. 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
00	Total salaries (see	200. 00	86, 913, 294	. 0	86, 913, 294	3, 089, 162. 63	28. 13	1.0
00	instructions) Non-physician anesthetist Part		C	0	0	0.00	0.00	2.0
00	A Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 0
00	B Physician-Part A -		C	0	0	0.00	0. 00	4.0
01	Administrative Physicians - Part A - Teaching		<i>.</i>		0	0.00	0. 00	4.0
00	Physician and Non Physician-Part B		C	0	0	0.00	0.00	•
00	Non-physician-Part B for hospital-based RHC and FQHC		C	0	0	0.00	0.00	6.0
00	services Interns & residents (in an	21.00	C	1, 703, 560	1, 703, 560	36, 118. 27	47.17	7.0
01	approved program) Contracted interns and residents (in an approved		С	0	0	0.00	0. 00	7.0
00	programs) Home office and/or related organization personnel		C	0	0	0.00	0.00	8.0
00	SNĚ	44.00	0	0	0	0.00		•
. 00	Excluded area salaries (see instructions)		6, 274, 997	508, 446	6, 783, 443	245, 333. 53	27.65	10.0
. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		7, 327, 154	0	7, 327, 154	133, 840. 66	54. 75	11.0
. 00	Care Contract labor: Top level management and other management and administrative		C	0	0	0.00	0. 00	12. C
. 00	services Contract Labor: Physician-Part		577, 217	0	577, 217	3, 848. 12	150. 00	13.0
. 00	A - Administrative Home office and/or related		c ,		0	0.00		14.0
. 00	organization salaries and wage-related costs			0	0	0.00	0.00	14.0
. 01	Home office salaries		15, 474, 561	0	15, 474, 561	581, 753. 79	26.60	14.0
. 02	Related organization salaries		C	0	0	0.00		
. 00	Home office: Physician Part A - Administrative		Ĺ	0	0	0.00	0.00	15. C
. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		C	0	0	0.00	0.00	16. C
. 00	Wage-related costs (core) (see instructions)		22, 874, 483	0	22, 874, 483			17.0
. 00	Wage-related costs (other) (see instructions)							18. C
. 00	Excluded areas		2, 033, 895	0	2, 033, 895			19.0
. 00	Non-physician anesthetist Part A		C	0	0			20.0
. 00	Non-physician anesthetist Part B		C	0	0			21.0
. 00	Physician Part A - Administrative		C	0	0			22.0
. 01 . 00	Physician Part A - Teaching Physician Part B		C	0	0			22. C 23. C
. 00	Wage-related costs (RHC/FQHC)		C	0	0			24.0
. 00	Interns & residents (in an approved program)		313, 675	0	313, 675			25.0
. 50	Home office wage-related (core)		3, 464, 709	0	3, 464, 709			25.5
. 51	Related organization wage-related (core)		C	0	0			25.5
. 52	Home office: Physician Part A - Administrative – wage-related (core)		C	0	0			25. 5
. 53	Home office & Contract Physicians Part A - Teaching -		C	0	0			25.5
	wage-related (core)							
. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	273, 126	0	273, 126	11, 067. 32	24.68	26.0
. 00	Administrative & General	5.00						

Heal th	Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		eri od:	Worksheet S-3	
						rom 01/01/2019		
						o 12/31/2019		
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	6/8/2020 3:16 Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
		Number	Reported	(from Wkst.	$(col.2 \pm col.)$	Salaries in	col. 5)	
				(110m WKSt. A-6)	3)	col. 4	COI. 5)	
		1.00	2.00	3.00	4.00	5.00	6,00	
28.00	Administrative & General under	1.00	3, 819, 225		3, 819, 225			28.00
20100	contract (see inst.)		0/01//220	0	0,01,7220	01,010101	00101	20.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	327, 775	0	327, 775	14, 316. 91	22.89	30.00
31.00	Laundry & Linen Service	8.00	516, 302	-168, 229	348, 073	22, 683. 61	15.34	31.00
32.00	Housekeepi ng	9.00	2,047,038	0	2, 047, 038	138, 019. 84	14.83	32.00
33.00	Housekeeping under contract		0	0	C	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10. 00	3, 074, 633	-2, 453, 746	620, 887	37, 752. 57	16. 45	34.00
35.00	Dietary under contract (see		17, 640	0	17, 640	264.00	66. 82	35.00
	instructions)							
36.00	Cafeteri a	11.00	0	2, 453, 746	2, 453, 746	149, 143. 01	16. 45	36.00
37.00	Maintenance of Personnel	12.00	0	0	C	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	220, 719	220, 719	2, 080. 00	106. 11	38.00
39.00	Central Services and Supply	14.00	643, 107	0	643, 107	38, 766. 10	16. 59	39.00
40.00	Pharmacy	15.00	4, 161, 967	0	4, 161, 967	122, 118. 33	34.08	40.00
41.00	Medical Records & Medical	16.00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17.00	3, 795, 580	0	3, 795, 580	116, 721. 11	32. 52	42.00
43.00	Other General Service	18.00	0	0	(C	0.00	0.00	43.00

Heal th	Financial Systems	REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2019	Worksheet S-3 Part III	
						To 12/31/2019	Date/Time Pre	
							6/8/2020 3:16	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		90, 750, 159	-1, 703, 560	89, 046, 599	3, 110, 905. 03	28.62	1.00
	instructions)							
2.00	Excluded area salaries (see		6, 274, 997	508, 446	6, 783, 443	3 245, 333. 53	27.65	2.00
	instructions)							
3.00	Subtotal salaries (line 1		84, 475, 162	-2, 212, 006	82, 263, 156	2, 865, 571. 50	28. 71	3.00
	minus line 2)							
4.00	Subtotal other wages & related		23, 378, 932	0	23, 378, 932	2 719, 442. 57	32.50	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 339, 192	0	26, 339, 192	0.00	32.02	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		134, 193, 286	-2, 212, 006	131, 981, 280	3, 585, 014. 07	36.81	6.00
7.00	Total overhead cost (see		25, 208, 130	166, 676	25, 374, 806	999, 020. 72	25.40	7.00
	instructions)							
								-

OSPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019		pare
				6/8/2020 3:16 Amount	pm
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				1
	RETIREMENT COST]
. 00	401K Employer Contributions			0	
. 00	Tax Sheltered Annuity (TSA) Employer Contribution			3, 047, 135	2.
. 00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.
. 00	Qualified Defined Benefit Plan Cost (see instructions)			0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
00	401K/TSA Plan Administration fees			0	5.
00	Legal/Accounting/Management Fees-Pension Plan			0	6.
00	Employee Managed Care Program Administration Fees			0	7.
	HEALTH AND INSURANCE COST				
00	Health Insurance (Purchased or Self Funded)			0	8.
01	Health Insurance (Self Funded without a Third Party Administra			0	
02	Health Insurance (Self Funded with a Third Party Administrato	r)		13, 592, 053	
03	Health Insurance (Purchased)			0	1 °
00	Prescription Drug Plan			86, 540	
0. 00	Dental, Hearing and Vision Plan			521, 489	
. 00	Life Insurance (If employee is owner or beneficiary)			109, 752	
2.00	Accident Insurance (If employee is owner or beneficiary)			0	
3. 00	Disability Insurance (If employee is owner or beneficiary)			357, 707	
1.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	
5.00	'Workers' Compensation Insurance			656, 992	
5.00	Retirement Health Care Cost (Only current year, not the extra	ordinary accrual require	ed by FASB 106.	0	16.
	Non cumulative portion)				
7 00	TAXES			(100 7/7	1 1 7
7.00	FICA-Employers Portion Only			6, 480, 767	
3.00 9.00	Medicare Taxes - Employers Portion Only Unemployment Insurance			0 84, 275	
0. 00	State or Federal Unemployment Taxes OTHER			0	20
1.00	Executive Deferred Compensation (Other Than Retirement Cost R	enorted on lines 1 throu	igh (above (see	0	21.
. 00	instructions))	eported on times i through	igii 4 above. (see	0	21.
2.00	Day Care Cost and Allowances			0	22
3.00	Tui ti on Rei mbursement			285, 343	
. 00	Total Wage Related cost (Sum of lines 1 -23)			25, 222, 053	
	Part B - Other than Core Related Cost				1 ~ "

		ID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-00	048 Period:	Washishast C 2	
HUSPII	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-00	From 01/01/2019	Worksheet S-3 Part V	
			To 12/31/2019		nared
			10 12/01/2017	6/8/2020 3:16	
	Cost Center Description		Contract Labor	Benefit Cost	
	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Iden	ti fi cati on:			
1.00	Total facility's contract labor and benefi	t cost	7, 327, 154	25, 222, 053	1.00
2.00	Hospi tal		7, 327, 154	23, 188, 158	2.00
3.00	Subprovider - IPF		0	986, 439	3.00
4.00	Subprovider - IRF		0	451, 728	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				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	Hospi tal -Based Hospi ce		0	407, 186	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		0	0	17.00
18.00	Other		0	188, 542	18.00

lealth Financial Systems	REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-1
HOSPITAL-BASED HOSPICE IDENTIFICATIO	N DATA		Provider C	CN: 15-0048	Period:	Worksheet S-9	
					From 01/01/2019		
			Hospi ce CCI	N: 15-1524	To 12/31/2019		pared
						6/8/2020 3:16	pm
		1			Hospi ce I		
	Undupl i cated						
	Days						
	Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
			Skilled	Nursi ng		cols. 1, 2 &	
			Nursi ng	Facility		5)	
			Facility				
	1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS FOR (OST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00 Hospice Continuous Home Care							1.0
2.00 Hospice Routine Home Care							2.0
3.00 Hospice Inpatient Respite Car							3.0
4.00 Hospice General Inpatient Car	9						4.0
5.00 Total Hospice Days							5.0
Part II - CENSUS DATA FOR COS	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015			
5.00 Number of patients receiving							6.0
hospi ce care							
7.00 Total number of unduplicated							7.0
Continuous Care hours billable	9						
to Medicare							
8.00 Average Length of Stay (line)	5						8.0
/line 6)							
9.00 Unduplicated census count							9.0
IOTE: Parts I and II, columns 1 and	2 also include	the days repor	ted in columns	3 and 4.			
			Title XVIII	Title XIX	Other	Total (sum of	
						cols, 1	
						through 3)	
			1.00	2.00	3.00	4,00	
PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1,	2015		
10.00 Hospice Continuous Home Care			0		0 0	0	10.0
11.00 Hospice Routine Home Care			14,098	77	75 2, 598	17, 471	11. (
2.00 Hospice Inpatient Respite Car	9		122		1 22	145	12.0
3.00 Hospice General Inpatient Car			795	4	19 177		
14.00 Total Hospice Days			15,015				
PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING PE					
15.00 Hospice Inpatient Respite Car			0		0 0		15.0
16.00 Hospice General Inpatient Car			0		0 0		16.0
is as maspiles contrar impatrent our	,		1 0	I	- -		1 10.0

Heal th Fi	nanci al	System	IS			
HOSPI TAL	UNCOMPE	NSATED	AND	I NDI GENT	CARE	DATA

REID HOSPITAL & HEALTH CARE SERVICES

Provider CCN: 15-0048	Period: From 01/01/2019	Worksheet S-10)
		Date/Time Pre 6/8/2020 3:16	
		1.00	
 	-)		

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by li	ne 202 column 8)	0. 283682	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			56, 076, 851	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		-	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment		?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d		0	5.00
6.00	Medicaid charges			169, 597, 241	6.00
7.00	Medicaid cost (line 1 times line 6)			48, 111, 685	7.00 8.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 min < zero then enter zero)	ius sum or lines	2 and 5; 11	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each lin	e)		I	
9.00	Net revenue from stand-al one CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mi	< zero then	0	12.00	
	enter zero)				
	Other state or local government indigent care program (see instructions f				
13.00	Net revenue from state or local indigent care program (Not included on li		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in	lines 6 or	0	14.00
15 00	10) State on least indigent care program east (line 1 times line 14)				15 00
15.00	State or local indigent care program cost (line 1 times line 14)	nrogrom (line	1E minua lina	0	15.00 16.00
16.00	Difference between net revenue and costs for state or local indigent care 13; if < zero then enter zero)	e program (Trne	is minus iine	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and stat	e/local indigen	t care program	ns (see	
	instructions for each line)	erroear rinargen	c care program	13 (300	
17.00	Private grants, donations, or endowment income restricted to funding char	ity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital op			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent		sum of lines	0	19.00
	8, 12 and 16)				
		Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
	Uncompared (and (and instructions for each line)	1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	12 409 120	3, 329, 557	16, 937, 677	20.00
20.00	(see instructions)	13, 608, 120	3, 329, 337	10, 937, 077	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see	3, 860, 379	3, 329, 557	7, 189, 936	21.00
	instructions)				
22.00	Payments received from patients for amounts previously written off as	0	0	0	22.00
	charity care				
23.00	Cost of charity care (line 21 minus line 22)	3, 860, 379	3, 329, 557	7, 189, 936	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days bey	ond a length of	stav limit	N 1.00	24.00
21.00	imposed on patients covered by Medicaid or other indigent care program?	iona a rengen or	Stuy IIIII t		21.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	length of	0	25.00
	stay limit		0		
26.00	Total bad debt expense for the entire hospital complex (see instructions)			18, 994, 796	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see inst	ructions)		1, 336, 124	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instruc	tions)		2, 055, 575	
28.00	Non-Medicare bad debt expense (see instructions)			16, 939, 221	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see	instructions)		5, 524, 803	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			12, 714, 739	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			12, 714, 739	31.00

CLASSI FI CAT	ION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	CN: 15-0048 F	Period: From 01/01/2019	Worksheet A	
					o 12/31/2019	Date/Time Pre 6/8/2020 3:16	
C	cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
	IEW CAP REL COSTS-BLDG & FIXT		0	C			
	IEW CAP BLDG & FIXT - OFFSITE		0	0		6, 215, 457	
	IEW CAP REL COSTS-MVBLE EQUIP	273, 126	0 32, 954	0 306, 080		0 302, 967	
	IONPATI ENT TELEPHONES	275, 120	52, 754	300, 000		0	
	DATA PROCESSING	236, 700	3, 394, 463	3, 631, 163	8 0	3, 631, 163	5.
	PURCHASING RECEIVING AND STORES	40, 848	17, 593	58, 441		58, 441	
	MMI TTI NG CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 084, 816 0	1, 403, 315 259, 499	4, 488, 131 259, 499		4, 472, 955 93, 580	
	THER A&G	3, 169, 373	17, 381, 720				
	PERATION OF PLANT	327, 775	-21, 525	306, 250		306, 250	
00800 D	AUNDRY & LINEN SERVICE	516, 302	503, 670	1, 019, 972	-308, 304	711, 668	8.
	IOUSEKEEPI NG	2,047,038	656, 785			2, 703, 823	
00 01000 E 00 01100 C	DI E I ARY CAFETERI A	3, 074, 633	3, 455, 106	6, 529, 739		1, 319, 058 5, 210, 681	
	URSI NG ADMI NI STRATI ON	0	0			220, 719	
	CENTRAL SERVICES & SUPPLY	643, 107	3, 856, 156	4, 499, 263		4, 499, 263	
	PHARMACY	4, 161, 967	32, 816, 000			36, 975, 653	
	IEDI CAL RECORDS & LI BRARY	0	0	C	-	0	
	SOCIAL SERVICE	2, 373, 482	523, 448			2, 896, 930	
	NSERVICE EDUCATION &R SERVICES-SALARY & FRINGES APPRVD	1, 422, 098 0	2, 024, 256	3, 446, 354		3, 446, 354 1, 789, 013	
	&R SERVICES-SALARI & TRINGES APPRVD	1, 881, 991	1, 298, 709	-		1, 391, 687	
	ARAMED ED PRGM	212,071	38, 710	250, 781		250, 781	
	ENT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS	20, 976, 608	11, 219, 074				
	NTENSI VE CARE UNI T SUBPROVI DER – I PF	3, 385, 039	2, 440, 435	5, 825, 474		5, 825, 474	
	SUBPROVIDER - IRF	3, 289, 920 1, 506, 466	448, 334 405, 397			3, 738, 254 1, 911, 863	
00 04300 N		371, 264	100, 820			472, 084	
ANCI LLA	ARY SERVICE COST CENTERS	1			I.		
	DERATING ROOM DELIVERY ROOM & LABOR ROOM	1, 384, 115	43, 490, 787				
	ADIOLOGY-DIAGNOSTIC	703, 560 6, 669, 577	287, 986 7, 222, 920				
	CARDI AC CATHETERI ZATI ON	1, 890, 765	8, 791, 490				
00 06000 L	ABORATORY	4, 102, 420	8, 615, 626				
	RESPI RATORY THERAPY	1, 484, 967	542, 623				
	PHYSI CAL THERAPY	6, 573, 684	1, 579, 584	8, 153, 268			
	LECTROCARDI OLOGY LECTROENCEPHALOGRAPHY	996, 152 284, 526	927, 456 67, 176	1, 923, 608 351, 702		1, 923, 608 351, 702	
	IEDI CAL SUPPLI ES CHARGED TO PATI ENTS	204, 320	07, 170			0	
	MPL. DEV. CHARGED TO PATIENT	0	0	C	17, 054, 425	17, 054, 425	
	ORUGS CHARGED TO PATIENTS	0	0	C	0 0	0	
	RENAL DIALYSIS	0	783, 130	783, 130	0	783, 130	
	NCILLARY – OTHER CARDIAC REHABILITATION	340, 145	0 92, 323	432, 468	-37, 631	0 394, 837	
	ENT SERVICE COST CENTERS	340, 143	72, 323	+32, 400	57,031	574,037	1 ''
00 09100 E	MERGENCY	6, 187, 668	4, 048, 062	10, 235, 730	-412, 040	9, 823, 690	91
	BSERVATION BEDS (NON-DISTINCT PART)						92
		1, 842, 260	425, 137	2, 267, 397	-151, 644	2, 115, 753	93
	REIMBURSABLE COST CENTERS	192, 291	427, 048	619, 339	0	619, 339	96
	PURPOSE COST CENTERS		1277010	017,007	u	017,007	1 1
3. 00 11300 I	NTEREST EXPENSE		8, 963, 080	8, 963, 080			113
5.0011600 H		962, 914	1, 178, 642				
	SUBTOTALS (SUM OF LINES 1 through 117) IBURSABLE COST CENTERS	86, 609, 668	169, 697, 989	256, 307, 657	15, 848, 665	272, 156, 322	1118
	FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C) 0	0	190
	PHYSICIANS' PRIVATE OFFICES	0	9, 040, 760				
. 00 07950 F	RENTAL SPACE	0	14, 296, 864	14, 296, 864		4, 331, 646	
. 01 07951 F		168, 683	426, 236	594, 919		594, 919	
	RETAIL SERVICES	134, 943	29, 244	164, 187		164, 187	
	REID CONTRACTED SERVICES REID PHYSICIAN ASSOC.	0	0		308, 304	308, 304	194 194
	CONNERSVILLE LOCATION		0 786, 620	786, 620	-162, 084	624, 536	
	ACANT SPACE	0	60, 560			35, 206	
	IOME OFFICE	0	0	(0 0		194
4. 08 07958 C	CAMBRIDGE RHC	0	0	C	0 0		194
	OTAL (SUM OF LINES 118 through 199)	86, 913, 294	194, 338, 273	281, 251, 567		281, 251, 567	1000

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN	I: 15-0048	Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pr	
	Cost Center Description	Adjustments	Vet Expenses			6/8/2020 3:1	6 pm
	bost benter beschiption		or Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	1 001 001	01.074.740				
00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 331, 931	21, 376, 768				1
01	00101 NEW CAP BLDG & FIXT - OFFSITE	0	6, 215, 457				1
00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	16, 946, 752	17, 249, 719				4
)1	00540 NONPATI ENT TELEPHONES	0	0				5
)2	00550 DATA PROCESSI NG	10, 080, 905	13, 712, 068				5
)3	00560 PURCHASING RECEIVING AND STORES	0	58, 441				5
)4	00570 ADMI TTI NG	0	4, 472, 955				5
)5	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	93, 580				5
)6	00590 OTHER A&G	9, 260, 213	29, 680, 071				5
00	00700 OPERATION OF PLANT	0	306, 250				7
00	00800 LAUNDRY & LINEN SERVICE	0	711, 668				8
00	00900 HOUSEKEEPI NG	-109	2, 703, 714				9
00	01000 DI ETARY	-15, 794	1, 303, 264				10
00	01100 CAFETERI A	-3, 945, 629	1, 265, 052				11
00	01300 NURSING ADMINISTRATION	0	220, 719				13
	01400 CENTRAL SERVICES & SUPPLY	0	4, 499, 263				14
	01500 PHARMACY	-215, 440	36, 760, 213				15
	01600 MEDICAL RECORDS & LIBRARY	0	o				16
	01700 SOCIAL SERVICE	0	2, 896, 930				17
	01701 I NSERVI CE EDUCATI ON	-1, 467, 760	1, 978, 594				17
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	1, 789, 013				21
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	-947, 705	443, 982				22
	02300 PARAMED ED PRGM	-68, 434	182, 347				23
00	INPATIENT ROUTINE SERVICE COST CENTERS	00, 101	102, 017				
00	03000 ADULTS & PEDI ATRI CS	-6, 491, 036	25, 266, 992				30
	03100 I NTENSI VE CARE UNI T	0	5, 825, 474				31
00	04000 SUBPROVI DER – I PF	0	3, 738, 254				40
00	04100 SUBPROVIDER - IRF	-3, 680	1, 908, 183				41
	04300 NURSERY	0	472, 084				43
00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	472,004				
00	05000 OPERATING ROOM	-9, 637, 323	23, 123, 074				50
00	05200 DELIVERY ROOM & LABOR ROOM	-225	987, 145				52
00	05400 RADI OLOGY-DI AGNOSTI C	-202, 068	13, 548, 101				54
00	05900 CARDI AC CATHETERI ZATI ON	-1, 081	5, 769, 735				59
00	06000 LABORATORY	-1, 279, 660	11, 400, 963				60
00	06500 RESPI RATORY THERAPY	-2, 985	2,023,770				65
00	06600 PHYSI CAL THERAPY	-102, 124	7, 814, 548				66
	06900 ELECTROCARDI OLOGY	-56, 816	1, 866, 792				69
	07000 ELECTROENCEPHALOGRAPHY	-2, 284	349, 418				70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,204	0				71
	07200 I MPL. DEV. CHARGED TO PATIENT	0	17, 054, 425				72
	07300 DRUGS CHARGED TO PATIENTS	0	0				73
	07400 RENAL DIALYSIS		783, 130				74
	03950 ANCI LLARY - OTHER		103, 130				74
	07697 CARDI AC REHABI LI TATI ON	-1, 485	393, 352				76
71	OUTPATIENT SERVICE COST CENTERS	-1,400	373, 302				⊣ ′°
00	09100 EMERGENCY	-2, 445, 526	7, 378, 164				91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 440, 520	7, 370, 104				91
	04040 FAMILY PRACTICE	0	2, 115, 753				92
00	OHORO REIMBURSABLE COST CENTERS	U U	2, 110, 703				- 73
00	09600 DURABLE MEDICAL EQUIP-RENTED	-427, 479	101 040				- 0/
00	SPECIAL PURPOSE COST CENTERS	-427,479	191, 860				96
0.00	11300 INTEREST EXPENSE		0				1110
	11600 HOSPI CE	0 -717	2, 529, 478				113
s. 00 8. 00		10, 304, 441	2, 529, 478 282, 460, 763				118
. 00	NONREI MBURSABLE COST CENTERS	10, 304, 441	202,400,703				\dashv
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	19200 PHYSICIANS' PRIVATE OFFICES		1				190
			3,036,447				
	07950 RENTAL SPACE	0	4, 331, 646				194
	07951 FOUNDATION	0	594, 919				194
	07952 RETAIL SERVICES	0	164, 187				194
	07953 REID CONTRACTED SERVICES	0	308, 304				194
	07954 REID PHYSICIAN ASSOC.	0	0				194
	07955 CONNERSVILLE LOCATION	0	624, 536				194
	07956 VACANT SPACE	0	35, 206				194
l. 07	07957 HOME OFFICE	0	o				194
	07958 CAMBRIDGE RHC	o	o				194
+. 00							200

Health Financial Systems RECLASSIFICATIONS

REID HOSPITAL & HEALTH CARE SERVICES

Provider CCN: 15-0048

					6/8/2020 3:16 pm
		Increases			
	Cost Center	Line #	Salary	Other	
		3.00	4.00	5.00	
. 00	A - CAPITAL EXPENSE RECLASS NEW CAP REL COSTS-BLDG &	1.00	0	10, 889, 775	1.1
00	FIXT	1.00	0	10, 669, 775	1.
. 00	NEW CAP BLDG & FIXT -	1.01	o	5, 965, 094	2.
	OFFSI TE		0	0,,00,07,	
00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 941	3.
	FLXT				
. 00	NEW CAP BLDG & FIXT -	1.01	0	243, 387	4.
	OFFSITE	1.00		100.011	_
. 00	NEW CAP REL COSTS-BLDG &	1.00	0	190, 041	5.
. 00	FIXT NEW CAP BLDG & FIXT -	1.01	0	6, 976	6.
00	OFFSITE	1.01	0	0, 970	0.
00		0.00	o	0	7.
00		0.00	o	Ö	8.
00		0.00	o	0	9.
). 00		0.00	o	0	10.
1.00		0.00	o	0	11.
2.00		0.00	Ö	Ö	12.
3.00		0.00	o	0	13.
1.00		0.00	o	0	14.
5.00		0.00	o	0	15.
5.00		0.00	Ő	Ö	16.
7.00		0.00	Ő	Ő	17.
3.00		0.00	o	Ő	18.
9.00		0.00	o	0	19.
	<u> </u>		ō	17, 297, 214	
	B - CAFETERIA RECLASS	II			
. 00	CAFETERI A	11.00	2, 453, 746	2, 756, 935	 1.
	0 — — — — — — —		2, 453, 746	2, 756, 935	
	C - LAUNDRY RECLASS	· · · · · · · · · · · · · · · · · · ·			
. 00	REID CONTRACTED SERVICES	194.03	168, 229	140, 075	1.
	0 — — — — — — —		168, 229	140, 075	
	D - NURSING VP RECLASS	•			
00	NURSING ADMINISTRATION	13.00	220, 719	0	1.
	0 — — — — — —		220, 719	<u>O</u>	
	E - OCCUPATIONAL MEDICINE REC	CLASS			
. 00	OTHER A&G	5.06	<u>334, 9</u> 05	7 <u>5, 1</u> 93	1.
	0		334, 905	75, 193	
	F - IMPLANTABLE DEVICES RECLA				
00	IMPL. DEV. CHARGED TO	72.00	0	17, 054, 425	1.
	PATI ENT				
00		0.00	0	0	2.
00		0.00	0	0	3.
00		0.00	0	0	4.
00	L	0.00	•	<u>0</u>	5.
	0		0	17, 054, 425	
	G - INTEREST RECLASS		-		
00	NEW CAP REL COSTS-BLDG &	1.00	0	8, 963, 080	1.
	<u>FIX</u> T	+		8,963,080	
	U J - INTERN AND RESIDENT		U	8, 903, 080	
00		21.00	1 702 540	05 452	1
00	I &R SERVICES-SALARY &	21.00	1, 703, 560	85, 453	1.
	FRINGES_APPRVD	\vdash — — $+$	1, 703, 560	85, 453	
	N - HOSPICE		1, 703, 560	00, 403	
	HOSPICE	116.00	340, 217	49, 322	1.
00					
00	TOTALS		340, 217	49, 322	''

REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Provider CCN: 15-0048 Period: From 01/01/2019 Worksheet A-6

						From 01/01/2019 To 12/31/2019	Date/Time Prepare 6/8/2020 3:16 pm
		Decreases				1	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	4	
	6.00	7.00	8.00	9.00	10.00		
~~	A - CAPITAL EXPENSE RECLASS						
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 113		2	1.
. 00	ADMI TTI NG	5.04	0	15, 176		·	2.
. 00	CASHI ERI NG/ACCOUNTS	5.05	0	165, 919	13	3	3.
	RECEIVABLE						
. 00	OTHER A&G	5.06	0	320, 614			4.
. 00	PHARMACY	15.00	0	2, 314			5.
. 00	ADULTS & PEDIATRICS	30.00	0	44, 304			6.
. 00	OPERATING ROOM	50.00	0	6, 278			7.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	115, 556		-	8.
. 00	LABORATORY	60.00	0	37, 423			9.
0. 00	RESPI RATORY THERAPY	65.00	0	835		0	10.
1.00	PHYSI CAL THERAPY	66.00	0	236, 596	(0	11.
2.00	CARDI AC REHABI LI TATI ON	76.97	0	37, 631	(12.
3.00	EMERGENCY	91.00	0	1, 942	(13.
4.00	FAMILY PRACTICE	93.00	0	151, 644	(14.
5.00	HOSPI CE	116.00	0	900	(15.
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6, 004, 313	(16.
7.00	RENTAL SPACE	194.00	0	9, 965, 218	(17.
8.00	CONNERSVILLE LOCATION	194.05	0	162, 084	(b	18.
9.00	VACANT SPACE	194.06	0	25, 354	(b	19.
	0 — — — — — — —			17, 297, 214		1	
	B - CAFETERIA RECLASS	II				1	
. 00	DI ETARY	10.00	2, 453, 746	2, 756, 935	()	1.
	0		2, 453, 746	2, 756, 935		1	
	C - LAUNDRY RECLASS	LL			1		
. 00	LAUNDRY & LINEN SERVICE	8.00	168, 229	140, 075	(כו בי	1.
			168, 229	140, 075		-	
	D - NURSING VP RECLASS	I			1		
. 00	OTHER A&G	5.06	220, 719	0	(1.
			220, 719	0	`		
	E - OCCUPATIONAL MEDICINE REC	CLASS	2207717				
. 00	EMERGENCY	91.00	334, 905	75, 193	(1.
			334, 905	75, 193			
	F - IMPLANTABLE DEVICES RECLA	192	001, 700	70,170			
. 00	ADULTS & PEDIATRICS	30.00	0	3, 811	(1.
. 00	OPERATING ROOM	50.00	0	12, 108, 227			2.
. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	4, 176			3.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	26, 772			4.
. 00	CARDI AC CATHETERI ZATI ON	59.00	0	4, 911, 439			5.
. 00			— — — -	17,054,425		1	5.
	G - INTEREST RECLASS	<u> </u>	UU	17,034,423			
. 00	INTEREST EXPENSE	112 00	0	8, 963, 080	1.	1	1.
. 00		1 <u>13.</u> 00		<u> </u>			1.
			U	8, 963, 080			
	J - INTERN AND RESIDENT	22.02	1 702 5/0	05 450			
00		22.00	1, 703, 560	85, 453	(ין	1.
. 00	I&R SERVICES-OTHER PRGM.				L		1
. 00	COSTS_APPRVD	\vdash — — $+$					
. 00	COSTS_APPRVD		1, 703, 560	85, 453			
	COSTS_APPRVD O N - HOSPI CE						
. 00 . 00	COSTS_APPRVD	<u> </u>	<u>1, 703, 560</u> <u>340, 217</u> 340, 217	85, 453 49, 322 49, 322		2	1.

In Lieu of Form CMS-2552-10 Worksheet A-7

						01/01/2019 12/31/2019	Part I Date/Time Pre 6/8/2020 3:16	
				Acqui si ti on	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	14, 477, 094	1, 804, 345		0	1, 804, 345	0	1.00
2.00	Land Improvements	14, 989, 210	0		0	0	1, 471, 519	2.00
3.00	Buildings and Fixtures	297, 210, 638	14, 121, 351		0 '	14, 121, 351	0	3.00
4.00	Building Improvements	12, 458, 447	520, 683		0	520, 683	0	4.00
5.00	Fixed Equipment	2, 182, 235	0		0	0	1, 427	5.00
6.00	Movable Equipment	182, 552, 200	0		0	0	10, 298, 095	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	523, 869, 824	16, 446, 379		0 '	16, 446, 379	11, 771, 041	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	523, 869, 824	16, 446, 379		0 '	16, 446, 379	11, 771, 041	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	16, 281, 439	0					1.00
2.00	Land Improvements	13, 517, 691	0					2.00
3.00	Buildings and Fixtures	311, 331, 989	0					3.00
4.00	Building Improvements	12, 979, 130	0					4.00
5.00	Fixed Equipment	2, 180, 808	0					5.00
6.00	Movable Equipment	172, 254, 105	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	528, 545, 162	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	528, 545, 162	0					10.00

In Lieu of Form CMS-2552-10 Worksheet A-7

RECONC	TELEVITOR OF CAPITAL COSTS CENTERS		Provider CC	IN: 15-0048	Period: From 01/01/2019 To 12/31/2019		
			SU	IMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	· · ·	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0		0 0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY OF	E CAPI TAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Heal th	Fi nanci al	Systems		
RECONC	LI ATLON C	E CAPLTAL	COSTS	C

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	F	eriod: rom 01/01/2019 o 12/31/2019		pared:
		COMF	PUTATION OF RA	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 - col. 2)			
		1.00	2.00	3.00	4,00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	1.00	0.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	356, 291, 057	C	356, 291, 057	0. 674098	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	172, 254, 105	0	172, 254, 105	0. 325902	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	C	0	0. 000000	0	2.00
3.00	Total (sum of lines 1-2)	528, 545, 162		528, 545, 162		0	3.00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel ate				
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C				01 101 70/	100.044	1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	0		0	21, 184, 786		1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	5, 965, 094		1.01
2.00 3.00	NEW CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			0 27, 149, 880	0 197, 017	2.00 3.00
3.00	Total (sum of Times 1-2)	0		JMMARY OF CAPIT		197, 017	3.00
			30	JIVIIVIART OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C NEW CAP REL COSTS-BLDG & FIXT	-		1.041		21 274 740	1 00
1.00 1.01	NEW CAP REL COSIS-BLDG & FIXI NEW CAP BLDG & FIXT - OFFSITE	0	-	1, 941 243, 387		21, 376, 768	
2.00	NEW CAP BLDG & FIXI - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP	0		243, 387	0	6, 215, 457 0	1. 01 2. 00
2.00	Total (sum of lines 1-2)	0		245, 328	0	27, 592, 225	2.00
5.00		0	1 0	240, 320	U	21, 372, 223	3.00

RELD HOSPITAL & HEALTH CARE SERVICES

Heal th	Financial Systems	REI D	HOSPI TAL & HEAL	TH CARE SERVICES	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0048	Peri od:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
				Expense Classification of	n Worksheet A	6/8/2020 3:16	pm
			-	To/From Which the Amount i			
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - NEW CAP	1.00		IEW CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter		F	I XT			1
1.01	2) Investment income - NEW CAP		0	IEW CAP BLDG & FIXT -	1.01	0	1.01
1.01	BLDG & FIXT - OFFSITE (chapter			OFFSITE	1.01	Ŭ	1.01
2.00	2)				2.00		2 00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			IEW CAP REL COSTS-MVBLE	2.00	0	2.00
	2)						
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time	В	OF	PURCHASING RECEIVING AND	5.03	0	4.00
	discounts (chapter 8)			STORES			
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)						
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
	21)						
8.00	Tel evi si on and radi o servi ce		0		0.00	0	8.00
9.00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physici an	A-8-2	-14, 487, 302		0.00	0	
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	69, 800, 181			0	12.00
10.00	transactions (chapter 10)						40.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	-3, 345, 9420	AFFTERLA	0.00 11.00		
15.00	Rental of quarters to employee		0		0.00		
1 (00	and others	P			F 03		1/ 00
16.00	Sale of medical and surgical supplies to other than	В		PURCHASING RECEIVING AND	5.03	0	16.00
	patients						
17.00	Sale of drugs to other than patients	В	-215, 281 F	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and	В	ON	IEDI CAL RECORDS & LI BRARY	16.00	0	18.00
	abstracts						
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20.00	Vending machines	В	-13, 739 E	DI ETARY	10.00		20.00
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						1
23.00	Adjustment for respiratory	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						1
24.00	Adjustment for physical	A-8-3	OF	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of						1
25.00	limitation (chapter 14) Utilization review –		0	** Cost Center Deleted **	* 114.00		25.00
	physicians' compensation		Ű				
26.00	(chapter 21) Depreciation - NEW CAP REL			IEW CAP REL COSTS-BLDG &	1.00	0	26.00
∠U. UU	COSTS-BLDG & FIXT			IXT	1.00	0	20.00
26. 01	Depreciation - NEW CAP BLDG &		O	IEW CAP BLDG & FIXT -	1.01	0	26. 01
27.00	FIXT - OFFSITE Depreciation - NEW CAP REL			DFFSITE IEW CAP REL COSTS-MVBLE	2.00	0	27.00
27.00	COSTS-MVBLE EQUIP		E	QUIP			27.00
	Non-physician Anesthetist		0	** Cost Center Deleted **			28.00
29.00 30.00	Physicians' assistant Adjustment for occupational	A-8-3	0	** Cost Center Deleted **	* 0.00		29.00 30.00
55.00	therapy costs in excess of		0	Soot Sonter Dereted	07.00		55.00
	limitation (chapter 14)						

	Financial Systems MENTS TO EXPENSES	KEID	HUSPITAL & HEA		eriod:	eu of Form CMS-2 Worksheet A-8	
					rom 01/01/2019 5 12/31/2019		
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30. 99	Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech	A-8-3	C	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for		C		0.00	0	32.00
33.00	Depreciation and Interest MISCELLANEOUS INCOME	В	-599, 687	CAFETERI A	11.00	0	33.00
	MI SCELLANEOUS I NCOME	В		EMPLOYEE BENEFITS DEPARTMENT	4.00		33.01
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		DATA PROCESSING OTHER A&G	5.02		
	MI SCELLANEOUS I NCOME	В		OPERATING ROOM	5. 06 50. 00		33.03 33.04
33.05	MI SCELLANEOUS I NCOME	В	-2, 985	RESPI RATORY THERAPY	65.00	0	33.05
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		INSERVICE EDUCATION PARAMED ED PRGM	17.01 23.00		33.06 33.07
	MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00		33.07
33.09	MI SCELLANEOUS I NCOME	В	-95, 705	PHYSI CAL THERAPY	66.00		33.09
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00		33. 10 33. 11
	MI SCELLANEOUS I NCOME	B		DURABLE MEDICAL EQUIP-RENTED	96.00		33.12
	MI SCELLANEOUS I NCOME	В		HOUSEKEEPING	9.00		33. 13
33. 14	INTEREST INCOME	В	-3, 903, 421	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.14
33. 15	UNNECESSARY BORROWI NG	A	-5, 059, 659	NEW CAP REL COSTS-BLDG & FLXT	1.00	11	33. 15
	SELF INSURANCE ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A A		EMPLOYEE BENEFITS DEPARTMENT	4.00 5.06		33. 17 33. 18
	MARKETI NG/ADVERTI SI NG	A		DIETARY	10.00		33.19
33.20	MARKETI NG/ADVERTI SI NG	A		INSERVICE EDUCATION	17.01		33.20
33. 21	MARKETI NG/ADVERTI SI NG	A	- 107	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33. 21
	MARKETI NG/ADVERTI SI NG	A		ADULTS & PEDIATRICS	30.00		
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A A		SUBPROVI DER – I RF RADI OLOGY-DI AGNOSTI C	41.00 54.00		33.23 33.24
	MARKETI NG/ADVERTI SI NG	A		CARDI AC CATHETERI ZATI ON	59.00		33.25
	MARKETI NG/ADVERTI SI NG	A		PHYSICAL THERAPY	66.00		33.26
33. 27 33. 28	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A A		ELECTROENCEPHALOGRAPHY	70.00 76.97		
	MARKETI NG/ADVERTI SI NG	A		EMERGENCY	91.00		33. 29
	MARKETING/ADVERTISING NON-ALLOWABLE EXPENSES	A		DURABLE MEDICAL EQUIP-RENTED	96.00 5.06		
	NON-ALLOWABLE EXPENSES	A A		DIETARY	10.00		
33.33	NON-ALLOWABLE EXPENSES	A	-1, 287, 543	INSERVICE EDUCATION	17.01	0	33. 33
	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		ADULTS & PEDIATRICS SUBPROVIDER – IRF	30. 00 41. 00		
	NON-ALLOWABLE EXPENSES	A		OPERATING ROOM	50.00		
	NON-ALLOWABLE EXPENSES	A		DELIVERY ROOM & LABOR ROOM	52.00		33.37
33.38 33.39	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		PHYSICAL THERAPY MERGENCY	66.00 91.00		33.38 33.39
	NON-ALLOWABLE EXPENSES	Â	-717	HOSPICE	116.00		
	HAF EXPENSE	A	-14, 904, 737		5.06		
33. 42 33. 43	BOND REFUNDING - 2015 BONDS BOND REFUNDING - 2016 BONDS	A A		OTHER A&G OTHER A&G	5.06 5.06		
33.44	OCC MED - EMPLOYEE COST	Â	-53, 169	EMERGENCY	91.00	0	33.44
	OCC MED - EMPLOYEE COST	A			15.00		
33.46 33.47	OCC MED - EMPLOYEE COST OCC MED - EMPLOYEE COST	A A		RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00		33.46 33.47
50.00	TOTAL (sum of lines 1 thru 49)		10, 304, 441		20.00		50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)	1				1	1

 column 6, line 200.)

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first definitions).
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.

Heal th	Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVICES	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0048	Period: From 01/01/2019	Worksheet A-8	-1
OFFICE				To 12/31/2019		pared:
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	21, 547, 740	27, 442, 895	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NEW CAPITAL	10, 295, 011	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	30, 066, 924	0	3.00
4.00	5.02	DATA PROCESSI NG	INFORMATION SYSTEMS	10, 426, 086	0	4.00
4.01	5.06	OTHER A&G	A&G	24, 907, 315	0	4.01
4.02	0.00			0	0	4.02
5.00	0		0	97, 243, 076	27, 442, 895	5.00

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nae ne					or this parti	
				Related Organization(s) and/	or Home Office	
						1
						1
						1
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
-	B. INTERRELATIONSHIP TO RELATIONSHIP	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	A	REID 0/P SURGER	55.00	0.00	6.00
7.00	В		0.00 REID HOME OFFIC	100.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0048 Peri od: Worksheet A-8-1 From 01/01/2019 OFFICE COSTS То 12/31/2019 Date/Time Prepared:

			6/8/2020 3:16	5 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-5, 895, 155	0		1.00
2.00	10, 295, 011	9		2.00
3.00	30, 066, 924	0		3.00
4.00	10, 426, 086	0		4.00
4.01	24, 907, 315	0		4.01
4.02	0	0		4.02
5.00	69, 800, 181			5.00

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas	iot been posted to worksheet A,			shourd be find cated fit corulin 4 of	this part.
	Rel ated Organization(s)				
	and/or Home Office				
	Type of Business	1			
	6.00	1			
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S)	AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		6.00
7.00	HOME OFFICE	7.00
8.00		8.00 9.00
9.00		9.00
10.00		10.00
8.00 9.00 10.00 100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT
 REID HOSPITAL & HEALTH CARE SERVICES

 Provider CCN: 15-0048
 Period:

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVIDE	R BASED PHYSIC	TAN ADJUSTMENT		Provider C		Period: From 01/01/2019	WORKSneet A-8	5-2
						To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	pili
	WRSt. A EINC #	I denti fi er	Remuneration	Component	Component	ROE AMOUNT	ider Component	
		r dontri i or		oomponont	oomponent		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	17.01	INSERVICE EDUCATION	148, 678	23, 131	125, 547	179,000	837	1.00
2.00	22.00	I&R SERVICES-OTHER PRGM.	947, 598	947, 598	0	197, 500	0	2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	6, 476, 335	6, 476, 335	0	1111000		3.00
4.00		SUBPROVIDER – IRF	0	0	0	1111000		4.00
5.00		OPERATING ROOM	3, 740, 444	3, 740, 444	0	210,100		5.00
6.00		RADI OLOGY-DI AGNOSTI C	6, 960	6, 960	0	200,000		6.00
7.00		LABORATORY	874, 947	874, 947	0	200,000		7.00
8.00		ELECTROCARDI OLOGY	56, 816	56, 816	0	179, 000		8.00
9.00		EMERGENCY	2, 307, 554		0	177,000		9.00
10.00	0.00		0	0	-	i i	-	10.00
200.00			14, 559, 332					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		INSERVICE EDUCATION	72,030	3, 602	0			1.00
2.00		I&R SERVICES-OTHER PRGM.	0	0	0	0	0	2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	0	0	-	-	0	3.00
4.00		SUBPROVIDER – IRF	0	0	-	, s	0	4.00
5.00		OPERATING ROOM	0	0	-	0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	-	i i	Ŭ	6.00
7.00		LABORATORY	0	0	-	0	0	7.00
8.00		ELECTROCARDI OLOGY	0	0	-	, s	0	8.00
9.00		EMERGENCY	0	0	-	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			72, 030	3, 602		0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		I NSERVI CE EDUCATI ON	0	72, 030				1.00
2.00	22.00	I&R SERVICES-OTHER PRGM.	0	0	0	947, 598		2.00
		COSTS APPRVD						
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	6, 476, 335		3.00
4.00	41.00	SUBPROVIDER - IRF	0	0	0	0		4.00
5.00		OPERATING ROOM	0	0	0	0,710,111		5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	-	6, 960		6.00
7.00		LABORATORY	0	0	-	÷,		7.00
8.00		ELECTROCARDI OLOGY	0	0	-	00/0/0		8.00
9.00		EMERGENCY	0	0	-	2, 307, 554		9.00
10.00	0.00		0	0	-	0		10.00
200.00			0	72, 030	53, 517	14, 487, 302		200.00

	Financial Systems REID LLOCATION - GENERAL SERVICE COSTS	HOSPI TAL & HEAI	Provider C	CN: 15-0048 P	eriod: rom 01/01/2019 o 12/31/2019	u of Form CMS-: Worksheet B Part I Date/Time Pre 6/8/2020 3:16	
			CAP	ITAL RELATED CC	ISTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE		EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	21, 376, 768	21, 376, 768				1.00
1.01 2.00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP	6, 215, 457	C	6, 215, 457	0		1.01 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	17, 249, 719	C	9, 026	0	17, 258, 745	1
5.01	00540 NONPATIENT TELEPHONES	0	C	0 0	0	0	1
5.02	00550 DATA PROCESSING	13, 712, 068	81, 099		0	47, 151	
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	58, 441 4, 472, 955	217, 154 11, 309		0	8, 137 614, 495	
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 472, 933	11, 303		0	014, 495	
5.06	00590 OTHER A&G	29, 680, 071	96, 717		0	654, 085	1
7.00	00700 OPERATION OF PLANT	306, 250	269, 368			65, 293	
8.00	00800 LAUNDRY & LINEN SERVICE	711, 668	301, 950			69, 336	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 703, 714 1, 303, 264	199, 701 451, 958		0	407, 770 123, 681	
11.00	01100 CAFETERIA	1, 265, 052	231, 597		0	488, 786	1
13.00	01300 NURSING ADMINISTRATION	220, 719	47, 857		0	43, 967	
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 499, 263	205, 894		0	128, 107	
15.00	01500 PHARMACY	36, 760, 213	241, 633		0	829, 064	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 896, 930	30, 379	106, 525	0	0 472, 798	1
17.00	01701 I NSERVI CE EDUCATI ON	1, 978, 594	254, 803		0	283, 282	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 789, 013	C		0	339, 349	
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	443, 982	C	1 V	0	35, 543	
23.00	02300 PARAMED ED PRGM	182, 347	25, 972	60, 472	0	42, 245	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	25, 266, 992	2, 860, 726	0	0	4, 110, 792	30.00
31.00	03100 I NTENSI VE CARE UNI T	5, 825, 474	601, 011		0	674, 300	1
40.00	04000 SUBPROVI DER – I PF	3, 738, 254	546, 863		0	655, 352	
41.00	04100 SUBPROVIDER - IRF	1, 908, 183	438, 127		0	300, 088	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	472, 084	65, 628	3 0	0	73, 956	43.00
50.00	05000 OPERATI NG ROOM	23, 123, 074	1, 117, 765	295, 387	0	275, 716	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	987, 145	203, 568		0	140, 149	
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 548, 101	1, 731, 652		0	1, 328, 580	1
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 769, 735	332, 402	1	0	376, 640	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	11, 400, 963 2, 023, 770	712, 220 40, 317		0	817, 202 295, 805	
66.00	06600 PHYSI CAL THERAPY	7, 814, 548	197, 889		0	1, 309, 478	
69.00	06900 ELECTROCARDI OLOGY	1, 866, 792	171, 623		0		
	07000 ELECTROENCEPHALOGRAPHY	349, 418	C	87, 820	0		70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 17, 054, 425	(0	0	
	07300 DRUGS CHARGED TO PATIENTS	17,034,423	0		0	0	1
74.00	07400 RENAL DI ALYSI S	783, 130	36, 474	1 O	0	0	1
	03950 ANCI LLARY - OTHER	0	C	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	393, 352	200, 361	0	0	67, 757	76.97
91.00	09100 EMERGENCY	7, 378, 164	757, 922	2 0	0	1, 165, 870	91 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101, 122		U	1, 100, 070	92.00
93.00	04040 FAMILY PRACTICE	2, 115, 753	C) 19, 112	0	366, 978	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	191, 860	43, 426	64, 804	0	38, 304	96.00
113 00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	2, 529, 478	10, 893	3 0	0	259, 584	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	282, 460, 763	12, 736, 258	1, 928, 334	0	17, 164, 751	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0		190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 036, 447	0		0		192.00
194.00	07950 RENTAL SPACE 07951 FOUNDATI ON	4, 331, 646 594, 919	C	440, 678	0		194.00 194.01
	07951 FOUNDATION 07952 RETAIL SERVICES	594, 919 164, 187	5, 043 57, 281		0		194.01
	07953 REID CONTRACTED SERVICES	308, 304	0,,201	0	0		194.02
194.04	07954 REID PHYSICIAN ASSOC.	0	C	7, 040	0	0	194.04
	07955 CONNERSVILLE LOCATION	624, 536	(0	0		194.05
	07956 VACANT SPACE 07957 HOME OFFICE	35, 206	1, 731, 970 6, 846, 216		0		194.06 194.07
	07958 CAMBRIDGE RHC	0	0, 840, 210				194.07
	The second s	, ¶	e		9	Ũ	1

Health Fin	ancial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019	Worksheet B Part I	
				T	o 12/31/2019	Date/Time Pre 6/8/2020 3:16	
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	Net Expenses		NEW CAP BLDG 8		EMPLOYEE	
		for Cost	FIXT	FIXT - OFFSITE	E EQUI P	BENEFI TS	
		Allocation (from Wkst A				DEPARTMENT	
		col. 7)					
		0	1.00	1.01	2.00	4.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	C	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)) 291, 556, 008	21, 376, 768	6, 215, 457	0	17, 258, 745	202.00

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	Cost Conton Description		DATA	T		Part I Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	
CE	NERAL SERVICE COST CENTERS	5.01	5.02	5.03	5.04	5.05	
	D100 NEW CAP REL COSTS-BLDG & FIXT						1 1.
	0101 NEW CAP BLDG & FIXT - OFFSITE						1.
00 00	D200 NEW CAP REL COSTS-MVBLE EQUIP						2.
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.
	0540 NONPATI ENT TELEPHONES	0					5.
1	0550 DATA PROCESSING	0	13, 865, 026				5.
	D560 PURCHASING RECEIVING AND STORES	0	18, 340		(040 (50		5.
	0570 ADMI TTI NG 0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	907, 829	560 0	6, 049, 659	270, 032	5
	0590 OTHER A&G	0	559, 369		0	270,032	
	0700 OPERATION OF PLANT	0	45, 850		0	0	
00 00	D800 LAUNDRY & LINEN SERVICE	0	18, 340	38	0	0	8
	0900 HOUSEKEEPI NG	0	27, 510		0	0	
	1000 DI ETARY	0	394, 310		0	0	10
	I 100 CAFETERI A I 300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	11
	1400 CENTRAL SERVICES & SUPPLY	0	100, 870		0	0	13
	1500 PHARMACY	0	504, 349		0	0	15
	1600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16
	1700 SOCIAL SERVICE	0	247, 590	1, 056	0	0	17
. 01 01	1701 I NSERVI CE EDUCATI ON	0	605, 219	1	0	0	17
	2100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	-	0	0	21
	2200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	247, 590		0	0	22
	2300 PARAMED ED PRGM IPATIENT ROUTINE SERVICE COST CENTERS	0	119, 210	52	0	0	23
	BOOO ADULTS & PEDIATRICS	0	2, 540, 085	29, 082	346, 018	15, 434	30
	3100 I NTENSI VE CARE UNI T	0	394, 310		59, 677	2, 662	
	1000 SUBPROVI DER – I PF	0	146, 720		63, 715	2,842	
	100 SUBPROVI DER – I RF	0	320, 950		29, 831	1, 331	
. 00 04	1300 NURSERY	0	0	1, 935	11, 767	525	43
	ICI LLARY SERVI CE COST CENTERS						
	5000 OPERATING ROOM	0	1, 036, 209		1,065,534	47, 716	
	5200 DELIVERY ROOM & LABOR ROOM	0	256, 760		61, 217	2, 731	
	5400 RADI OLOGY-DI AGNOSTI C 5900 CARDI AC CATHETERI ZATI ON	0	1, 109, 569 210, 910		888, 531 675, 262	39, 633 30, 120	
	5000 LABORATORY	0	871, 149		635, 778	28, 359	
	5500 RESPIRATORY THERAPY	0	119, 210		168, 057	7, 496	
. 00 06	5600 PHYSI CAL THERAPY	0	1, 063, 719		134, 363	5, 993	
. 00 06	5900 ELECTROCARDI OLOGY	0	311, 780	2, 389	209, 981	9, 366	69
	7000 ELECTROENCEPHALOGRAPHY	0	155, 890		28, 300	1, 262	
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71
	7200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	198, 211	8, 841	
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	0	27, 510		811, 321 7, 729	36, 189 345	
	3950 ANCI LLARY - OTHER	0	27, 310	0.00	,, ,2,	0	
	7697 CARDI AC REHABI LI TATI ON	0	64, 190	-	8, 407	375	
OL	ITPATIENT SERVICE COST CENTERS				· · · ·		
	P100 EMERGENCY	0	1, 017, 869	13, 313	566, 402	25, 264	91
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	_					92
		0	91, 700	2, 383	41, 214	1, 838	93
	THER REIMBURSABLE COST CENTERS 2600 DURABLE MEDICAL EQUIP-RENTED	0	73, 360	5, 230	2, 967	132	96
	PECIAL PURPOSE COST CENTERS	0	73, 300	5,230	2, 907	132	70
	1300 I NTEREST EXPENSE						113
	1600 HOSPI CE	0	210, 910	4, 944	35, 377	1, 578	
з. оо	SUBTOTALS (SUM OF LINES 1 through 117)	0	13, 819, 176	300, 744	6, 049, 659	270, 032	118
	NREIMBURSABLE COST CENTERS	L		1			
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190
	2200 PHYSICIANS' PRIVATE OFFICES	0		100	0		192
	7950 RENTAL SPACE 7951 FOUNDATI ON		45, 850	770 383	0		194 194
	7952 RETAIL SERVICES	n 1		75	0		194
	7953 REID CONTRACTED SERVICES	0	0	0	0		194
	7954 REID PHYSICIAN ASSOC.	0	0	0	o		194
4. 05 07	7955 CONNERSVILLE LOCATION	0	0	0	0	0	194
	7956 VACANT SPACE	0	0	0	0		194
4.07 07	7957 HOME OFFICE	0	0	0	0		194
	7958 CAMBRIDGE RHC	0	0	0	0	0	194
4.0807 0.00 1.00	Cross Foot Adjustments Negative Cost Centers		_	_	_	0	200 201

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OOCT A			OFF

		HOSPI TAL & HEAL				u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: com 01/01/2019 o 12/31/2019	Worksheet B Part I Date/Time Pre 6/8/2020 3:16	epared:
	Cost Center Description	Subtotal	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5A. 05	5.06	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS				1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5.01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00590 OTHER A&G	31, 006, 533	31, 006, 533				5.06
7.00	00700 OPERATION OF PLANT	722, 412	85, 970	808, 382			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 101, 332	131, 063		1, 242, 842		8.00
9.00	00900 HOUSEKEEPI NG	3, 338, 888	397, 341		0	3, 742, 896	
10.00	01000 DI ETARY	2, 276, 491	270, 912		0	232, 071	
11.00		1, 985, 435	236, 275		0	0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	312, 543 4, 970, 653	37, 194 591, 528		0	5, 350 46, 815	
14.00	01500 PHARMACY	38, 369, 077	4, 566, 176		0	71, 895	
16.00	01600 MEDI CAL RECORDS & LI BRARY	106, 525	12, 677		0	0	1
17.00	01700 SOCIAL SERVICE	3, 648, 753	434, 216		0	28, 758	
17.01	01701 I NSERVI CE EDUCATI ON	3, 121, 899	371, 518		0	38, 790	
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 128, 362	253, 284	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	727, 183	86, 538		0	0	•
23.00	02300 PARAMED ED PRGM	430, 298	51, 207	2, 377	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				070.000	1 0 10 05 1	
30.00	03000 ADULTS & PEDIATRICS	35, 169, 129	4, 185, 267		373, 298	1, 243, 954	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	7, 567, 516 5, 156, 746	900, 565 613, 673		76, 160 86, 243	229, 730 237, 087	
40.00	04100 SUBPROVIDER - IRF	3, 000, 706	357,096		35, 738	111, 020	
43.00	04300 NURSERY	625, 895	74, 484		0	9, 363	
	ANCI LLARY SERVI CE COST CENTERS			, , ,			
50.00	05000 OPERATI NG ROOM	27, 016, 434	3, 215, 064		189, 138	344, 762	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 655, 764	197, 043		66, 837	76, 911	
54.00	05400 RADI OLOGY-DI AGNOSTI C	18, 729, 030	2, 228, 829		121, 778	213, 345	
59.00	05900 CARDI AC CATHETERI ZATI ON	7, 418, 251	882,802		67, 417	50, 159	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	14, 470, 957 2, 665, 835	1, 722, 102 317, 245		0	180, 240 33, 440	
66.00	06600 PHYSI CAL THERAPY	11, 482, 744	1, 366, 492		11, 865	29, 427	
69.00	06900 ELECTROCARDI OLOGY	2, 770, 364	329, 684		0	50, 159	
70.00	07000 ELECTROENCEPHALOGRAPHY	679, 976	80, 920		5, 034	00,107	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	17, 261, 477	2, 054, 185	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	847, 510	100, 857		0	0	
74.00	07400 RENAL DI ALYSI S	855, 838	101, 848		0	52, 166	
76.00	03950 ANCI LLARY - OTHER	0	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	734, 773	87, 441	3, 101	U	13, 376	76.97
91.00		10, 924, 804	1, 300, 095	26, 223	172, 423	299, 953	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,000,070	20,220	172, 120	2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	92.00
93.00	04040 FAMILY PRACTICE	2, 638, 978	314, 049	0	36, 911	80, 255	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	420, 083	49, 992	3, 178	0	0	96.00
112 00	SPECIAL PURPOSE COST CENTERS	[]					1112 00
) 11300 INTEREST EXPENSE) 11600 HOSPI CE	3, 052, 764	363, 291	0	0	E7 100	113.00 116.00
118.00		269, 391, 958	28, 368, 923		1, 242, 842	3, 736, 208	
110.00	NONREI MBURSABLE COST CENTERS	207, 371, 730	20, 300, 723	412,200	1, 242, 042	3,730,200	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 477, 380	651, 830	91, 615	0		192.00
	07950 RENTAL SPACE	4, 818, 944	573, 474		0		194.00
	07951 FOUNDATI ON	633, 947	75, 442		0		194.01
	207952 RETAIL SERVICES	248, 424	29, 563		0		194.02
	307953 REID CONTRACTED SERVICES	341, 815	40, 677		0		194.03
	07954 RELD PHYSICIAN ASSOC.	7,040	838		0		194.04 194.05
	07955 CONNERSVI LLE LOCATI ON 07956 VACANT SPACE	624, 536 2, 154, 558	74, 322 256, 401		0		194.05
	07950 VACANT SPACE	7, 857, 406	935, 063		0		194.00
	307958 CAMBRI DGE RHC	0	,55, 505 N	200, 007	0		194.07
200.00		o	0	Ĭ	0	0	200.00
201.00	Negative Cost Centers	o	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	291, 556, 008	31, 006, 533	808, 382	1, 242, 842	3, 742, 896	202.00

USTA	LLOCATION - GENERAL SERVICE COSTS		Provider C		riod: om 01/01/2019 12/31/2019	Worksheet B Part I Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1 1.
. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.
. 00 . 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 4.
01	00540 NONPATI ENT TELEPHONES						5.
02	00550 DATA PROCESSI NG						5.
03	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 5.
04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.
06	00590 OTHER A&G						5.
	00700 OPERATION OF PLANT						7.
00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.
	01000 DI ETARY	2, 795, 111					10
1.00	01100 CAFETERI A	0	2, 229, 723				11
	01300 NURSI NG ADMI NI STRATI ON	0	1, 910				13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	35, 605 112, 160		5, 651, 725 1, 822	43, 129, 294	14
	01600 MEDI CAL RECORDS & LI BRARY	0	112, 100	1	1, 022	43, 129, 294	
	01700 SOCIAL SERVICE	0	65, 676	0	0	0	
	01701 INSERVICE EDUCATION	0	41, 527		0	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	33, 173		0	0	
	02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	0	5, 916 4, 900		0	0	
5. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 700		0	0	23
	03000 ADULTS & PEDIATRICS	1, 883, 531	637, 385	161, 233	15, 508	8, 017	30
	03100 I NTENSI VE CARE UNI T	258, 030	91, 804		14, 150	469	
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	445, 471 208, 079	110, 103 44, 709		520 2, 039	802 51	40
	04300 NURSERY	208,079	44, 709 8, 699		2,039	0	
	ANCI LLARY SERVI CE COST CENTERS		-,				
	05000 OPERATING ROOM	0	44, 597		2, 729, 944	122, 350	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	16, 111 186, 072		12, 386 25, 814	950 909, 902	
	05900 CARDI AC CATHETERI ZATI ON	0	51, 685		2, 305, 297	394	
	06000 LABORATORY	0	152, 574		446, 558	81	60
	06500 RESPI RATORY THERAPY	0	44, 440		3, 944	14	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	177, 169		245	643 205 208	
	07000 ELECTROENCEPHALOGRAPHY	0	31, 120 10, 893		16, 362 0	305, 398 0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ő	10, 0, 0	-	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	о	C	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	1, 677		0	41, 600, 955	
	07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	0	C C		35 0	33 0	
	07697 CARDI AC REHABI LI TATI ON	0	12, 471	3, 155	40	0	
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	168, 094	42, 520	7, 779	32, 295	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	0	63, 912	0	o	33	92 93
	OTHER REIMBURSABLE COST CENTERS						1
6.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	9, 727	0	67, 793	0	96
2 00	SPECIAL PURPOSE COST CENTERS			1	1		1110
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	42, 424	0	627	146, 907	113
18.00		2, 795, 111	2, 206, 533		5, 651, 725	43, 129, 294	
_	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE	0		0	0		192 194
4.01	07950 RENTAL SPACE 07951 FOUNDATI ON	0	6, 388	Ŭ	0		194
4. 02	07952 RETAIL SERVICES	0	6, 733		Ō	0	194
	07953 REI D CONTRACTED SERVI CES	0	10, 069	0	О		194
	07954 REID PHYSICIAN ASSOC.	0	C	0	0		194
	07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	0			0		194 194
	07950 VACANT SFACE 07957 HOME OFFICE	0	C	0	o		194
4. 08	07958 CAMBRI DGE RHC	0	C	0	Ō		194
0 00	Cross Foot Adjustments						200
)0. 00)1. 00		1			1		201.

	LLOCATION - GENERAL SERVICE COSTS		Provi der CC		eriod: rom 01/01/2019 o 12/31/2019 INTERNS &	6/8/2020 3:16	pared pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	EDUCATI ON	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 0
13.00 14.00 15.00 16.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	119, 202					1. C 1. C 2. C 4. C 5. C 5. C 5. C 5. C 7. C 8. C 9. C 10. C 11. C 13. C 14. C 15. C 17. C
17.01 21.00 22.00	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0 0 0	0 0 0	3, 581, 629 0 0	2, 414, 819	819, 637	17.0 21.0 22.0
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	8, 586			23.0
30. 00	03000 ADULTS & PEDI ATRI CS	6, 842	3, 060, 633	1, 143, 717	1, 875, 937	636, 729	30. 0
1.00		1, 180				66, 271	
10.00 11.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 260 590				0	
43.00	04300 NURSERY	233				0	
	ANCILLARY SERVICE COST CENTERS						
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	20, 649 1, 210			123, 396 0	41, 883 0	1
52.00	05400 RADI OLOGY-DI AGNOSTI C	17, 569			0	9, 013	
9.00	05900 CARDI AC CATHETERI ZATI ON	13, 352			0	0	
0.00		12, 571			0	0	
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 323 2, 657			0	0	65.0 66.0
9.00	06900 ELECTROCARDI OLOGY	4, 152			64, 041	21, 737	
	07000 ELECTROENCEPHALOGRAPHY	560			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0 3, 919		0	0	0	
	07200 IMPL. DEV. CHARGED TO PATTENT 07300 DRUGS CHARGED TO PATTENTS	16, 042		0	0	0	
4.00	07400 RENAL DI ALYSI S	153		0	0	0	74.
	03950 ANCI LLARY - OTHER	0			0	0	
6. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	166	0	21, 464	0	0	76.
1.00	09100 EMERGENCY	11, 200	835, 013	311, 348	129, 644	44, 004	91. (
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					_	92.
3.00	04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	815	0	111, 163	0	0	93.
6. 00	09600 DURABLE MEDICAL EQUIP-RENTED	59	0	16, 946	0	0	96.
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	700		ED 100			113. (116. (
16.00 18.00		700 119, 202		52, 193 3, 558, 809		819, 637	
	NONREI MBURSABLE COST CENTERS						1.10.1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			-		190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			0		192. 104
	07950 RENTAL SPACE 07951 FOUNDATI ON		0	-	0		194. 194.
	07952 RETAIL SERVICES	0	0		0		194.
94.03	07953 REID CONTRACTED SERVICES	0	0	0	0	0	194.
	07954 REID PHYSICIAN ASSOC.	0	0	0	0		194.
	07955 CONNERSVI LLE LOCATI ON 07956 VACANT SPACE	0	0	0	0		194. 194.
	07956 VACANT SPACE 07957 HOME OFFICE		0	0 0	0		194. (
	07958 CAMBRI DGE RHC	0	0	0	0		194. (
00.00	Cross Foot Adjustments				0	0	200. (
01.00	Negative Cost Centers	0	0	0	0	0	201.

Health Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVI	CES	In Lieu of Form CMS-2552-1		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048		Peri od:	Worksheet B	
			F	rom 01/01/2019		
			T	o 12/31/2019	Date/Time Pre	
					6/8/2020 3:16	pm
				INTERNS &	RESI DENTS	
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	I NSERVI CE	SERVI CES-SALAR	SERVI CES-OTHER	
	RECORDS &		EDUCATI ON	Y & FRINGES	PRGM. COSTS	
	LI BRARY					
	16.00	17.00	17.01	21.00	22.00	
202.00 TOTAL (sum lines 118 through 201)	119, 20	2 4, 177, 774	3, 581, 629	2, 414, 819	819, 637	202.00

	ncial Systems REID TION - GENERAL SERVICE COSTS	HOSPI TAL & HEAL		CN: 15-0048 Pe	eri od:	u of Form CMS-: Worksheet B	2552-10
				Fr Tc	com 01/01/2019 0 12/31/2019	Part I Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post	Total	0/0/2020 3.10	
				Stepdown			
		23.00	24.00	Adjustments 25.00	26.00		
	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101	NEW CAP BLDG & FIXT - OFFSITE						1.01
	NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01 00540	NONPATI ENT TELEPHONES						5.01
	DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 02 5. 03
5.04 00570	ADMI TTI NG						5.04
	CASHI ERI NG/ACCOUNTS RECEI VABLE OTHER A&G						5.05 5.06
	OPERATION OF PLANT						7.00
	LAUNDRY & LINEN SERVICE						8.00
	HOUSEKEEPI NG DI ETARY						9.00
11.00 01100	CAFETERI A						11.00
	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY						13.00
	PHARMACY						15.00
	MEDICAL RECORDS & LIBRARY						16.00
	SOCIAL SERVICE INSERVICE EDUCATION						17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD						21.00
	I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM	497, 368					22.00
	IENT ROUTINE SERVICE COST CENTERS	477,300					23.00
	ADULTS & PEDIATRICS	0	50, 499, 219		47, 986, 553		30.00
	INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	9, 837, 614 6, 890, 953		9, 576, 096 6, 890, 953		31.00
	SUBPROVIDER - IRF	0	3, 865, 123	0	3, 865, 123		41.00
	NURSERY	0	739, 145	0	739, 145		43.00
50.00 05000	OPERATING ROOM	0	34, 144, 699		33, 979, 420		50.00
	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0 497, 368	2, 120, 259 23, 392, 143		2, 120, 259 23, 356, 576		52.00 54.00
	CARDI AC CATHETERI ZATI ON	497, 308	10, 896, 698		10, 896, 698		59.00
		0	17, 271, 960		17, 271, 960		60.00
	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	3, 158, 217 13, 425, 688		3, 158, 217 13, 425, 688		65.00 66.00
69.00 06900	ELECTROCARDI OLOGY	0	3, 653, 364	-85, 778	3, 567, 586		69.00
	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	800, 709	0	800, 709		70.00
	IMPL. DEV. CHARGED TO PATIENT	0	19, 319, 581		19, 319, 581		72.00
	DRUGS CHARGED TO PATIENTS	0	42, 567, 465		42, 567, 465		73.00
	RENAL DI ALYSI S ANCI LLARY – OTHER	0	1,011,335 0		1, 011, 335 0		74.00
76.97 07697	CARDI AC REHABI LI TATI ON	0	875, 987	0	875, 987		76.97
	TIENT SERVICE COST CENTERS	0	14, 305, 395	- 173, 648	14, 131, 747		91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	_		0			92.00
	PAMILY PRACTICE REIMBURSABLE COST CENTERS	0	3, 246, 116	0	3, 246, 116		93.00
	DURABLE MEDICAL EQUIP-RENTED	0	567, 778	8 0	567, 778		96.00
	AL PURPOSE COST CENTERS			1			112 00
116.00 11600	I NTEREST EXPENSE HOSPI CE	o	3, 716, 088	0	3, 716, 088		113.00 116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	497, 368	266, 305, 536		263, 071, 080		118.00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	PHYSICIANS' PRIVATE OFFICES	0	6, 220, 825	0	6, 220, 825		192.00
	RENTAL SPACE	0	5, 411, 830		5, 411, 830		194.00
194.0107951 194.0207952	POUNDATION RETAIL SERVICES	0	730, 366 300, 392		730, 366 300, 392		194.01 194.02
194.0307953	REID CONTRACTED SERVICES	Ö	392, 561	0	392, 561		194.03
	REID PHYSICIAN ASSOC. CONNERSVILLE LOCATION	0	7, 878 698, 858		7, 878 698, 858		194.04 194.05
	VACANT SPACE	0	2, 489, 754		2, 489, 754		194.05
		0	8, 998, 008	0	8, 998, 008		194.07
	CAMBRI DGE RHC	0	0	0	0		194.08
200.00	Cross Foot Adjustments		L.	/			200.00

Health Financial Systems	REID HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
				From 01/01/2019		
				To 12/31/2019		
					6/8/2020 3:16	pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM		Residents Cos	t		
			& Post			
			Stepdown			
			Adjustments			
	23.00	24.00	25.00	26.00		
202.00 TOTAL (sum lines 118 through 201)	497, 368	291, 556, 008	-3, 234, 45	6 288, 321, 552		202.00

ALLUCA	TION OF CAPITAL RELATED COSTS			FI To		Worksheet B Part II Date/Time Pre 6/8/2020 3:16	pared:
			CAP	ITAL RELATED CO	STS		
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE		Subtotal	
	1	0	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS	I I					
14.00 15.00 16.00 17.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	410 0 237, 189 4, 036 9, 237 5, 462 14, 664 21, 264 58, 127 36, 170 67, 865 0 256, 066 323, 411 0 24, 026	0 81, 099 217, 154 11, 309 0 96, 717 269, 368 301, 950 199, 701 451, 958 231, 597 47, 857 205, 894 241, 633 0 30, 379	0 24, 708 0 42, 511 176, 452 15, 434 35, 155 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9, 436 0 342, 996 221, 190 63, 057 181, 914 126, 815 325, 787 360, 077 235, 871 519, 823 231, 597 47, 857 461, 960 565, 044 106, 525 54, 405	$\begin{array}{c} 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
21. 00 22. 00	01701 I NSERVI CE EDUCATI ON 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 28, 504 1, 417	254, 803 0 0 25, 972	0 0	0 0 0	254, 803 0 28, 504 87, 861	21.00 22.00
30.00 31.00 40.00 41.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY	572, 841 491, 038 27, 896 45, 246 6, 616	2, 860, 726 601, 011 546, 863 438, 127 65, 628	0 0 0	0 0 0 0	3, 433, 567 1, 092, 049 574, 759 483, 373 72, 244	31.00 40.00 41.00
50. 00 52. 00 54. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	994, 297 37, 670 1, 022, 461	1, 117, 765 203, 568 1, 731, 652	0	0 0 0	2, 407, 449 241, 238 2, 790, 216	52.00
59.00 60.00 65.00 66.00 69.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	239, 355 485, 054 56, 352 107, 388 99, 209	332, 402 712, 220 40, 317 197, 889 171, 623	0 0 954, 825	0 0 0 0	571, 757 1, 197, 274 96, 669 1, 260, 102 270, 832	60.00 65.00 66.00
71.00 72.00 73.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	18, 824 0 0 0 9, 941	0 0 0 0 36, 474		0 0 0 0	106, 644 0 0 0 46, 415	71.00 72.00 73.00
76. 00 76. 97	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0 7, 432	0 200, 361	0000	0	0 207, 793	76.00 76.97
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	272, 117 23, 853	757, 922 0			1, 030, 039 0 42, 965	92.00
	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	1, 590	43, 426	64, 804	0	109, 820	
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	650 5, 607, 678	10, 893 12, 736, 258		0	11, 543 20, 272, 270	113.00 116.00 118.00
192.00 194.00 194.01 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES	0 111, 234 100, 462 1, 246 343 0	0 0 5, 043 57, 281 0	2, 440, 833 440, 678 0	0 0 0 0 0 0	2, 552, 067 541, 140 6, 289 57, 624	
194.04 194.05 194.06 194.07	07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION 07956 VACANT SPACE 07957 HOME OFFICE 07958 CAMBRIDGE RHC	0 31, 802 0 0	0 0 1, 731, 970 6, 846, 216 0		0 0 0 0	7, 040 31, 802 2, 119, 352 7, 857, 406 0	194. 04 194. 05 194. 06

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod: rom 01/01/2019	Worksheet B Part II	
					Date/Time Pre	pared:
					6/8/2020 3:16	pm
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	Di rectl y		NEW CAP BLDG &		Subtotal	
	Assigned New Capital	FIXT	FIXT - OFFSITE	EQUI P		
	Related Costs					
	0	1.00	1.01	2.00	2A	
201.00 Negative Cost Centers		C	C	0	0	201.00
202.00 TOTAL (sum lines 118 through 20	5, 852, 765	21, 376, 768	6, 215, 457	0	33, 444, 990	202.00

Heal th	Fi nanc	i al	Syste	ems		
				DEI	ATED	C

		HOSPI TAL & HEAL				u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	1	Period: From 01/01/2019 Fo 12/31/2019	Worksheet B Part II Date/Time Pre 6/8/2020 3:16	pared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	ADMI TTI NG	
	GENERAL SERVICE COST CENTERS	4.00	5.01	5.02	5.03	5.04	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 436					4.00
5.01	00540 NONPATI ENT TELEPHONES	0	0				5.01
5.02 5.03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	26	0				5.02 5.03
5.03 5.04	00570 ADMITTING	336	0			86, 264	1
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		0 0	00,201	1
5.06	00590 OTHER A&G	358	0	13, 839	9 629	0	
7.00	00700 OPERATION OF PLANT	36	0	1, 134		0	
8.00	00800 LAUNDRY & LINEN SERVICE	38	0			0	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	223 68	0			0	
	01100 CAFETERIA	267	0		0 2,403	0	
	01300 NURSI NG ADMI NI STRATI ON	24	0		0 0	0	
	01400 CENTRAL SERVICES & SUPPLY	70	0	2, 490	6 26, 796	0	14.00
	01500 PHARMACY	454	0	,		0	
	01600 MEDICAL RECORDS & LIBRARY	0	0	(10		0	
	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	259 155	0	6, 12 14, 97		0	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	186	0			0	1
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	19	0			0	
23.00	02300 PARAMED ED PRGM	23	0	2, 94	9 38	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	2, 241	0			4, 933	
	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	369 359	0 0			851 908	1
	04100 SUBPROVI DER – I RF	164	0			425	1
	04300 NURSERY	40	0		1, 420	168	1
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	151	0			15, 215	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	77 727	0			873	1
	05900 CARDI AC CATHETERI ZATI ON	206	0			12, 666 9, 626	
	06000 LABORATORY	447	0			9,063	
65.00	06500 RESPI RATORY THERAPY	162	0	2, 94	9 8, 204	2, 396	65.00
	06600 PHYSI CAL THERAPY	717	0				
		109	0	· ·		2, 993	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31 0	0	3, 85	7 446 D 0	403 0	1
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		73.00
	07400 RENAL DIALYSIS	0	0	68	1 477	110	
	03950 ANCI LLARY - OTHER	0	0		-	0	1
/6.9/	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	37	0	1, 588	3 243	120	76.97
91.00	09100 EMERGENCY	638	0	25, 182	2 9, 769	8, 074	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 FAMILY PRACTICE	201	0	2, 26	9 1, 749	588	93.00
0/ 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	21		1 01	- 2 020	42	
96.00	SPECIAL PURPOSE COST CENTERS	21	0	1, 81	5 3, 838	42	96.00
113.00	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	142	0	5, 218	3, 628	504	116.00
118.00		9, 385	0	341, 888	3 220, 673	86, 264	118.00
	NONREI MBURSABLE COST CENTERS			1			1.00.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 0		0 0 74		190.00 192.00
102 00		0	0				192.00
	07950 RENTAL SPACE			1, 10			
194.00	07950 RENTAL SPACE 07951 FOUNDATI ON	18	0	(281	0	194.01
194.00 194.01 194.02	07951 FOUNDATI ON 07952 RETAIL SERVICES	18 15	0		281 0 55	0	194. 02
194.00 194.01 194.02 194.03	07951 FOUNDATI ON 07952 RETAI L SERVI CES 07953 REI D CONTRACTED SERVI CES	18	0 0 0	(D 55 D 0	0 0	194. 02 194. 03
194.00 194.01 194.02 194.03 194.04	07951 FOUNDATI ON 07952 RETAI L SERVI CES 07953 REI D CONTRACTED SERVI CES 07954 REI D PHYSI CI AN ASSOC.	18 15	0 0 0 0		D 55 D 0 D 0	0 0 0	194. 02 194. 03 194. 04
194.00 194.01 194.02 194.03 194.04 194.05	07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION	18 15	0 0 0 0		55 0 0 0 0 0 0 0	0 0 0 0	194. 02 194. 03 194. 04 194. 05
194.00 194.01 194.02 194.03 194.04 194.05 194.06	07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	18 15	0 0 0 0 0 0		D 55 D 0 D 0	0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 05
194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07	07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION	18 15	0 0 0 0 0 0 0 0 0 0 0 0 0		55 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05
194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 200.00	07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION 07956 VACANT SPACE 07957 HOME OFFICE 07958 CAMBRIDGE RHC Cross Foot Adjustments	18 15	0 0 0 0 0 0 0 0 0		55 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 200. 00
194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08	07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION 07956 VACANT SPACE 07957 HOME OFFICE 07958 CAMBRIDGE RHC Cross Foot Adjustments Negative Cost Centers	18 15			55 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	194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08

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ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet B Part II Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.05	5.06	7.00	8.00	9.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04		101 014					5.04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G	181, 914 0	141, 641				5.0
7.00	00700 OPERATION OF PLANT	0	393	327, 714	L		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	599	4, 235			8.00
9.00	00900 HOUSEKEEPI NG	0	1, 816	2, 703		241, 436	9.00
10.00	01000 DI ETARY	0	1, 238	6, 339	0	14, 970	10.00
11.00		0	1, 080	3, 248		0	
13.00		0	170	671		345	
14.00		0	2, 704	2, 888		3, 020	
15.00		0	20, 773	3, 310		4, 638	
16.00 17.00		0	58 1, 985	C 150	-	0 1, 855	
17.00		0	1, 985	3, 201		2, 502	
21.00		0	1, 158	3, 201 C		2, 302	
22.00		0	396	C		0	
23.00		0	234	964	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	10, 395	19, 132	39, 745	109, 760	80, 239	30.00
31.00		1, 793	4, 117	8, 430		14, 819	
40.00		1, 914	2, 805	7,670		15, 293	
41.00	04100 SUBPROVIDER - IRF	896	1, 632	6, 145		7, 161	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	354	340	921	0	604	43.00
50.00		32, 177	14, 697	13, 948	55, 612	22, 239	50.00
52.00		1, 839	901	2, 855		4, 961	
54.00		26, 694	10, 189	18, 499		13, 762	
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 287	4, 036	1, 577	19, 823	3, 236	59.00
60.00		19, 101	7, 872	6, 933	0	11, 626	60.00
65.00		5, 049	1, 450	410		2, 157	
66.00		4,037	6, 247	16, 556		1, 898	
69.00		6, 308	1, 507	191		3, 236	
70.00 71.00		850 0	370 0	1, 854 C		0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	5, 955	9, 390	C	-	0	
	07300 DRUGS CHARGED TO PATIENTS	24, 374	461	0		0	
		232	466	512	-	3, 365	
76.00		0	0	0.2	0	0	
76.97		253	400	1, 257	0	863	76.97
	OUTPATIENT SERVICE COST CENTERS						
		17, 016	5, 943	10, 631	50, 697	19, 349	
		1 000	1 404	~	10.050	F 477	92.00
93.00	04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	1, 238	1, 436	C	10, 853	5, 177	93.00
96.00		89	229	1, 288	8 0	0	96.00
70.00	SPECIAL PURPOSE COST CENTERS		227	1,200		0	70.00
113.00	0 11300 I NTEREST EXPENSE						113.00
116.00	D 11600 HOSPI CE	1, 063	1, 661	C	0 0	3, 689	116.00
118.00) 181, 914	129, 583	167, 131	365, 431	241, 004	118.00
	NONREI MBURSABLE COST CENTERS	-1				-	
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	27 140	-		190.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 RENTAL SPACE	0	2, 980	37, 140			192.00 194.00
	0/950 RENTAL SPACE 107951 FOUNDATI ON	0	2, 622 345	7, 869 71			194.00
	207952 RETAIL SERVICES	0	135	235			194.0
	3 07953 REID CONTRACTED SERVICES		135	230			194. 0
	4 07954 REID PHYSICIAN ASSOC.	0	4				194.0
194.04		0	340	0	0		194.0
	5 07955 CONNERSVILLE LOCATION			04 049			194.0
194.05	5 07955 CONNERSVILLE_LOCATION 6 07956 VACANT_SPACE	ol	1, 172	31, 943	0	0	1174.0
194.05 194.06		0	1, 172 4, 274	31, 943 83, 325			
194. 05 194. 06 194. 07	6 07956 VACANT SPACE	0 0 0				0	194. 0 194. 0
194.05 194.06 194.07 194.08 200.00	6 07956 VACANT SPACE 7 07957 HOME OFFICE 8 07958 CAMBRIDGE RHC 0 Cross Foot Adjustments	0 0 0				0 0	194. 0 194. 0 200. 0
194. 05 194. 06 194. 07	6 07956 VACANT SPACE 7 07957 HOME OFFICE 8 07958 CAMBRIDGE RHC 0 Cross Foot Adjustments 0 Negative Cost Centers	0 0 0 181, 914				0 0	194. 0 194. 0 200. 0 201. 0

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ALLOCATI	ON OF CAPITAL RELATED COSTS Cost Center Description	DI ETARY	Provider C		eriod: com 01/01/2019 o 12/31/2019	Worksheet B Part II Date/Time Pre 6/8/2020 3:16	pared:
	Cost Center Description	DI ETARY				0/0/2020 3.10	pm
			CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	ENERAL SERVICE COST CENTERS D100 NEW CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	0101 NEW CAP BLDG & FIXT - OFFSITE 0200 NEW CAP REL COSTS-MVBLE EQUIP 02400 EMPLOYEE BENEFITS DEPARTMENT 0540 NONPATIENT TELEPHONES 0550 DATA PROCESSING 0560 PURCHASING RECEIVING AND STORES 0570 ADMITTING 0580 CASHIERING/ACCOUNTS RECEIVABLE 0590 OTHER A&G 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA	554, 598 0	236, 192				1. 01 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00
14.00 0' 15.00 0' 16.00 0' 17.00 0' 21.00 0' 22.00 0' 23.00 0'	1300 NURSI NG ADMI NI STRATI ON 1400 CENTRAL SERVI CES & SUPPLY 1500 PHARMACY 1600 MEDI CAL RECORDS & LI BRARY 1700 SOCI AL SERVI CE 1701 I NSERVI CE EDUCATI ON 2100 I &R SERVI CES-SALARY & FRI NGES APPRVD 2200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 2300 PARAMED ED PRGM	0 0 0 0 0 0 0 0 0	202 3, 772 11, 881 0 6, 957 4, 399 3, 514 627 519		503, 706 162 0 0 0 0 0 0 0 0	643, 554 0 0 0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00
	NPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS 3000 ADULTS & PEDI ATRI CS	373, 725	67, 516	22, 149	1, 382	120	30.00
31.00 03	3100 I NTENSI VE CARE UNI T	51, 198	9, 725	3, 190	1, 261	7	31.00
	4000 SUBPROVIDER - IPF	88, 389	11, 663		46	12	40.00
	4100 SUBPROVI DER – I RF 4300 NURSERY	41, 286 0	4, 736 921		182 77	1	41.00 43.00
A	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	4, 724		243, 301	1, 826	50.00
	5200 DELIVERY ROOM & LABOR ROOM 5400 RADIOLOGY-DIAGNOSTIC	0	1, 707 19, 710	1	1, 104 2, 301	14 13, 577	52.00 54.00
	5900 CARDI AC CATHETERI ZATI ON	0	5, 475		205, 460	6	59.00
	6000 LABORATORY	0	16, 162		39, 800	1	60.00
	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY	0	4, 708 18, 767	1	352 22	0 10	65.00 66.00
	6900 ELECTROCARDI OLOGY	0	3, 297		1, 458	4, 557	69.00
	7000 ELECTROENCEPHALOGRAPHY	О	1, 154	0	0	0	70.00
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00
	7200 I MPL. DEV. CHARGED TO PATI ENT 7300 DRUGS CHARGED TO PATI ENTS	0	0 178		0	0 620, 749	
	7400 RENAL DI ALYSI S	0	0		3	0	74.00
	3950 ANCI LLARY - OTHER	0	0	0	0	0	76.00
	7697 CARDIAC REHABILITATION	0	1, 321	433	4	0	76. 97
	9100 EMERGENCY	0	17, 806	5, 841	693	482	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		(770		0	0	92.00
	4040 FAMILY PRACTICE	0	6, 770	0	0	0	93.00
	9600 DURABLE MEDICAL EQUI P-RENTED	0	1, 030	0	6, 042	0	96.00
	PECIAL PURPOSE COST CENTERS			1			
	1300 I NTEREST EXPENSE 1600 HOSPI CE	o	4, 494	0	56	2 102	113. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	554, 598	233, 735		503, 706	643, 554	
	ONREIMBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSICIANS' PRIVATE OFFICES	0	0		0		190. 00 192. 00
	7950 RENTAL SPACE	0	0	-	0		192.00
194.010	7951 FOUNDATI ON	О	677		0		194.01
	7952 RETAIL SERVICES	0	713		0		194.02
	7953 REID CONTRACTED SERVICES 7954 REID PHYSICIAN ASSOC.	0	1, 067 0	0	0		194. 03 194. 04
	7955 CONNERSVILLE LOCATION	o	0	0	0		194.04
	7956 VACANT SPACE	0	0	0	0	0	194.06
194.060						0	194.07
194.060 [°] 194.070 [°]	7957 HOME OFFICE	0	0	0	0		
194.060 ⁻ 194.070 ⁻ 194.080 ⁻	7958 CAMBRIDGE RHC	0 0	0 0	0	0		194. 08
194.060 [°] 194.070 [°]		0 0	0 0 0	0	0	0	

Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVIC	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0048 P	eriod: rom 01/01/2019	Worksheet B Part II	pared:
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	EDUCATI ON	SERVI CES-SALAR Y & FRI NGES	RESI DENTS SERVI CES-OTHER PRGM. COSTS	
	16.00	17.00	17.01	21.00	22.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TI ING 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.06 00590 OTHER A&G 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01400 CENTRAL 13.00 01300 <td>106, 583</td> <td></td> <td></td> <td></td> <td></td> <td>1.00 1.01 2.00 4.00 5.01 5.02 5.03 5.04 5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00</td>	106, 583					1.00 1.01 2.00 4.00 5.01 5.02 5.03 5.04 5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00
17.00 01700 SOCI AL SERVICE 17.01 01701 I NSERVICE EDUCATION 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 23.00 02300 PARAMED ED PRGM			281, 732 0 0 675	4, 858	35, 721	17.00 17.01 21.00 22.00 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	6,099	53, 121	89, 964			30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 052		12, 601			31.00
40. 00 04000 SUBPROVI DER – I PF 41. 00 04100 SUBPROVI DER – I RF	1, 123		15, 125			40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	526		6, 185 1, 191			41.00
ANCI LLARY SERVI CE COST CENTERS		1				
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	18, 730		19, 728 2, 524			50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 662		26, 286			52.00
59.00 05900 CARDI AC CATHETERI ZATI ON	11, 903		7, 109			59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	11, 207 2, 962		21, 221 6, 114			60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	2, 368		24, 668			66.00
69. 00 06900 ELECTROCARDI OLOGY	3, 701		4, 710			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS	499		1, 475			70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 494	0	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	14, 301		0			73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - OTHER	136		0			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	148	0	1, 688			76.97
0UTPATI ENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	9, 984	14, 493	24, 491			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 904	14, 475	24,471			92.00
93. 00 04040 FAMILY PRACTICE	726	0	8, 744			93.00
OTHER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	52	2 0	1, 333			96.00
SPECIAL PURPOSE COST CENTERS			.,		1	
113. 00 11300 I NTEREST EXPENSE	()		4 105			113.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	624 106, 583	72, 511	4, 105 279, 937		0	116.00 118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES		-	0			190.00 192.00
194.0007950 RENTAL SPACE			0			192.00
194. 01 07951 FOUNDATI ON	C	0	871			194.01
194. 02 07952 RETAI L_SERVI CES 194. 03 07953 REI D_CONTRACTED_SERVI CES			924 0			194.02 194.03
194.0407954 REID PHYSICIAN ASSOC.			0			194.04
194. 05 07955 CONNERSVILLE LOCATION	c	0	0			194.05
194. 06 07956 VACANT SPACE 194. 07 07957 HOME OFFI CE			0			194.06 194.07
194. 08 07958 CAMBRI DGE_RHC			0			194.07
200.00 Cross Foot Adjustments			-	4, 858		200.00
201.00 Negative Cost Centers	C	0	0	0	0	201.00

Health Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/8/2020 3:16	
				INTERNS &	RESI DENTS	pin
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	I NSERVI CE	SERVI CES-SALAR	SERVI CES-OTHER	
	RECORDS &		EDUCATI ON	Y & FRINGES	PRGM. COSTS	
	16.00	17.00	17.01	21.00	22.00	
202.00 TOTAL (sum lines 118 through 20	01) 106, 58	72, 511	281, 732	4, 858	35, 721	202.00

	Systems REID PITAL RELATED COSTS	HOSPI TAL & HEAL		CN: 15-0048	In Lie Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Prepared 6/8/2020 3:16 pm	
Cost	Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	<u>- 67 67 2 8 2 0 3. 10 pill</u>	
		23.00	24.00	25.00	26.00		
	RVICE COST CENTERS CAP REL COSTS-BLDG & FIXT					1	
.01 00101 NEW .00 00200 NEW .01 00540 NONP .02 00550 DATA .03 00560 PURC .04 00570 ADMI .05 00580 CASH .06 00590 OTHE .00 00700 OPER .00 00700 DER .00 01000 DI ET 1.00 01100 CAFE .00 01400 CENT .00 01500 PHAR 6.00 01600 MEDI 7.00 01700 SOCI	CAP BLDG & FIXT - OFFSITE CAP REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT ATIENT TELEPHONES . PROCESSING HASING RECEIVING AND STORES TTING IERING/ACCOUNTS RECEIVABLE R A&G ATION OF PLANT DRY & LINEN SERVICE EKEEPING ARY TERIA ING ADMINISTRATION RAL SERVICES & SUPPLY MACY CAL RECORDS & LIBRARY					1 2 4 5 5 5 5 5 5 5 5 5 5 7 7 8 9 9 10 11 13 14 15 16 17	
1.00 02100 I&R	SERVICES-SALARY & FRINGES APPRVD					21	
	SERVICES-OTHER PRGM. COSTS APPRVD	02 262				22	
	MED ED PRGM ROUTINE SERVICE COST CENTERS	93, 263		I		23	
0.00 03000 ADUL	TS & PEDIATRICS		4, 398, 269	1	0 4, 398, 269	30	
	NSIVE CARE UNIT ROVIDER – IPF		1, 245, 040 755, 081	1	0 1, 245, 040 0 755, 081	31	
	ROVIDER - IRF		574, 325		574, 325	40	
3. 00 04300 NURS			78, 789		78, 789	43	
	SERVICE COST CENTERS ATING ROOM		2, 917, 361		2, 917, 361	50	
	VERY ROOM & LABOR ROOM		289,678	1	2, 917, 301	52	
4.00 05400 RADI	OLOGY-DI AGNOSTI C		3, 054, 397	7 (3, 054, 397	54	
	I AC CATHETERI ZATI ON		884, 525		0 884, 525	59	
0. 00 06000 LAB0 5. 00 06500 RESP	IRATORY THERAPY		1, 366, 137 135, 126		0 1, 366, 137 0 135, 126	60 65	
	I CAL THERAPY		1, 368, 529		1, 368, 529	66	
	TROCARDI OLOGY		312, 365		312, 365	69	
	TROENCEPHALOGRAPHY		119, 063		0 119,063	70	
	CAL SUPPLIES CHARGED TO PATIENTS . DEV. CHARGED TO PATIENT		21, 665		0 0 0 21,665	71	
3. 00 07300 DRUG	S CHARGED TO PATIENTS		671, 686		0 671, 686	73	
. 00 07400 RENA			52, 397		52, 397	74	
5.00 03950 ANCI	LLARY – OTHER TAC REHABILITATION		216, 148		0 0 0 216, 148	76	
	SERVICE COST CENTERS		210, 140	2	210, 140	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
I. 00 09100 EMER			1, 251, 128		0 1, 251, 128		
1 1	RVATION BEDS (NON-DISTINCT PART)		00 71/	1	0 71/	92	
	LY PRACTI CE IBURSABLE COST CENTERS		82, 716		0 82, 716	93	
	BLE MEDICAL EQUIP-RENTED		125, 599) (0 125, 599	96	
	IRPOSE COST CENTERS	I		1			
3. 00 11300 NTE 6. 00 11600 HOSP			20 010		20 010	113	
	OTALS (SUM OF LINES 1 through 117)	О	38, 919 19, 958, 943		0 38, 919 0 19, 958, 943	118	
	SABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
	, FLOWER, COFFEE SHOP & CANTEEN		C		0 0	190	
	ICIANS' PRIVATE OFFICES		2, 592, 261		2, 592, 261	192	
94. 00 07950 RENT 94. 01 07951 FOUN			553, 330 8, 768		0 553, 330 0 8, 768	194 194	
4. 02 07952 RETA	I L SERVICES		59, 917		59, 917	194	
4. 03 07953 REI D	CONTRACTED SERVICES		1, 271	(0 1, 271	194	
4. 04 07954 REI D	PHYSICIAN ASSOC.		7,044		7,044	194	
4. 05 07955 CONN 4. 06 07956 VACA	ERSVILLE LOCATION		32, 142		0 32, 142 0 2 152 467	194	
4. 06 07956 VACA 4. 07 07957 HOME			2, 152, 467 7, 945, 005		2, 152, 467 7, 945, 005	194 194	
4. 08 07958 CAMB			,, ,40,000	1	0 7,945,005	194	
	s Foot Adjustments	93, 263	133, 842	1	133, 842	200	
01.00 Nega	tive Cost Centers	0	C		0 0	201	

Health Financial Systems	REID H	HOSPI TAL & HEAI	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider CC		Peri od:	Worksheet B	
					From 01/01/2019 To 12/31/2019		norod
					To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
Cost Center Description		PARAMED ED	Subtotal	Intern &	Total		
		PRGM		Residents Cos	st		
				& Post			
				Stepdown			
				Adjustments			
		23.00	24.00	25.00	26.00		
202.00 TOTAL (sum lines 118 through	201)	93, 263	33, 444, 990		0 33, 444, 990		202.00

In Lieu of Form CMS-2552-10 U: Worksheet B-1

COST A	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0048	Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
		CAPI	TAL RELATED CO			6/8/2020 3: 16	pm
		CALL	TAL RELATED CO	5515			
	Cost Center Description		NEW CAP BLDG &		EMPLOYEE	NONPATI ENT	
		FIXT (SQUARE FEET)	FIXT - OFFSITE	EQUI P (SQUARE FEET	BENEFITS DEPARTMENT	TELEPHONES (PHONES)	
			(SQUARE FEET)		(GROSS		
		1.00	1 01	2.00	SALARI ES)	F 01	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	5.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	873, 266					1.00
1.01	00101 NEW CAP BLDG & FIXT - OFFSITE	0	275, 457				1.01
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	400		0 86, 640, 168		2.00 4.00
5.01	00540 NONPATI ENT TELEPHONES	0	400		0 00, 040, 100	0	•
5.02	00550 DATA PROCESSI NG	3, 313	1, 095		0 236, 700		
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	8, 871 462	0 1, 884		0 40, 848 0 3, 084, 816		
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	402	7, 820		0 3,084,810	0	
5.06	00590 OTHER A&G	3, 951	684		0 3, 283, 559		
7.00	00700 OPERATION OF PLANT	11,004	1, 558	1	0 327, 775		
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	12, 335 8, 158	0		0 348,073 0 2,047,038		
10.00	01000 DI ETARY	18, 463	0		0 620, 887	0	•
11.00	01100 CAFETERIA	9,461	0		0 2, 453, 746		
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 955 8, 411	0		0 220, 719 0 643, 107	0	
15.00	01500 PHARMACY	9, 871	0		0 4, 161, 967	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4, 721		0 0	0	
17.00 17.01	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	1, 241 10, 409	0		0 2, 373, 482 0 1, 422, 098	0	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	10,407	0		0 1, 703, 560		
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 178, 431	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,061	2, 680		0 212, 071	0	23.00
30.00	03000 ADULTS & PEDIATRICS	116, 864	0		0 20, 636, 391	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	24, 552	0		0 3, 385, 039	0	
40.00	04000 SUBPROVIDER - IPF	22, 340	0		0 3, 289, 920		
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	17, 898 2, 681	0		0 1, 506, 466 0 371, 264	0	
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATING ROOM	45, 662	13, 091		0 1, 384, 115		
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	8, 316 70, 740	0 1, 600		0 703, 560 0 6, 669, 577	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	13, 579	0		0 1, 890, 765		•
60.00	06000 LABORATORY	29, 095	0		0 4, 102, 420		
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 647 8, 084	0 42, 316		0 1, 484, 967 0 6, 573, 684	0	
	06900 ELECTROCARDI OLOGY	7,011	42, 510	1	0 996, 152		
	07000 ELECTROENCEPHALOGRAPHY	0	3, 892	1	0 284, 526		
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	1
	07400 RENAL DI ALYSI S	1, 490	0		0 0	0	
	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON	0 8, 185	0		0 0 0 340, 145	0	
70. 77	OUTPATIENT SERVICE COST CENTERS	0,105	0	1			/0. //
	09100 EMERGENCY	30, 962	0		0 5, 852, 763	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	0	847		0 1, 842, 260	0	92.00 93.00
93.00	OTHER REIMBURSABLE COST CENTERS	0	047		0 1, 842, 200	0	93.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	1, 774	2, 872		0 192, 291	0	96.00
112 00	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	445	0		0 1, 303, 131	0	113. 00 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	520, 291	85, 460		0 86, 168, 313		118.00
100.00	NONREI MBURSABLE COST CENTERS		~	1	0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 108, 173		0 0		190. 00 192. 00
194.00	07950 RENTAL SPACE	0	19, 530		0 0		192.00
	07951 FOUNDATION	206	0		0 168, 683		194.01
	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES	2, 340	0		0 134, 943 0 168, 229		194. 02 194. 03
	07954 REID CONTRACTED SERVICES	0	312		0 0		194.03
194.05	07955 CONNERSVILLE LOCATION	0	0		0 0	0	194.05
	07956 VACANT SPACE 07957 HOME OFFICE	70, 753	17, 168		0 0		194. 06 194. 07
	07957 HOME OFFICE 07958 CAMBRIDGE RHC	279, 676 0	44, 814 0	1	0 0		194.07 194.08
	1 1	, -I		1			

Heal th Fin	ancial Systems RELD	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		CAPI	TAL RELATED CC	ISTS			
	Cost Center Description	FLXT	NEW CAP BLDG & FIXT - OFFSITE	EQUI P	EMPLOYEE BENEFI TS	NONPATI ENT TELEPHONES	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)	(PHONES)	
		1.00	1.01	2.00	4.00	5. 01	
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	21, 376, 768	6, 215, 457		0 17, 258, 745	0	202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	24. 479103	22. 564164	0. 00000	0 0. 199200 9, 436		203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part				0. 000109	0. 000000	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th	Fi nanci al	S	ystems	
A T200		_	IAD IT 2 ITAT2	RV6

A	LLOCATION - STATISTICAL BASIS		Provider CC	1	Period: From 01/01/2019	Worksheet B-1	
					Го 12/31/2019	2019 Date/Time Pr 6/8/2020 3:1	
	Cost Center Description	DATA PROCESSI NG (TERMI NALS)	PURCHASI NG RECEI VI NG AND STORES (SUPPLY EXPENSE)	ADMI TTI NG (TOTAL REVENUE)	CASHI ERI NG/ACC OUNTS RECEI VABLE (TOTAL REVENUE)		
		5.02	5.03	5.04	5.05	5A. 06	
	GENERAL SERVICE COST CENTERS		1		1		
01 00 00 01 02 03 04 05 06 00 00 00 00 00 00 00 00 00 00 00 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE SUPPLY 01500 I& SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	1, 512 2 99 61 52 3 43 0 0 0 11 55 0 27 66 0 27 66 0 27	8, 749, 378 16, 222 0 24, 834 14, 369 1, 101 5, 594 94, 933 0 0 1, 057, 761 979, 521 0 30, 599 38 0 0 30, 599 38 0	927, 344, 82 (((((((((((((((((((927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-31, 006, 533 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7 8 9 10 11 13 14 15 16 17 17 21
	02300 PARAMED ED PRGM	13		(0	
	INPATIENT ROUTINE SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	<u> </u>		1-0
	03000 ADULTS & PEDI ATRI CS	277		53, 037, 750		0	
	03100 I NTENSI VE CARE UNI T	43		9, 147, 300		0	
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	16		9, 766, 278 4, 572, 574		0	
	04300 NURSERY	0		1, 803, 57		0	
	ANCILLARY SERVICE COST CENTERS		•	i	· · · · ·		
	05000 OPERATING ROOM	113		163, 377, 02		0	
	05200 DELIVERY ROOM & LABOR ROOM	28		9, 383, 29		0	
	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	121		136, 194, 232 103, 504, 290		0	
	06000 LABORATORY	95		97, 452, 158		0	
	06500 RESPI RATORY THERAPY	13		25, 759, 808		0	
	06600 PHYSI CAL THERAPY	116		20, 595, 21		0	
	06900 ELECTROCARDI OLOGY	34		32, 185, 984		0	
. 00	07000 ELECTROENCEPHALOGRAPHY	17	17, 616	4, 337, 800	4, 337, 806	0	70
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	C	0	30, 381, 862		0	
	07300 DRUGS CHARGED TO PATIENTS	C	0	124, 359, 37		0	
	07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	3	18, 814	1, 184, 700	1, 184, 700	0	
	07697 CARDI AC REHABI LI TATI ON		9, 580	1, 288, 60	1, 288, 607	0	
	OUTPATIENT SERVICE COST CENTERS	,	7, 500	1, 200, 00	1,200,007	0	1
	09100 EMERGENCY	111	385, 610	86, 818, 259	86, 818, 259	0	91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	04040 FAMILY PRACTICE	10	69, 022	6, 317, 339	6, 317, 339	0	93
	OTHER REIMBURSABLE COST CENTERS	I	1 1		1 1		
	09600 DURABLE MEDICAL EQUIP-RENTED	8	151, 483	454, 84	454, 844	0	96
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		1				1110
	11600 HOSPI CE	23	143, 208	5, 422, 538	5, 422, 538	0	113
8.00		1, 507		927, 344, 822		-31, 006, 533	
	NONREI MBURSABLE COST CENTERS	1, 307	5,710,711	, 2, 1, 344, 02.	- , , , , , , , , , , , , , , , , , , ,	51,000,000	1'''
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		(0 0	0	190
	19200 PHYSI CI ANS' PRI VATE OFFI CES		2, 902	(-		192
	07950 RENTAL SPACE	5	22, 301	(0 0		194
	07951 FOUNDATI ON	C	11, 081	(0 0		194
	07952 RETAIL SERVICES	C	2, 183	(0 0		194
	07953 REID CONTRACTED SERVICES	0	0	(0 0		194
	07954 RELD PHYSICIAN ASSOC.	C	0	(0 0		194
	07955 CONNERSVILLE LOCATION	C	0	(0		194
	07956 VACANT SPACE	0	0	(194
	07957 HOME OFFICE	[C	y 0	(0 ע	0	194
		-				~	
	07958 CAMBRIDGE RHC Cross Foot Adjustments	C	0	(0 0	0	194 200

	· · · · · · · · · · · · · · · · · · ·	HUJFTIAL & HLA	LTH CARE SERVI			u of Form CMS-2	
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	
			RECEIVING AND	· ·	OUNTS		
		(TERMI NALS)	STORES	REVENUE)	RECEI VABLE		
			(SUPPLY		(TOTAL		
			EXPENSE)		REVENUE)		
		5.02	5.03	5.04	5.05	5A. 06	
202.00	Cost to be allocated (per Wkst. B, Part I)	13, 865, 026	302, 072	6, 049, 65	9 270, 032		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9, 169. 990741	0. 034525	0. 00652	4 0. 000291		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	343, 022	221, 648	86, 26	4 181, 914		204.00
205.00	Unit cost multiplier (Wkst. B, Part	226. 866402	0. 025333	0. 00009	3 0. 000196		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th	Fi nanci al	Systems	
COCT A			

	Financial Systems REID LLOCATION - STATISTICAL BASIS	HOSPI TAL & HEA	Provider C	CN: 15-0048 Pe	eriod: rom 01/01/2019	Date/Time Pre	pared:
	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	6/8/2020 3:16 DI ETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 00
$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 01\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 IARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	260, 549, 475 722, 412 1, 101, 332 3, 338, 888 2, 276, 491 1, 985, 435 312, 543 4, 970, 653 38, 369, 077 106, 525 3, 648, 753 3, 121, 899 2, 128, 362 727, 183 430, 298	954, 480 12, 335 7, 872 18, 463 9, 461 1, 955 8, 411 9, 640 0 438 9, 322 0 0 2, 807	1, 906, 914 0 0 0 0 0 0 0	11, 193 694 0 16 140 215 0 86 116 0 0 0 0	56, 069 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 17.\ 01\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	35, 169, 129 7, 567, 516 5, 156, 746 3, 000, 706 625, 895	115, 758 24, 552 22, 340 17, 898 2, 681	116, 854 132, 324	3, 720 687 709 332 28	5, 176 8, 936 4, 174	
$\begin{array}{c} 50. \ 00\\ 52. \ 00\\ 54. \ 00\\ 59. \ 00\\ 60. \ 00\\ 65. \ 00\\ 69. \ 00\\ 70. \ 00\\ 70. \ 00\\ 71. \ 00\\ 71. \ 00\\ 73. \ 00\\ 74. \ 00\\ 76. \ 00\\ 76. \ 97\end{array}$	05500 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	27, 016, 434 1, 655, 764 18, 729, 030 7, 418, 251 14, 470, 957 2, 665, 835 11, 482, 744 2, 770, 364 679, 976 0 17, 261, 477 847, 510 855, 838 0 734, 773	40, 624 8, 316 53, 880 4, 593 20, 194 1, 194 48, 220 557 5, 400 0 0 0 1, 490 0 3, 662	102, 549 186, 846 103, 439 0 0 18, 204 0 7, 723 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 031 230 638 150 539 100 88 150 0 0 0 0 0 0 0 156 0 40		
91.00 92.00 93.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	10, 924, 804	30, 962		897		92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	420, 083	3, 752	0	0	0	96.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	3, 052, 764 238, 385, 425	0 486, 777	0 1, 906, 914	171 11, 173		113. 00 116. 00 118. 00
192.00 194.00 194.02 194.03 194.03 194.04 194.05 194.06 194.07	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION 07956 VACANT SPACE 07957 HOME OFFICE 07958 CAMBRIDGE RHC Cross Foot Adjustments	0 5, 477, 380 4, 818, 944 633, 947 248, 424 341, 815 7, 040 624, 536 2, 154, 558 7, 857, 406 0	0 108, 173 22, 920 684 0 0 93, 036 242, 684 0		0 0 10 10 0 0 0 0 0 0 0 0 0 0		190.00 192.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08 200.00 201.00

COST ALLOCATION - STATISTICAL BASIS				F	Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
			(SQUARE FEET)	(POUNDS OF LAUNDRY)	SERVI CE)		
		5.06	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	31, 006, 533	808, 382	1, 242, 842	3, 742, 896	2, 795, 111	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 119004	0. 846934	0. 651756	334. 396140	49.851273	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	141, 641	327, 714	365, 431	241, 436	554, 598	204. 0
205.00	Unit cost multiplier (Wkst. B, Part	0. 000544	0. 343343	0. 191635	21. 570267	9. 891348	205. 0
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 0
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 0

Heal th	Fi nanci al	Systems	
COCT A			

COCT A	2	HOSPITAL & HEA				u of Form CMS-	
LUST A	LLOCATION - STATISTICAL BASIS		Provider CC	1	Period: From 01/01/2019 Fo 12/31/2019	Worksheet B-1 Date/Time Pre 6/8/2020 3:16	epared:
	Cost Center Description	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVICES & SUPPLY (MED SUPPLIES)	PHARMACY (DRUGS)	MEDI CAL RECORDS & LI BRARY (TOTAL	
		11.00	NURSING HRS) 13.00	14.00	15.00	REVENUE) 16.00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	11.00	10.00	10.00	
15.00 16.00 17.00 17.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	2, 427, 688 2, 080 38, 766 122, 118 0 71, 507 45, 214 36, 118 6, 441 5, 335	1, 543, 730 0 0 0 0 0 0 0 0 0 0 0	18, 203, 56 5, 87(((((((927, 344, 822 0 0 0 0 0 0 0 0	17.0 17.0 21.0 22.0
31.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY	693, 976 99, 955 119, 879 48, 678 9, 471	99, 955 119, 879 48, 678	45, 57 1, 67	7 346 4 592 9 38	53, 037, 756 9, 147, 300 9, 766, 278 4, 572, 574 1, 803, 575	31.0 40.0 41.0
		40 554	40 554	0 702 02	1 00 210	1(2, 277, 021	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	48, 556 17, 541		8, 792, 82 ⁻ 39, 894		163, 377, 021 9, 383, 299	
54.00	05400 RADI OLOGY-DI AGNOSTI C	202, 592				136, 194, 232	
9.00	05900 CARDI AC CATHETERI ZATI ON	56, 274		7, 425, 114		103, 504, 290	
60.00	06000 LABORATORY	166, 120	0	1, 438, 314	4 60	97, 452, 158	
5.00	06500 RESPI RATORY THERAPY	48, 386				25, 759, 808	
6.00	06600 PHYSI CAL THERAPY	192, 899		789		20, 595, 215	
9.00		33, 883 11, 860		52, 700		32, 185, 984	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,860				4, 337, 806	70.
		0	0		0	30, 381, 862	
	07300 DRUGS CHARGED TO PATIENTS	1, 826	1, 826	(30, 709, 954	124, 359, 377	
	07400 RENAL DIALYSIS	0	0	11:		1, 184, 700	
	03950 ANCI LLARY - OTHER	0	0	(0	
0.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	13, 578	13, 578	129	9 0	1, 288, 607	76.
1.00	09100 EMERGENCY	183, 018	183, 018	25, 050	5 23, 840	86, 818, 259	91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				,		92.
3.00	04040 FAMILY PRACTICE	69, 586	0	(24	6, 317, 339	93.
	OTHER REIMBURSABLE COST CENTERS	10 501		040.05	-	45.4.0.4.4	
6.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	10, 591	0	218, 35	5 0	454, 844	96.
	DIESTIC I DIN ODE OUDT DENTEND						113.
13.00	11300 INTEREST EXPENSE						
	11300 I NTEREST EXPENSE 11600 HOSPI CE	46, 191	0	2, 020	0 108, 447	5, 422, 538	116.
16.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	46, 191 2, 402, 439				5, 422, 538 927, 344, 822	
16. 00 18. 00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS		1, 543, 730	18, 203, 56	7 31, 838, 177	927, 344, 822	118.
16.00 18.00 90.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 543, 730	18, 203, 56	7 <u>31, 838, 177</u> 0 <u></u> 0	927, 344, 822	118. 190.
16.00 18.00 90.00 92.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES		1, 543, 730	18, 203, 56	7 31, 838, 177 0 0 0 0	927, 344, 822 0 0	118. 190. 192.
16.00 18.00 90.00 92.00 94.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE	2, 402, 439 0 0 0	1, 543, 730 0 0 0 0	18, 203, 56	7 31, 838, 177 0 0 0 0 0 0 0 0	927, 344, 822 0 0 0 0 0	118. 190. 192. 194.
16.00 18.00 90.00 92.00 94.00 94.01	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION	2, 402, 439 0 0 0 0 6, 955	1, 543, 730 0 0 0 0 0 0	18, 203, 56	7 31, 838, 177 0 0 0 0	927, 344, 822 0 0 0 0 0 0 0	118. 190. 192. 194. 194.
16.00 18.00 90.00 92.00 94.00 94.01 94.02	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE	2, 402, 439 0 0 0	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	7 31, 838, 177 0 0 0 0 0 0 0 0 0 0 0 0	927, 344, 822 0 0 0 0 0 0 0 0 0 0	118. 190. 192. 194. 194. 194.
16.00 18.00 90.00 92.00 94.00 94.01 94.02 94.03	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE 07951 FOUNDATI ON 07952 RETAIL SERVI CES	2, 402, 439 0 0 0 6, 955 7, 331	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	7 31, 838, 177 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118. 190. 192. 194. 194. 194. 194. 194.
16.00 18.00 90.00 92.00 94.00 94.01 94.02 94.03 94.04 94.05	11600HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117)NONREI MBURSABLE COST CENTERS19000GI FT, FLOWER, COFFEE SHOP & CANTEEN19200PHYSI CI ANS' PRI VATE OFFI CES07950RENTAL SPACE07951FOUNDATI ON07952RETAI L SERVI CES07953REI D CONTRACTED SERVI CES07954REI D PHYSI CI AN ASSOC.07955CONNERSVI LLE LOCATI ON	2, 402, 439 0 0 0 6, 955 7, 331	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	31, 838, 177 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	927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118. 190. 192. 194. 194. 194. 194. 194. 194.
16.00 18.00 90.00 92.00 94.00 94.01 94.02 94.03 94.03 94.04 94.05 94.05	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATI ON 07952 RETAI L SERVICES 07953 REI D CONTRACTED SERVICES 07954 REI D PHYSI CI AN ASSOC. 07955 CONNERSVI LLE LOCATI ON 07956 VACANT SPACE	2, 402, 439 0 0 0 6, 955 7, 331	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	31, 838, 177 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	927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118. 190. 192. 194. 194. 194. 194. 194. 194. 194.
16.00 18.00 90.00 92.00 94.00 94.01 94.02 94.03 94.04 94.05 94.06 94.07	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATI ON 07952 RETAI L SERVICES 07953 REI D CONTRACTED SERVICES 07954 REI D PHYSI CI AN ASSOC. 07955 CONNERSVI LLE LOCATI ON 07956 VACANT SPACE 07957 HOME OFFI CE	2, 402, 439 0 0 0 6, 955 7, 331	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	31, 838, 177 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	927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118. (190. (192. (194. (
16.00 18.00 92.00 94.00 94.01 94.02 94.03 94.04 94.05 94.06 94.05	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATI ON 07952 RETAI L SERVICES 07953 REI D CONTRACTED SERVICES 07954 REI D PHYSI CI AN ASSOC. 07955 CONNERSVI LLE LOCATI ON 07956 VACANT SPACE 07957 HOME OFFICE 07958 CAMBRIDGE RHC	2, 402, 439 0 0 0 6, 955 7, 331	1, 543, 730 0 0 0 0 0 0 0 0	18, 203, 56	31, 838, 177 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	927, 344, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

Heal th Fi	nancial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLC	OCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MANHOURS)	ADMI NI STRATI ON		(DRUGS)	RECORDS &	
			(SUPPLY		LIBRARY	
				(MED SUPPLIES	5)	(TOTAL	
			NURSING HRS)			REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 229, 723	358, 653	5, 651, 72	43, 129, 294	119, 202	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 918455	0. 232329	0. 31047	3 1. 354641	0. 000129	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	236, 192	49, 269	503, 70	643, 554	106, 583	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 097291	0. 031916	0. 02767	0. 020213	0. 000115	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS	CEID HUSPITAL & HEF	Provi der C	CN: 15-0048 Pe	eriod: com 01/01/2019	Worksheet B-1 Date/Time Pre	
					6/8/2020 3: 16	
Cost Center Description	SOCI AL SERVI CE	I NSERVI CE	I NTERNS & SERVI CES-SALAR		PARAMED ED	
cost center bescription		EDUCATI ON	Y & FRINGES	PRGM. COSTS	PRGM	
	(TIME SPENT)	(IN HOUSE ED)	(ASSIGNED TIME)	(ASSI GNED TI ME)	(TIME SPENT)	
	17.00	17.01	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01 00540 NONPATI ENT TELEPHONES						5.01
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES						5.02 5.03
5. 04 00570 ADMI TTI NG						5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 OTHER A&G						5.05 5.06
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	55, 486					16.00 17.00
17. 01 01700 INSERVICE EDUCATION	0					17.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV		-	1, 546	1 544		21.00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPR 23.00 02300 PARAMED ED PRGM	RVD 0	-		1, 546	100	22.00 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 (10		1 001	4 001		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	40, 649 3, 085			1, 201 125	0	30.00 31.00
40. 00 04000 SUBPROVIDER - IPF	0	851	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0			0	0	41.00 43.00
ANCI LLARY SERVICE COST CENTERS				0	0	43.00
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			79 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	662			17	100	52.00 54.00
59.00 05900 CARDIAC CATHETERIZATION	0			0	0	59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		1, 194 344		0	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	O	1, 388	0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	265 83		41 0	0	69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00
74. 00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 ANCI LLARY - OTHER	0	0	0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	95	0	0	0	76.97
91.00 09100 EMERGENCY	11,090	1, 378	83	83	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 93. 00 04040 FAMILY PRACTICE)	492	0	0	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS		1				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	0	75	0	0	0	96.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	17) 55 496			1 546		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1 NONREI MBURSABLE COST CENTERS	17) 55,486	15, 751	1, 546	1, 546	100	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE	0			0		192.00 194.00
194. 01 07951 FOUNDATI ON	0	49	0	0	0	194.01
194. 02 07952 RETAIL SERVICES 194. 03 07953 REID CONTRACTED SERVICES	0	52	0	0		194.02 194.03
194. 04 07954 REID CONTRACTED SERVICES	0	0	0	0		194.03
194. 05 07955 CONNERSVILLE LOCATION	0	0	0	0		194.05
194. 06 07956 VACANT_SPACE 194. 07 07957 HOME_OFFI CE			0	0		194.06 194.07
194. 08 07958 CAMBRI DGE RHC	0	0	o o	0	0	194. 08
200.00 Cross Foot Adjustments						200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10

COST AL	LOCATION - STATISTICAL BASIS		Provider C	Provider CCN: 15-0048 Period: From 01/01/20		Worksheet B-1	
					o 12/31/2019	Date/Time Pre 6/8/2020 3:16	
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL SERVI CE			SERVI CES-OTHER	PARAMED ED	
			EDUCATI ON	Y & FRINGES	PRGM. COSTS	PRGM	
		(TIME SPENT)	(IN HOUSE ED)	(ASSIGNED TIME)	(ASSI GNED TI ME)	(TIME SPENT)	
		17.00	17.01	21.00	22.00	23.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4, 177, 774	3, 581, 629	2, 414, 819	819, 637	497, 368	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	75. 294200	225. 941774	1, 561. 978655	530. 166235	4, 973. 680000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	72, 511	281, 732	4, 858	3 35, 721	93, 263	204.00
205.00	Unit cost multiplier (Wkst. B, Part	1. 306834	17. 772647	3. 142303	23. 105433	932. 630000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pared: pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	47, 986, 553		47, 986, 55	3 0	47, 986, 553	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 576, 096		9, 576, 09	6 0	9, 576, 096	31.00
40. 00 04000 SUBPROVIDER - IPF	6, 890, 953		6, 890, 95		6, 890, 953	
41.00 04100 SUBPROVIDER - IRF	3, 865, 123		3, 865, 12	3 0	3, 865, 123	41.00
43. 00 04300 NURSERY	739, 145		739, 14		739, 145	
ANCI LLARY SERVI CE COST CENTERS				- <u> </u>		
50. 00 05000 OPERATI NG ROOM	33, 979, 420		33, 979, 42	0 0	33, 979, 420	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 120, 259		2, 120, 25		2, 120, 259	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	23, 356, 576		23, 356, 57		23, 356, 576	
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 896, 698		10, 896, 69		10, 896, 698	
60. 00 06000 LABORATORY	17, 271, 960		17, 271, 96		17, 271, 960	
65. 00 06500 RESPIRATORY THERAPY	3, 158, 217	0			3, 158, 217	
66. 00 06600 PHYSI CAL THERAPY	13, 425, 688	-	13, 425, 68		13, 425, 688	
69. 00 06900 ELECTROCARDI OLOGY	3, 567, 586		3, 567, 58		3, 567, 586	
70. 00 07000 ELECTROENCEPHALOGRAPHY	800, 709		800, 70		800, 709	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0000,707			0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	19, 319, 581		19, 319, 58	0	19, 319, 581	
73. 00 07300 DRUGS CHARGED TO PATIENTS	42, 567, 465		42, 567, 46	-	42, 567, 465	
74. 00 07400 RENAL DIALYSIS	1, 011, 335		1, 011, 33		1, 011, 335	
76. 00 03950 ANCI LLARY - OTHER	1, 011, 333			0 0	1, 011, 333	
76. 97 07697 CARDIAC REHABILITATION	875, 987		875, 98		875, 987	
OUTPATIENT SERVICE COST CENTERS	073, 907		075, 70	/	075, 907	10. 11
91. 00 09100 EMERGENCY	14, 131, 747		14, 131, 74	7 0	14, 131, 747	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 330, 949		5, 330, 94		5, 330, 949	
93. 00 04040 FAMILY PRACTICE	3, 246, 116		3, 246, 11		3, 246, 116	
OTHER REIMBURSABLE COST CENTERS	3, 240, 110		5, 240, 11	0 0	5, 240, 110	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	567, 778		567, 77	8 0	567, 778	06 00
SPECIAL PURPOSE COST CENTERS	507,778		507,77	0 0	507,778	90.00
113. 00 11300 I NTEREST EXPENSE			1			113.00
116. 00 11600 H0SPI CE	3, 716, 088		3, 716, 08	8	3, 716, 088	
200.00 Subtotal (see instructions)	268, 402, 029				268, 402, 029	
201.00 Less Observation Beds	5, 330, 949		5, 330, 94		5, 330, 949	
202.00 Total (see instructions)	263, 071, 080					
	203, 071, 080	0	203,071,08	u U	203, 071, 080	1202. UU

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 3:16	pared: pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·		•			
30.00 0	03000 ADULTS & PEDIATRICS	42, 996, 121		42, 996, 12	1		30.00
31.00 0	03100 INTENSIVE CARE UNIT	9, 147, 300		9, 147, 30	00		31.00
40.00 0	04000 SUBPROVIDER - IPF	9, 766, 278		9, 766, 27	8		40.00
41.00 0	04100 SUBPROVIDER - IRF	4, 572, 574		4, 572, 57	4		41.00
43.00 0	04300 NURSERY	1, 803, 575		1, 803, 57	5		43.00
	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	56, 749, 355	106, 627, 666			0.00000	
	D5200 DELIVERY ROOM & LABOR ROOM	8, 408, 216	975, 083			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	34, 922, 291	101, 271, 941			0.00000	
	05900 CARDI AC CATHETERI ZATI ON	39, 683, 089	63, 821, 201			0.00000	
	06000 LABORATORY	37, 298, 975	60, 153, 183			0.00000	
	06500 RESPI RATORY THERAPY	22, 744, 196	3, 015, 612			0.00000	
	06600 PHYSI CAL THERAPY	8, 456, 544	12, 138, 671			0.00000	
	06900 ELECTROCARDI OLOGY	12, 242, 101	19, 943, 883			0.00000	
	07000 ELECTROENCEPHALOGRAPHY	10, 214	4, 327, 592			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENT	19, 273, 451	11, 108, 411			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	49, 529, 771	74, 829, 606			0. 000000	
	07400 RENAL DIALYSIS	1, 114, 929	69, 771	1, 184, 70		0. 000000	
	03950 ANCI LLARY - OTHER	0	0		0 0.000000	0. 000000	
	07697 CARDI AC REHABI LI TATI ON	2, 321	1, 286, 286	1, 288, 60	0. 679794	0. 000000	76.97
	DUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	23, 162, 244	63, 656, 015				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 277, 306	6, 764, 329				
		17, 583	6, 299, 756	6, 317, 33	0. 513842	0. 000000	93.00
	THER REIMBURSABLE COST CENTERS	-					
	09600 DURABLE MEDICAL EQUIP-RENTED	0	454, 844	454, 84	4 1.248292	0.00000	96.00
	SPECIAL PURPOSE COST CENTERS	I					110.00
	11300 INTEREST EXPENSE	4 050 07/		F 400 F			113.00
	11600 HOSPI CE	1, 252, 876	4, 169, 662				116.00
200.00	Subtotal (see instructions)	386, 431, 310	540, 913, 512	927, 344, 82	.2		200.00
201.00	Less Observation Beds	20/ 421 242	F40 010 F40	007 044 00			201.00
202.00	Total (see instructions)	386, 431, 310	540, 913, 512	927, 344, 82	2		202.00

Health Financial Systems REID) HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Peri od:	Worksheet C	
			From 01/01/2019	Part I	
			To 12/31/2019	Date/Time Pre	
		T 1.11 N0/0.11		6/8/2020 3: 16	pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVIDER – IPF					40.00
41. 00 04100 SUBPROVIDER – IRF					41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 207982				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 225961				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 171495				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 105278				59.00
60. 00 06000 LABORATORY	0. 177235				60,00
65. 00 06500 RESPIRATORY THERAPY	0. 122603				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 651884				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110843				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 184588				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 635892				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 342294				73.00
74.00 07400 RENAL DIALYSIS	0. 853663				74.00
76.00 03950 ANCI LLARY - OTHER	0.000000				76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 679794				76.97
OUTPATIENT SERVICE COST CENTERS	0.440774				
91. 00 09100 EMERGENCY	0. 162774				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530885				92.00
93.00 04040 FAMILY PRACTICE	0. 513842				93.00
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	1. 248292				96.00
SPECIAL PURPOSE COST CENTERS					
113.0011300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
· · · · · · · · · · · · · · · · · · ·					•

REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10

			:N: 15-0048		Date/Time Pre 6/8/2020 3:16	pared: pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description Total (from We Part 1, 26	st. B, col.	herapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
1.0	0	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 47, 9	86, 553		47, 986, 55	53 0	47, 986, 553	30.00
31. 00 03100 I NTENSI VE CARE UNI T 9, 5	76, 096		9, 576, 09	06 0	9, 576, 096	31.00
40. 00 04000 SUBPROVIDER - IPF 6, 8	890, 953		6, 890, 95	03	6, 890, 953	40.00
41. 00 04100 SUBPROVI DER – I RF 3, 8	865, 123		3, 865, 12	23 0	3, 865, 123	41.00
43. 00 04300 NURSERY	39, 145		739, 14	15 0	739, 145	43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM 33, 9	79, 420		33, 979, 42	20 0	33, 979, 420	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 1	20, 259		2, 120, 25	59 0	2, 120, 259	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 23, 3	56, 576		23, 356, 57	6 0	23, 356, 576	54.00
	96, 698		10, 896, 69		10, 896, 698	
	71,960		17, 271, 96		17, 271, 960	
	58, 217	0	3, 158, 21		3, 158, 217	65.00
	25,688	0	13, 425, 68		13, 425, 688	66.00
69. 00 06900 ELECTROCARDI OLOGY 3, 5	67, 586		3, 567, 58		3, 567, 586	69.00
	300, 709		800, 70		800, 709	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	
	19, 581		19, 319, 58	31 0	19, 319, 581	72.00
	67, 465		42, 567, 46		42, 567, 465	73.00
	11, 335		1, 011, 33		1, 011, 335	
76. 00 03950 ANCI LLARY - OTHER	0			0 0	0	76.00
	375, 987		875, 98		875, 987	76.97
OUTPATI ENT SERVI CE COST CENTERS			,	-	,	
	31, 747		14, 131, 74	7 0	14, 131, 747	91.00
	30, 949		5, 330, 94		5, 330, 949	
	46, 116		3, 246, 1		3, 246, 116	
OTHER REIMBURSABLE COST CENTERS		I				
	67,778		567, 77	/8 0	567, 778	96.00
SPECIAL PURPOSE COST CENTERS				- <u>-</u>		
113.00 11300 I NTEREST EXPENSE						113.00
	16, 088		3, 716, 08	38	3, 716, 088	
	02, 029	o	268, 402, 02			
	30, 949	Ĵ	5, 330, 94		5, 330, 949	
	71,080	о	263, 071, 08			

COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/8/2020 3:16	
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·		•			
30.00	03000 ADULTS & PEDIATRICS	42, 996, 121		42, 996, 12	:1		30. 00
31.00	03100 I NTENSI VE CARE UNI T	9, 147, 300		9, 147, 30	0		31.00
40.00	04000 SUBPROVIDER - IPF	9, 766, 278		9, 766, 27	8		40.00
41.00	04100 SUBPROVIDER - IRF	4, 572, 574		4, 572, 57	4		41.00
43.00	04300 NURSERY	1, 803, 575		1, 803, 57			43.00
/	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	56, 749, 355	106, 627, 666	163, 377, 02	0. 207982	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 408, 216	975, 083	9, 383, 29	9 0. 225961	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 922, 291	101, 271, 941	136, 194, 23	2 0. 171495	0.000000	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	39, 683, 089	63, 821, 201	103, 504, 29	0 0. 105278	0.000000	59.00
60.00	06000 LABORATORY	37, 298, 975	60, 153, 183	97, 452, 15	8 0. 177235	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	22, 744, 196	3, 015, 612	25, 759, 80	0. 122603	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	8, 456, 544	12, 138, 671			0.000000	66.00
	06900 ELECTROCARDI OLOGY	12, 242, 101	19, 943, 883		4 0. 110843	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	10, 214	4, 327, 592	4, 337, 80	6 0. 184588	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.000000	71.0
	07200 IMPL. DEV. CHARGED TO PATIENT	19, 273, 451	11, 108, 411	30, 381, 86	0. 635892	0.000000	72.0
	07300 DRUGS CHARGED TO PATIENTS	49, 529, 771	74, 829, 606	124, 359, 37	0. 342294	0.000000	73.00
	07400 RENAL DIALYSIS	1, 114, 929	69, 771	1, 184, 70		0.00000	
	03950 ANCI LLARY - OTHER	0	0		0 0.000000	0.00000	
	07697 CARDI AC REHABI LI TATI ON	2, 321	1, 286, 286	1, 288, 60	0. 679794	0.00000	76.9
	DUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	23, 162, 244	63, 656, 015				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 277, 306	6, 764, 329			0.000000	
	04040 FAMILY PRACTICE	17, 583	6, 299, 756	6, 317, 33	9 0. 513842	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS	,					
	09600 DURABLE MEDICAL EQUIP-RENTED	0	454, 844	454, 84	4 1. 248292	0. 000000	96.00
	SPECIAL PURPOSE COST CENTERS	1 1		1			
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	1, 252, 876	4, 169, 662				116.00
200.00	Subtotal (see instructions)	386, 431, 310	540, 913, 512	927, 344, 82	2		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	386, 431, 310	540, 913, 512	927, 344, 82	2		202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0048	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared 6/8/2020 3:16 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
	1	11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS				30.
	03100 I NTENSI VE CARE UNI T				31.
	04000 SUBPROVIDER - IPF				40.
	04100 SUBPROVI DER – I RF				41.
43.00	04300 NURSERY				43.
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATI NG ROOM	0. 000000			50.
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.
60.00	06000 LABORATORY	0. 000000			60.
65.00	06500 RESPI RATORY THERAPY	0. 000000			65.
	06600 PHYSI CAL THERAPY	0. 000000			66.
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.
74.00	07400 RENAL DIALYSIS	0. 000000			74.
76.00	03950 ANCI LLARY - OTHER	0. 000000			76.
76.97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76.
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0. 000000			91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.
93.00	04040 FAMILY PRACTICE	0. 000000			93.
	OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000			96.
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113.
116.00	11600 HOSPI CE				116.
200.00	Subtotal (see instructions)				200.
201.00	Less Observation Beds				201.
202.00	Total (see instructions)				202.

Health Financial Systems	REID HOSPITAL & HEA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SER	VICE CAPITAL COSTS	Provider C		Period: From 01/01/2019	Worksheet D	
				To 12/31/2019		narod
				10 12/31/2019	6/8/2020 3: 16	pareu.
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST	CENTERS	-				
30. 00 ADULTS & PEDIATRICS	4, 398, 269) O	4, 398, 269	9 42, 505		30.00
31.00 INTENSIVE CARE UNIT	1, 245, 040		1, 245, 040	0 5, 176	240.54	31.00
40. 00 SUBPROVIDER - IPF	755, 081	0	755, 081	1 8, 936	84.50	40.00
41.00 SUBPROVIDER - IRF	574, 325	5 0	574, 32	5 4, 174	137.60	41.00
43.00 NURSERY	78, 789	2	78, 78	9 1, 889	41.71	43.00
200.00 Total (lines 30 through 199)	7, 051, 504	ļ	7, 051, 504	4 62, 680		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		1				
30. 00 ADULTS & PEDIATRICS	18, 784					30.00
31.00 INTENSIVE CARE UNIT	2, 708		•			31.00
40.00 SUBPROVIDER - IPF	5, 589					40.00
41.00 SUBPROVIDER - IRF	2,744	377, 574				41.00
43.00 NURSERY	0	-				43.00
200.00 Total (lines 30 through 199)	29, 825	3, 444, 995				200.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	6/8/2020 3:16	pared: pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 917, 361	163, 377, 021	0. 01785	57 35, 534, 512	634, 540	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	289, 678	9, 383, 299	0. 03087	2 17, 844	551	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 054, 397	136, 194, 232	0. 02242	19, 805, 816	444, 185	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	884, 525	103, 504, 290	0. 00854	22, 861, 784	195, 377	59.00
60. 00 06000 LABORATORY	1, 366, 137	97, 452, 158	0. 01401	9 19, 943, 956	279, 594	60.00
65. 00 06500 RESPI RATORY THERAPY	135, 126	25, 759, 808	0.00524	11, 184, 430	58, 674	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 368, 529	20, 595, 215	0. 06644	2, 655, 168	176, 433	66.00
69. 00 06900 ELECTROCARDI OLOGY	312, 365	32, 185, 984	0.00970	3, 954, 304	38, 377	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	119,063	4, 337, 806	0. 02744	5, 624	154	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	21,665	30, 381, 862	0.00071	3 11, 558, 495	8, 241	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	671, 686	124, 359, 377	0.00540	24, 830, 973	134, 112	73.00
74.00 07400 RENAL DIALYSIS	52, 397	1, 184, 700	0. 04422	703, 386	31, 109	74.00
76.00 03950 ANCI LLARY - OTHER	0	0	0. 00000	0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	216, 148	1, 288, 607			56	
OUTPATIENT SERVICE COST CENTERS	,	.,				
91. 00 09100 EMERGENCY	1, 251, 128	86, 818, 259	0, 01441	1 12, 904, 310	185, 964	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	488, 613					
93. 00 04040 FAMILY PRACTICE	82, 716	6, 317, 339				
OTHER REIMBURSABLE COST CENTERS	02//10	2,011,007		-	220	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	125, 599	454, 844	0. 27613	36 0	0	96.00
200.00 Total (lines 50 through 199)	13, 357, 133			167, 718, 469	-	
	1 10,007,100	500, 600, 100	I	1,,,		1-20.00

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pared:
			2 XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School		h Allied Health		
	Post-Stepdown		Post-Stepdow		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			······································	
		minus col. 4)				
	4.00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	42, 50	0.00	18, 784	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	5, 17			
40. 00 04000 SUBPROVIDER - IPF	0	0	8, 93			
41. 00 04100 SUBPROVI DER - I RF	0	0	4, 17			
43. 00 04300 NURSERY	U	0	1, 88			
200.00 Total (lines 30 through 199)		0	62,68			200.00
Cost Center Description	I npati ent	0	02,00		29, 023	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col.8)</u> 9.00					
	9.00		-			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						200.000
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 I NTENSI VE CARE UNI T	0					31.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41.00 04100 SUBPROVIDER – IRF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems RE	ID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S THROUGH COSTS	SERVI CE OTHER PAS	S Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	497, 368	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	c c		0 0	0	59.00
60. 00 06000 LABORATORY	0	c c		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	l c		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	l c		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	l c		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l c		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	l c		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l c		o o	0	73.00
74.00 07400 RENAL DIALYSIS	0	l c		o o	0	74.00
76.00 03950 ANCI LLARY - OTHER	0	l c		o o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	l c		0 0	0	76, 97
OUTPATIENT SERVICE COST CENTERS		· · · · · ·				
91. 00 09100 EMERGENCY	0	C)	0 0	0	1 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
93. 00 04040 FAMILY PRACTICE	0	l c		o o	0	•
OTHER REIMBURSABLE COST CENTERS	1 -			-1 -	-	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	96.00
200.00 Total (lines 50 through 199)	0			0 0	497, 368	

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	6 Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/8/2020 3:16	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		,	and 4)		,	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	0	0	(163, 377, 021	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(9, 383, 299	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	497, 368	497, 368	3 136, 194, 232	0.003652	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(103, 504, 290	0.000000	59.00
60. 00 06000 LABORATORY	0	0	(97, 452, 158	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(25, 759, 808	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(20, 595, 215	0. 000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(32, 185, 984	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	(4, 337, 806	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0 0	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(30, 381, 862	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(124, 359, 377	0.000000	73.00
74.00 07400 RENAL DI ALYSI S	0	0	(1, 184, 700	0. 000000	74.00
76. 00 03950 ANCI LLARY - OTHER	0	0	(0 0	0.000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(1, 288, 607	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0	0	(86, 818, 259	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(10, 041, 635	0.000000	92.00
93.00 04040 FAMILY PRACTICE	0	0	(6, 317, 339	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS]
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(454, 844	0. 000000	96.00
200.00 Total (lines 50 through 199)	0	497, 368	497, 368	853, 636, 436		200. 00

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2019 To 12/31/2019	6/8/2020 3:16	pared: pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	35, 534, 512		39, 421, 662	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	17, 844		2, 714	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 003652	19, 805, 816	72, 33	1 44, 614, 215	162, 931	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	22, 861, 784		33, 422, 168	0	59.00
60. 00 06000 LABORATORY	0. 000000	19, 943, 956		9, 976, 179	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	11, 184, 430		1, 381, 813	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	2, 655, 168		40, 690	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 954, 304		0 10, 878, 784	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 624		1, 941, 351	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	11, 558, 495		5, 055, 898	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	24, 830, 973		35, 058, 959	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	703, 386		35, 951	0	74.00
76.00 03950 ANCI LLARY - OTHER	0, 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0,000000	333		508, 501	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0.000000	12, 904, 310		0 16, 379, 840	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	1, 740, 235		1, 564, 318		92.00
93. 00 04040 FAMILY PRACTICE	0.000000	17, 299		1, 650, 058		93.00
OTHER REIMBURSABLE COST CENTERS		, = / /		.,,,		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)		167, 718, 469				
	1		,			

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/8/2020 3:16	pared:
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 207982			0 0	8, 198, 996	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 225961	2, 714		0 0	613	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171495			0 0	7, 651, 115	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 105278			0 0	3, 518, 619	59.00
60. 00 06000 LABORATORY	0. 177235	9, 976, 179		0 0	1, 768, 128	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 122603	1, 381, 813		0 0	169, 414	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 651884	40, 690		0 0	26, 525	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 110843	10, 878, 784		0 0	1, 205, 837	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 184588	1, 941, 351		0 0	358, 350	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 635892	5, 055, 898		0 0	3, 215, 005	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 342294	35, 058, 959		0 51,608	12,000,471	73.00
74.00 07400 RENAL DIALYSIS	0.853663	35, 951		0 0	30, 690	74.00
76. 00 03950 ANCI LLARY - OTHER	0.000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 679794	508, 501	1	0 0	345, 676	76.97
OUTPATIENT SERVICE COST CENTERS			•			1
91. 00 09100 EMERGENCY	0. 162774	16, 379, 840		0 0	2, 666, 212	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530885	1, 564, 318		0 0	830, 473	92.00
93.00 04040 FAMILY PRACTICE	0. 513842	1, 650, 058		0 0	847, 869	93.00
OTHER REIMBURSABLE COST CENTERS			•			1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	1. 248292	0		0 0	0	96.00
200.00 Subtotal (see instructions)	1	201, 933, 101		0 51,608	42, 833, 993	
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		201, 933, 101		0 51,608	42, 833, 993	202.00

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 1	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/8/2020 3:16	pared: pm
		Title XVI	Hospi tal	PPS	
	Cos				
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00			
ANCI LLARY SERVI CE COST CENTERS					1 50 0
00 05000 OPERATING ROOM	0	0			50.0
00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.0
00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.0
00 05900 CARDI AC CATHETERI ZATI ON	0	0			59.0
00 06000 LABORATORY	0	0			60.0
00 06500 RESPIRATORY THERAPY	0	0			65.0
00 06600 PHYSI CAL THERAPY	0	0			66. 0 69. 0
00 06900 ELECTROCARDI OLOGY	0	0			70.0
00 07000 ELECTROENCEPHALOGRAPHY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.0
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			72.0
00 07300 DRUGS CHARGED TO PATIENTS	0	17, 665			73.0
00 07400 RENAL DIALYSIS	0	17,000			74.0
00 03950 ANCI LLARY - OTHER	0	0			76.0
97 07697 CARDIAC REHABILITATION	0	0			76.9
OUTPATIENT SERVICE COST CENTERS	0	0			/0.9
00 09100 EMERGENCY	0	0			91.0
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.0
00 04040 FAMILY PRACTICE	0	0			93.0
OTHER REIMBURSABLE COST CENTERS	0	U			75.0
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96.0
0.00 Subtotal (see instructions)	0	17, 665			200.0
1.00 Less PBP Clinic Lab. Services-Program	0	17,000			200.0
Only Charges	0				201.0
2.00 Net Charges (line 200 - line 201)	0	17, 665			202.0

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0048	Peri od:	Worksheet D	
		Component	CCN: 15-S048	From 01/01/2019 To 12/31/2019		narod
		component	CCN. 15-3046	10 12/31/2019	6/8/2020 3: 16	
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.017.0/4	4/0 077 004	0.0470	7 75 (00	4 054	50.00
50. 00 05000 OPERATING ROOM	2, 917, 361					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	289, 678				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 054, 397					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	884, 525					59.00
60. 00 06000 LABORATORY	1, 366, 137				10, 638	
65. 00 06500 RESPI RATORY THERAPY	135, 126					65.00
66. 00 06600 PHYSI CAL THERAPY	1, 368, 529					
69. 00 06900 ELECTROCARDI OLOGY	312, 365					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	119,063				0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	-	0.0000		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	21, 665				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	671, 686					73.00
74.00 07400 RENAL DIALYSIS	52, 397					74.00
76. 00 03950 ANCI LLARY - OTHER	0	, s	0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	216, 148	1, 288, 607	0. 16773	38 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	1, 251, 128					1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
93. 00 04040 FAMILY PRACTICE	82, 716	6, 317, 339	0.01309	284	4	93.00
OTHER REI MBURSABLE COST CENTERS	405 500	454.04	0.07/1		-	04.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	125, 599				-	
200.00 Total (lines 50 through 199)	12, 868, 520	853, 636, 436	4	4, 156, 382	61,518	200. 00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S048	From 01/01/2019 To 12/31/2019		pared.
		oomportorre			6/8/2020 3: 16	pm
		Titl€	e XVIII	Subprovider -	PPS	
	. <u>-</u> , , ,		h	I PF		
Cost Center Description				Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	2.00	Adjustments	2.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1	0 0	0	50,00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	50.00
	0			0 0		52.00 54.00
	0			0 0	497, 368	54.00 59.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0			0 0	0	60, 00
	0			0 0	Ũ	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0			0 0	0	65.00
	0			0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0			0 0	0	74.00
76.00 03950 ANCI LLARY - OTHER	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	L C)	0 0	0	76. 97
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY			1	0	0	91.00
	0	C		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0			0	0	92.00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0	[(/	0 0	0	93.00
			1	0 0	0	0/ 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 200.00 Total (lines 50 through 199)	0	-		0 0 0 0		
200.00 Total (lines 50 through 199)	0	C	4	0 0	497, 368	200.00

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-						
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2019 To 12/31/2019		narad
			Component	JUN. 15-3046		6/8/2020 3: 16	
			Title	XVIII	Subprovider -	PPS	
					I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS		-				
	05000 OPERATING ROOM	0	0		0 163, 377, 021		1
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 9, 383, 299		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	497, 368				
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 103, 504, 290		1
60.00	06000 LABORATORY	0	0		0 97, 452, 158		
65.00	06500 RESPI RATORY THERAPY	0	0		0 25, 759, 808		
66.00	06600 PHYSI CAL THERAPY	0	0		0 20, 595, 215		66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 32, 185, 984		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 337, 806		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 30, 381, 862		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 124, 359, 377		1
	07400 RENAL DIALYSIS	0	0		0 1, 184, 700		1
76.00	03950 ANCI LLARY - OTHER	0	0		0 0	01000000	1
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 288, 607	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS	1					
	09100 EMERGENCY	0	0		0 86, 818, 259		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 10, 041, 635		1
93.00	04040 FAMILY PRACTICE	0	0		0 6, 317, 339	0.00000	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 454, 844		
200.00	Total (lines 50 through 199)	0	497, 368	497, 36	8 853, 636, 436	1	200. 00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D		
THROUGH COSTS				From 01/01/2019			
		Component	CCN: 15-SO48	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pared: pm	
		Title	XVIII	Subprovider -	PPS		
				I PF			
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent		
	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through		Pass-Through		
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
	7)		x col. 10)		x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0. 000000	75, 639		0 0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 003652	434, 357	1, 58	36 3, 169	12	54.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	27, 092		0 0	0	59.00	
60. 00 06000 LABORATORY	0. 000000	758, 851		0 400	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	623, 847		0 303	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	285, 464		0 0	0	66.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	19, 712		0 447	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	8		0 0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 313, 459		0 0	0	73.00	
74.00 07400 RENAL DIALYSIS	0. 000000	37, 700		0 0	0	74.00	
76.00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0. 000000	579, 969		0 1, 119	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00	
93.00 04040 FAMILY PRACTICE	0. 000000	284		0 0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0			
200.00 Total (lines 50 through 199)		4, 156, 382	1, 58	5, 438	12	200. 00	

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-								
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D		
			Component	CCN: 15-S048	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	narod	
			component	CCN. 13-3046	10 12/31/2019	6/8/2020 3: 16	pareu. pm	
			Title	× XVIII	Subprovider -	PPS		
					I PF			
				Charges		Costs		
	Cost Center Description	Cost to Charge			Cost	PPS Services		
			Services (see	Reimbursed	Reimbursed	(see inst.)		
		Worksheet C,	inst.)	Servi ces	Services Not			
		Part I, col. 9		Subject To	Subject To			
				Ded. & Coins				
		1.00		(see inst.)	(see inst.)	F 00		
		1.00	2.00	3.00	4.00	5.00		
F0 00	ANCI LLARY SERVICE COST CENTERS	0.007000	0	1	0			
50.00	05000 OPERATING ROOM	0. 207982 0. 225961	0		0 0	0		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 225961	0		0 0	-		
54.00 59.00	05400 RADI OLOGY-DI AGNOSTI C		3, 169		0 0	543		
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 105278 0. 177235	400		0 0	0		
60.00 65.00	06500 RESPIRATORY THERAPY	0. 177235	303		0 0	37		
65.00 66.00	06600 PHYSI CAL THERAPY	0. 122603	303		0 0	37		
66.00 69.00	06900 ELECTROCARDI OLOGY	0. 051884	447		0 0	50		
70, 00	07000 ELECTROCARDI OLOGY	0. 110843	447		0 0	50		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 184588	0		0 0	0		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 635892	0		0 0	0	1	
72.00	07300 DRUGS CHARGED TO PATIENTS	0. 342294	0		0 3, 058	0		
74.00	07400 RENAL DI ALYSI S	0. 853663	0		0 3,038	0		
76.00	03950 ANCI LLARY - OTHER	0. 000000	0		0 0	0		
	07697 CARDI AC REHABI LI TATI ON	0. 679794	0		0 0	0		
70. 77	OUTPATIENT SERVICE COST CENTERS	0. 07 77 74	0		0 0	0	10. 71	
91,00	09100 EMERGENCY	0. 162774	1, 119		0 0	182	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530885	1, 117		0 0	0		
93.00	04040 FAMILY PRACTICE	0. 513842	0		0 0	0		
75.00	OTHER REIMBURSABLE COST CENTERS	0. 313042	0		0 0	0	73.00	
96,00	09600 DURABLE MEDICAL EQUIP-RENTED	1. 248292	0		0 0	0	96.00	
200.00		1. 270272	5, 438		0 3, 058	-	200.00	
200.00			5, 450		0 0,000		201.00	
201.00	Only Charges							
202.00			5, 438		0 3, 058	883	202.00	
				•			•	

	HOSPI TAL & HEAL			In Lie	u of Form CMS	-2552-
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0048	Peri od:	Worksheet D	
		Component (CCN: 15-S048	From 01/01/2019 To 12/31/2019	Part V Date/Time Pr	onarod
		Component (CN. 15-5040	10 12/31/2019	6/8/2020 3: 1	epareu 6 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Coston Description	Cost	ts Cost				
Cost Center Description	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0100	1100				
0. 00 05000 OPERATING ROOM	0	0				50. (
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.
0. 00 06000 LABORATORY	0	0				60.
5. 00 06500 RESPI RATORY THERAPY	0	0				65.
6. 00 06600 PHYSI CAL THERAPY	0	0				66.
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	1,047				73.
4.00 07400 RENAL DIALYSIS	0	0				74.0
6.00 03950 ANCI LLARY - OTHER	0	0				76. (
6. 97 07697 CARDI AC REHABILI TATI ON	0	0				76.
OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
1.00 09100 EMERGENCY	0	0				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.
3. 00 04040 FAMILY PRACTICE	0	0				93.
OTHER REIMBURSABLE COST CENTERS						
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96. (
00.00 Subtotal (see instructions)	0	1, 047				200.
01.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	1, 047				202. (

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-25						
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0048	Period: From 01/01/2019	Worksheet D Part II	
		Component	CCN: 15-T048	To 12/31/2019	Date/Time Pre	pared:
					6/8/2020 3:16	pm
Title XVIII Subprovider - PPS						
Cost Costos Deceminting	0			I RF		
Cost Center Description	Capital	Total Charges (from Wkst. C,			Capital Costs (column 3 x	
	(from Wkst. B,			Program	column 4)	
	Part II, col.		(col . 1 ÷ col	. Charges	Corumn 4)	
	26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	2, 917, 361	163, 377, 021	0. 01785	52, 920	945	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	289, 678				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 054, 397				-	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	884, 525					59.00
60, 00 06000 LABORATORY	1, 366, 137					60,00
65. 00 06500 RESPI RATORY THERAPY	135, 126					
66. 00 06600 PHYSI CAL THERAPY	1, 368, 529					66.00
69. 00 06900 ELECTROCARDI OLOGY	312, 365					69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	119,063				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0.00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	21,665	30, 381, 862	0.00071	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	671, 686	124, 359, 377	0.00540	839, 924	4, 536	73.00
74.00 07400 RENAL DI ALYSI S	52, 397	1, 184, 700	0.04422	44, 200	1, 955	74.00
76. 00 03950 ANCI LLARY – OTHER	0		0.0000	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	216, 148	1, 288, 607	0. 16773	88 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		•	·			
91.00 09100 EMERGENCY	1, 251, 128	86, 818, 259	0. 01441	1 20, 870	301	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	10, 041, 635	0.0000	0 0	0	92.00
93.00 04040 FAMILY PRACTICE	82, 716	6, 317, 339	0. 01309	03 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	125, 599					96.00
200.00 Total (lines 50 through 199)	12, 868, 520	853, 636, 436	•	4, 278, 394	173, 909	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0048 Component CCN: 15-T048 Period: From 01/01/2019 To 12/31/2019 Worksheet D Part IV Date/Time Prepar 6/8/2020 3: 16 pm Cost Center Description Non Physician Anesthetist 1.00 Nursing School Adjustments Nursing School Adjustments Allied Health Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments	2-10
Component CCN: 15-T048 To 12/31/2019 Date/Time Prepar 0/2/31/2019 Date/Time Prepar 0/2/32/2013 16 pm Title XVIII Subprovider - IRF PPS Cost Center Description Non Physician Anesthetist Nursing School Post-Stepdown Nursing School Allied Health Cost Adjustments Adjustments Adjustments Adjustments	
Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Adjustments Adjustments Adjustments Adjustments	ed·
Cost Center Description Non Physician Anesthetist Nursing School Nursing Schol Nursing School Nursing School Nursing Schol Nursing School Nursi	
Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Adjustments Adjustments Adjustments Adjustments 1.00 2A 2.00 3A 3.00	
Anesthetist CostPost-Stepdown AdjustmentsPost-Stepdown Adjustments1.002A2.003A3.00	
Cost Adjustments Adjustments 1.00 2A 2.00 3A 3.00	
1.00 2A 2.00 3A 3.00	
	0.00
	2.00
	1.00
	9.00
	0.00
	5.00
	b. 00
	9.00
	0.00
	. 00
	2.00
	3.00
	1.00
	b. 00
	o. 97
OUTPATIENT SERVICE COST CENTERS	
	. 00
	2.00
	8.00
OTHER REIMBURSABLE COST CENTERS	
	b. 00
200.00 Total (Lines 50 through 199) 0 0 0 0 497,368 200). 00

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-							
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider CO		Period:	Worksheet D		
THROUG	H COSTS		Component (From 01/01/2019 To 12/31/2019		narod:	
			Component (JUN: 15-1046	10 12/31/2019	6/8/2020 3: 16		
			Title	XVIII	Subprovider -	PPS		
					I RF			
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,			
		Education Cost		Cost (sum of		(col. 5 ÷ col.		
			4)	col s. 2, 3,	8)	7)		
		4.00	F 00	and 4)	7.00	0.00		
		4.00	5.00	6.00	7.00	8.00		
50.00	ANCI LLARY SERVICE COST CENTERS				0 4/0 077 004	0.000000	50.00	
	05000 OPERATING ROOM	0	0		0 163, 377, 021		•	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 9, 383, 299		•	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	497, 368					
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 103, 504, 290		•	
60.00	06000 LABORATORY	0	0		0 97, 452, 158			
65.00	06500 RESPI RATORY THERAPY	0	0		0 25, 759, 808			
66.00	06600 PHYSI CAL THERAPY	0	0		0 20, 595, 215			
69.00	06900 ELECTROCARDI OLOGY	0	0		0 32, 185, 984			
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 4, 337, 806			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0. 000000		
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 30, 381, 862			
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 124, 359, 377		•	
	07400 RENAL DI ALYSI S	0	0		0 1, 184, 700			
76.00	03950 ANCI LLARY - OTHER	0	0		0 0	0. 000000	•	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 1, 288, 607	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS	1					-	
	09100 EMERGENCY	0	0		0 86, 818, 259			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 10, 041, 635		•	
93.00	04040 FAMILY PRACTICE	0	0		0 6, 317, 339	0.000000	93.00	
	OTHER REIMBURSABLE COST CENTERS						-	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 454, 844			
200.00	Total (lines 50 through 199)	0	497, 368	497, 36	8 853, 636, 436		200.00	

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
		Component	CCN: 15-T048	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title	XVIII	Subprovider -	PPS	•
				I RF		
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	52, 920		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 003652	149, 340		15 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	13, 123		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	401, 853		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	419, 322		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 329, 727		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 115		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	839, 924		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	44, 200		0 0	0	74.00
76.00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	,					
91. 00 09100 EMERGENCY	0. 000000	20, 870		0 240	-	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
93.00 04040 FAMILY PRACTICE	0. 000000	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS	1		1			
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0		
200.00 Total (lines 50 through 199)		4, 278, 394	54	15 240	0	200. 00

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od:	Worksheet D	
			Component		From 01/01/2019	Part V	nored.
			component (CCN: 15-T048	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pareu:
			Title	XVIII	Subprovider -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	0. 207982	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 225961	0		0 0	0	02.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 171495	0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 105278	0		0 0	0	
60.00	06000 LABORATORY	0. 177235	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 122603	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 651884	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 110843	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 184588	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 635892	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 342294	0		0 344	0	73.00
74.00	07400 RENAL DI ALYSI S	0.853663	0		0 0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 679794	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 162774	240		0 0	39	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 530885	0		0 0	0	92.00
93.00	04040 FAMILY PRACTICE	0. 513842	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS			L			1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1. 248292	0		0 0	0	96.00
200.00			240		0 344	39	200.00
201.00					0 0		201.00
	Only Charges						
202.00			240		0 344	39	202.00

ND VACCINE COST	Title	CN: 15-0048 CCN: 15-T048	Peri od: From 01/01/2019 To 12/31/2019 Subprovi der -	Worksheet D Part V Date/Time Pre 6/8/2020 3:16 PPS	
Cost	sts	XVIII		PPS	
Cost			I RF		
Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
6.00	7.00				
	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50.00 52.00 54.00 59.00 60.00 65.00 66.00 70.00 71.00 72.00 73.00 74.00 76.00 76.97
0	0				91.00 92.00 93.00
0 1 0	118				96.00 200.00 201.00 202.00
	Services Subject To Ded. & Coins. (see inst.) 6.00 0 0 0 0 0 0 0 0 0 0 0 0	Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) 6.00 7.00 0 0	Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) 6.00 7.00 0 0	Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) 6.00 7.00 0 118 0 118	Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) 6.00 7.00 0 0

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-255	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Period: Worksheet D	
From 01/01/2019 Part V	!
To 12/31/2019 Date/Time Prepar 6/8/2020 3:16 pr	rea: n
Title XIX Hospital Cost	
Charges Costs	
Cost Center Description Cost to ChargePPS Reimbursed Cost Cost PPS Services	
Ratio From Services (see Reimbursed Reimbursed (see inst.)	
Worksheet C, inst.) Services Services Not	
Part I, col. 9 Subject To Subject To	
Ded. & Coins. Ded. & Coins.	
(see inst.) (see inst.)	
<u>1.00</u> <u>2.00</u> <u>3.00</u> <u>4.00</u> <u>5.00</u>	
ANCI LLARY SERVICE COST CENTERS	
	0.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 225961 0 89, 246 0 0 5	2.00
	4.00
59. 00 05900 CARDIAC CATHETERIZATION 0. 105278 0 760, 115 0 0 5	9.00
60. 00 06000 LABORATORY 0. 177235 0 1, 996, 499 0 0 6	0. 00
65. 00 06500 RESPI RATORY THERAPY 0. 122603 0 88, 820 0 0 6	5.00
66. 00 06600 PHYSI CAL THERAPY 0. 651884 0 863, 618 0 0 6	6.00
69. 00 06900 ELECTROCARDI OLOGY 0. 110843 0 277, 984 0 0 6	9.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 184588 0 67, 379 0 0 7	0. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000 0 0 0 0 7	1.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0. 635892 0 235, 267 0 0 7	2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 342294 0 1, 719, 130 0 0 7	3.00
74. 00 07400 RENAL DI ALYSI S 0. 853663 0 960 0 0 7	4.00
76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 0 0 7	6.00
76. 97 07697 CARDIAC REHABILITATION 0. 679794 0 6, 502 0 0 7	6. 97
OUTPATI ENT SERVI CE COST CENTERS	
91.00 09100 EMERGENCY 0.162774 0 3,575,022 0 0 9	1.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 530885 0 527, 106 0 0 9	2.00
93. 00 04040 FAMILY PRACTICE 0. 513842 0 141, 611 0 0 9	3.00
OTHER REIMBURSABLE COST CENTERS	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 1. 248292 0 0 0 0 0 9	6.00
200.00 Subtotal (see instructions) 0 15, 444, 229 0 0 20	0.00
	1.00
Only Charges	
	2.00

APPORT	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2019 To 12/31/2019	6/8/2020 3:1	
			Titl	e XIX	Hospi tal	Cost	_
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				_
	ANCI LLARY SERVICE COST CENTERS	404 700		1			
	05000 OPERATING ROOM	421, 789		•			50.0
	05200 DELIVERY ROOM & LABOR ROOM	20, 166					52.0
	05400 RADI OLOGY-DI AGNOSTI C	525, 969					54.0
	05900 CARDI AC CATHETERI ZATI ON	80, 023					59.0
	06000 LABORATORY	353, 850					60.0
	06500 RESPIRATORY THERAPY	10, 890					65.0
	06600 PHYSI CAL THERAPY	562, 979					66.0
		30, 813					69.0
	07000 ELECTROENCEPHALOGRAPHY	12, 437					70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	°	e e e e e e e e e e e e e e e e e e e				
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	149,604					72.0
	07300 RENAL DIALYSIS	588, 448 820					74.0
	03950 ANCI LLARY - OTHER	820					76.0
	07697 CARDIAC REHABILITATION	4, 420	-				76.0
	OUTPATIENT SERVICE COST CENTERS	4,420	0				/0.9
	09100 EMERGENCY	581, 921	0				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	279, 833		•			91.0
	04040 FAMILY PRACTICE	72,766					92.0
	OTHER REIMBURSABLE COST CENTERS	/2, /00	0				93.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.0
96. 00 200. 00		3, 696, 728		•			200.0
200.00		3, 090, 728	0				200.0
201.00	Only Charges	0					201.0
202.00		3, 696, 728	0				202.0

REI D	HOSPI TAL	&	HEALTH	CARE	SERVI CES	

JUNIPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	
				6/8/2020 3:16	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		42, 505	1.00
. 00	Inpatient days (including private room days, excluding swing-			42, 505	
8.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3.00
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ped days)		37, 783	4.00
. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7.00
	reporting period				
3.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December (31 of the cost	0	8.00
. 00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	18, 784	9.00
	newborn days)	0			
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
1.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		coom days) after	0	11.00
1.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.00
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privation	te room days)	0	12.00
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	to room dave)	0	13.00
3.00	after December 31 of the cost reporting period (if calendar y			0	13.00
4.00	Medically necessary private room days applicable to the Progr			0	
5.00	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
7.00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	17.00
	reporting period				
8.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18.00
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.00
	reporting period	-			
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	าร)		47, 986, 553	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23.00
4. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		47, 986, 553	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	a and abaamuation had a		0	
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed cr	lar ges)	0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
2.00	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	
4.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		-	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	
37.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (line	47, 986, 553	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
8.00	Adjusted general inpatient routine service cost per diem (see	•		1, 128. 96	
9.00	Program general inpatient routine service cost (line 9 x line			21, 206, 385	
10.00	Medically necessary private room cost applicable to the Progr			0	

lealth Financial S	ystems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-1
COMPUTATION OF IN	PATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
					From 01/01/2019		
					To 12/31/2019		
			Ti +1 /	e XVIII	Hospi tal	6/8/2020 3: 16 PPS	pili
Cost	Center Description	Total	Total	Average Per	Program Days	Program Cost	
COST	Senter Description			sDiem (col. 1 -		(col. 3 x col.	
		Inpatrent Cost	linpatrent bays	col. 2)	-	4)	
		1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (ti	tle V & XIX only)	0		0.00			42.0
	are Type Inpatient Hospital Units			<u>1</u> 0.00	5	0	72.0
43.00 INTENSIVE C		9, 576, 096	5, 176	5 1, 850. 10	2, 708	5, 010, 071	43.0
4.00 CORONARY CA		7,070,070	0,170	1,000.10	2,700	0,010,071	44.0
	SIVE CARE UNIT						45.0
	ITENSIVE CARE UNIT						46.0
							1
	AL CARE (SPECIFY) Center Description						47.0
COST	Jenter Description					1.00	
18.00 Program ing	atient ancillary service cost (Wk	ct D 2 col 2	Lino 200)			39, 757, 600	48.0
				ano)			1
	ram inpatient costs (sum of lines	41 through 48)(see instruction	JNS)		65, 974, 056	49.0
	H COST ADJUSTMENTS	ationt routing	oomulooo (fro	williot D. oum	of Dorto L and	2 505 150	
0.00 Pass throug	h costs applicable to Program inp	atient routine	services (IIO	I WKSL. D, SUM	or Parts r and	2, 595, 150	50.0
	h costs applicable to Program inp	ationt ancillar	w convioor (fu	rom Wkat D a	um of Dorte II	2 244 402	51.0
	In costs appricable to Program Trip		y services (II	UNI WKSI. D, SI	III OF PAILS II	2, 344, 602	51.0
and IV) 52.00 Total Progr	am excludable cost (sum of lines	50 and 51)				4, 939, 752	52.0
	ram inpatient operating cost exclu		lated non nh	veician anocth	atist and	61, 034, 304	
	ication costs (line 49 minus line		a a ceu, non-pny	Jarcian anesthe	stist, dilu	01, 034, 304	33.0
	NT AND LIMIT COMPUTATION	52)					
4.00 Program dis						0	54.0
	int per di scharge					0.00	
	nt (line 54 x line 55)				1 FO)	0	
	between adjusted inpatient operat	ing cost and ta	irget amount (i	The 56 minus I	The 53)	0	
	ent (see instructions)					0	
	ines 53/54 or 55 from the cost re	eporting period	ending 1996, i	updated and com	npounded by the	0.00	59.
market bask							
	ines 53/54 or 55 from prior year					0.00	
	54 is less than the lower of line					0	61. (
	iting costs (line 53) are less tha		is (lines 54 x	60), or 1% of	the target		
	ne 56), otherwise enter zero (see	instructions)					
	nent (see instructions)					0	
	npatient cost plus incentive paym	nent (see instru	ictions)			0	63.0
	ATIENT ROUTINE SWING BED COST						1
	ving-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost reportir	ng period (See	0	64.0
	ns)(title XVIII only)		01 -6 +6			0	
	ving-bed SNF inpatient routine cos	sts after Decemb	er 31 of the o	cost reporting	period (See	0	65.0
	ns)(title XVIII only) care swing-bed SNF inpatient routi	no ocoto (lino	(1 plup lipp	(E) (+; + ~ V)/	anly) Far	0	111
	structions)	ne costs (Trne	o4 prus rine o	ss)(title xviii	onry). For	0	66. (
	XIX swing-bed NF inpatient routin	o costs through	Docombor 21	of the cost rou	porting poriod	0	67.0
(line 12 x		le costs through	December 31 (Ji the cost rep	bor tring period	0	07.0
	XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repor	ting period	0	68.0
(line 13 x	0			the cost repor	ting period		00.
	e V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69.0
	SKILLED NURSING FACILITY, OTHER N			,		-	1
	sing facility/other nursing facil						70.
	eneral inpatient routine service c	2					71.
, , , , , , , , , , , , , , , , , , , ,	itine service cost (line 9 x line			,			72.
	necessary private room cost applic		line 14 v li	ne 35)			73.
5	ram general inpatient routine serv	5	•	· ·			74.
5	ated cost allocated to inpatient				art II column		75.
26, line 45	· · · ·		20010 (110011				
	ppital-related costs (line 75 ÷ li	ne 2)					76.
	ital-related costs (line 9 x line						77.
5 1	routine service cost (line 74 minu						78.
	charges to beneficiaries for exces		rovi der recor	(ah			79.
55 5	am routine service costs for comp	• •			is line 70)		80.
Ű,					13 IIIC /7)		80.
	routine service cost per diem limi)				
	routine service cost limitation (I		· .				82.
	inpatient routine service costs (•	15)				83.
	oatient ancillary services (see in						84.
5 1	review - physician compensation						85.
5.00 Utilization	am inpatient operating costs (sum	n of lines 83 th	rough 85)				86.
5.00 Utilization 6.00 Total Progr	· · · · ·		5 /				
35.00 Utilization 36.00 Total Progr PART IV - C	OMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<u> </u>			. =	1
85.00 Utilization 86.00 Total Progr PART IV - C 87.00 Total obser	OMPUTATION OF OBSERVATION BED PAS vation bed days (see instructions	S THROUGH COST				4, 722	
85.00 Utilization 66.00 <u>Total Progr</u> <u>PART IV - C</u> 87.00 Total obser 88.00 Adjusted ge	OMPUTATION OF OBSERVATION BED PAS	S THROUGH COST 5) diem (line 27 ÷	line 2)			4, 722 1, 128. 96 5, 330, 949	88.

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 398, 269	47, 986, 553	0. 091650	5, 330, 949	488, 613	90.00
91.00 Nursing School cost	0	47, 986, 553	0.00000	5, 330, 949	0	91.00
92.00 Allied health cost	0	47, 986, 553	0.00000	5, 330, 949	0	92.00
93.00 All other Medical Education	0	47, 986, 553	0.00000	5, 330, 949	0	93.00

	nancial Systems REID HOSPITAL & HEALTH			u of Form CMS-2			
COMPUTATI	ON OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	Worksheet D-1			
		Component CCN: 15-SO48	From 01/01/2019 To 12/31/2019	Date/Time Prep	pared:		
				6/8/2020 3:16	pm		
		Title XVIII	Subprovider - IPF	PPS			
	Cost Center Description						
PAF	RT I - ALL PROVIDER COMPONENTS			1.00			
	PATIENT DAYS						
	patient days (including private room days and swing-bed days			8, 936	1.00		
	patient days (including private room days, excluding swing-			8, 936			
	ivate room days (excluding swing-bed and observation bed day not complete this line.	ys). If you have only pr	livate room days,	0	3.00		
	mi-private room days (excluding swing-bed and observation be	ed days)		8, 936	4.00		
	tal swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5.0		
	porting period		04 6 11 1				
	tal swing-bed SNF type inpatient days (including private roo porting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00		
	tal swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00		
re	porting period						
	tal swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8.00		
	porting period (if calendar year, enter 0 on this line) tal inpatient days including private room days applicable to	o the Program (excluding	swing_bed and	5, 589	9.00		
	wborn days)		Swirig bed and	3, 307	/ /. 0		
	ing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10.00		
	rough December 31 of the cost reporting period (see instruction and SNE type instructions down applies to title VULL of		and dave) often		11 00		
	ring-bed SNF type inpatient days applicable to title XVIII on ecember 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11.00		
2.00 Swi	ing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00		
	rough December 31 of the cost reporting period						
	ring-bed NF type inpatient days applicable to titles V or XIX Fter December 31 of the cost reporting period (if calendar yo			0	13.0		
	dically necessary private room days applicable to the Progra			0	14.0		
	tal nursery days (title V or XIX only)	(0			
	rsery days (title V or XIX only)			0	16.00		
	ING BED ADJUSTMENT dicare rate for swing-bed SNF services applicable to service	as through December 21 c	of the cost	0.00	17.00		
	porting period	es through becember 31 c	in the cost	0.00	17.00		
8.00 Me	dicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0		
	porting period dicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	0.00	19.00		
	porting period	U III					
	dicaid rate for swing-bed NF services applicable to services porting period	s after December 31 of t	he cost	0.00	20.00		
	tal general inpatient routine service cost (see instructions	5)		6, 890, 953	21.00		
	ing-bed cost applicable to SNF type services through December		ing period (line	0			
1	x line 17)						
	ring-bed cost applicable to SNF type services after December line 18)	31 of the cost reportin	ig period (line 6	0	23.00		
24. 00 Swi	ing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00		
	x line 19) ing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	о	25.00		
	line 20)		period (inic o	Ű	20.00		
	tal swing-bed cost (see instructions)			0			
-	neral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 890, 953	27.00		
	IVATE ROOM DIFFERENTIAL ADJUSTMENT neral inpatient routine service charges (excluding swing-bea	d and observation bed ch	arges)	0	28.0		
	ivate room charges (excluding swing-bed charges)			0			
	mi-private room charges (excluding swing-bed charges)			0			
	neral inpatient routine service cost/charge ratio (line 27 · rerage private room per diem charge (line 29 ÷ line 3)	÷line 28)		0. 000000 0. 00			
	erage semi-private room per diem charge (line 30 ÷ line 4)			0.00			
	5 1 5 7						
	0 Average per diem private room cost differential (line 34 x line 31)						
	,						
	neral inpatient routine service cost net of swing-bed cost a	and private room cost di	Tierential (line	6, 890, 953	37.00		
					1		
27	minus line 36) RT II - HOSPITAL AND SUBPROVIDERS ONLY						
27 PAF PRC	RT II - HOSPITÁL AND SUBPROVIDERS ONLY OGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU						
27 PAF PRC 8.00 Adj	RT II - HOSPITÁL AND SUBPROVIDERS ONLY OGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU justed general inpatient routine service cost per diem (see	instructions)		771.15			
27 PAF PRC 38. 00 Adj 39. 00 Pro	RT II - HOSPITÁL AND SUBPROVIDERS ONLY OGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	instructions) 38)		771. 15 4, 309, 957 0	39.00		

eal th	Financial Systems RELD	HOSPI TAL & HEAL	TH CARE SERVI	CES	In_Lie	u of Form CMS-	<u>255</u> 2
	ATION OF INPATIENT OPERATING COST		Provider C	CCN: 15-0048	Peri od:	Worksheet D-1	
			Component	CCN: 15-SO48	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
			Titl	e XVIII	Subprovider -	PPS	- p
	Cast Castan Description	Totol	Tatal	Average Der	I PF	Program Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per		(col. 3 x col.	
			inputiont buj	col . 2)		4)	
	F	1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	(0.0	00 0	0	42
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0.0	0 00	0	43
I. 00	CORONARY CARE UNIT	0	(. 0	43
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 068, 656	48
. 00	Total Program inpatient costs (sum of lines			ons)		5, 378, 613	
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (fro	n Wkst. D, sur	n of Parts I and	472, 271	50
I. 00	III) Pass through costs applicable to Program inpa	atient ancillary	, services (f	rom Wkst D <	sum of Parts II	63, 104	51
	and IV)		, 55. 1. 665 (11			00,104	
2.00	Total Program excludable cost (sum of lines					535, 375	
3.00	Total Program inpatient operating cost exclu		ated, non-phy	ysician anesth	netist, and	4, 843, 238	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION) <i></i>					1
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operations	ng cost and tar	get amount (ine 56 minus	line 53)	0	
3.00 9.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996 u	undated and co	ompounded by the	0.00	
. 00	market basket	bor tring period t	sharing 1770,		inpounded by the	0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (TTHES 54 X	60), OF 1% OF	the target		
2.00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	
1.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decen	nder 31 of the	e cost reporti	ng period (See	0	64
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the (cost reporting	g period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line (55)(title XVII	l only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	enorting period	0	67
. 00	(line 12 x line 19)			51 110 0051 10	sporting period	0	
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)			(0)			
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
0. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service co	2					71
2.00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applicated						73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		74
	26, line 45)				corumit		
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		ovider record	(sh			78
. 00	Total Program routine service costs for compa				nus line 79)		80
. 00	Inpatient routine service cost per diem limi			(81
. 00	Inpatient routine service cost limitation (I	ne 9 x line 81)					82
. 00	Reasonable inpatient routine service costs (s)				83
1.00	Program inpatient ancillary services (see in:)				84
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 00)				
7.00	Total observation bed days (see instructions					0	87
		Niom (lino 27 ·	1100 2)			0.00	88
3. 00 9. 00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see	•	rine z)				89

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-S048	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	755, 081	6, 890, 953	0. 10957	6 0	0	90.00
91.00 Nursing School cost	0	6, 890, 953	0.0000	0 0	0	91.00
92.00 Allied health cost	0	6, 890, 953	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	6, 890, 953	0.00000	0 0	0	93.00

	Financial Systems REID HOSPITAL & HEALTH			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2019	Worksheet D-1	
		Component CCN: 15-T048	To 12/31/2019		
		Title XVIII	Subprovider -	6/8/2020 3: 16 PPS	pm
			IRF		
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS	s oveluding nowhern)		4, 174	 1.0
. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			4, 174 4, 174	
. 00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.0
	do not complete this line.		-		
. 00	Semi-private room days (excluding swing-bed and observation be		04 6 11	4, 174	
. 00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5.0
. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)	-			
. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.0
. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line)			0	
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 744	9.0
0.00	newborn days) Swing had SNE type inpatient days applies to total of XVIII or	alv (including privato r	nor davc)	0	10.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oolii uays)	0	10.0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. C
	December 31 of the cost reporting period (if calendar year, er				
2.00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	x only (including privat	e room days)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including privat	e room days)	0	13.0
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
5.00 6.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
0.00	SWING BED ADJUSTMENT			0	10.0
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18.0
0.00	reporting period	es arter becember 51 01	the cost	0.00	10.0
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.0
0.00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 21 of t	he cost	0.00	20.0
0.00	reporting period	s al tel becember 31 01 t	ne cost	0.00	20.0
1.00	Total general inpatient routine service cost (see instructions			3, 865, 123	
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.0
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line 6	0	23.0
0.00	x line 18)			0	20.0
4.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.0
5 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.0
5.00	x line 20)	of the cost reporting		0	20.0
6. 00	Total swing-bed cost (see instructions)			0	
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 865, 123	27.0
8.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28.0
	Private room charges (excluding swing-bed charges)		ur goo)	0	
0. 00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.00000	
2.00 3.00	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	
4.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	, ,	<i>,</i>	0.00	35. (
	Private room cost differential adjustment (line 3 x line 35)		cc	0	36.0
6.00		and nuivata kaom acat di	tterential (line)	3, 865, 123	37.0
6.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di		-, ,	
6. 00	27 minus line 36)	and private room cost di			
6. 00 7. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			-
6. 00 7. 00 8. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	JSTMENTS instructions)		926.00	38.0
8. 00 9. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS instructions) 38)			38. C 39. C

eal th	Financial Systems RELD	HOSPI TAL & HEAL	TH CARE SERV	CES	In_Lie	eu of Form CMS-	<u>255</u> 2
	ATION OF INPATIENT OPERATING COST			CCN: 15-0048	Peri od:	Worksheet D-1	
			Component	CCN: 15-T048	From 01/01/2019 To 12/31/2019		
			Ti tl	e XVIII	Subprovider -	PPS	, bui
	Cast Contan Description	Total	Tatal	Average Der	I RF	Dragnam Cast	-
	Cost Center Description	Total Inpatient Costl	Total npatient Dav	Average Per		Program Cost (col. 3 x col.	
			npatront baj	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0		0 0. (00 0	0	42
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.0	00 0	0	43
1. 00	CORONARY CARE UNI T	0			50 0	0	44
5.00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			2,008,762	48
. 00	Total Program inpatient costs (sum of lines			ons)		4, 549, 706	
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (fro	n Wkst. D, sur	n of Parts I and	377, 574	50
I. 00	III) Pass through costs applicable to Program inpa	atient ancillary	, services (f	rom Wkst D (sum of Parts II	174, 454	51
	and IV)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
2.00	Total Program excludable cost (sum of lines	,				552, 028	
3. 00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anesth	netist, and	3, 997, 678	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION)					
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operations	ing cost and tar	get 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 re	oorting period e	nding 1996	undated and co	ompounded by the		
. 00	market basket	bor tring period e	inding 1770,	apuatea ana et	sinpounded by the	0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (TTHES 54 X	60), OF 1% OF	the target		
2.00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	nder 31 of th	e cost reporti	ng period (see	0	64
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reporting	g period (See	0	65
	instructions)(title XVIII only)						
b. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	54 plus line	65)(title XVII	il only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	eporting period	0	67
. 00	(line 12 x line 19)		becomber of	51 110 0051 10	sporting period		
3.00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68
	(line 13 x line 20)			(0)			
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service co	2					71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost application for the service of the service						73
. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II column		75
	26, line 45)						'`
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider recor	ds)			78
. 00	Total Program routine service costs for compa				nus line 79)		80
. 00	Inpatient routine service cost per diem limi			(81
. 00	Inpatient routine service cost limitation (1	ne 9 x line 81)					82
. 00	Reasonable inpatient routine service costs (5)				83
1.00	Program inpatient ancillary services (see in:)				84
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
7 00	Total observation bed days (see instructions					0	87
7.00							
7.00 3.00 9.00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see	•	line 2)			0.00	88

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-TO48	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	574, 325	3, 865, 123	0. 14859	02 0	0	90.00
91.00 Nursing School cost	0	3, 865, 123	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 865, 123	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	3, 865, 123	0.00000	0 0	0	93.00

REI D	HOSPI TAL	&	HEALTH	CARE	SERVI CES	

PA I. 00 Ir 2. 00 Ir 3. 00 Pr da 4. 00 Se 5. 00 Ta 5. 00 Ta 7. 00 Ta 8. 00 Ta 7. 00 Ta 7. 00 Ta 7. 00 Ta	ION OF INPATIENT OPERATING COST Cost Center Description INT I - ALL PROVIDER COMPONENTS IPATIENT DAYS IPATIENT DAYS Inpatient days (including private room days and swing-bed day patient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed day o not complete this line. patient of CNE the inpatient days (including private room days (excluding swing-bed and observation bed day patient of CNE the inpatient days (including private room days for the inpatient days (including private room days private room days for the inpatient days (including private room days private room days for the inpatient days (including private room days private room days for the inpatient days (including private room days private room days for the inpatient days (including private room days private room days (including private room days for the inpatient days (including private room days private room days (including private room days for the inpatient days for the inpatient days (including private room days (includin	bed and newborn days)	Peri od: From 01/01/2019 To 12/31/2019 Hospi tal	Worksheet D-1 Date/Time Prep 6/8/2020 3:16 Cost	pared:
I. 00 Ir 2. 00 Ir 3. 00 Pr dc Se 4. 00 Se 5. 00 Tc 6. 00 Tc 7. 00 Tc 3. 00 Tc	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed day npatient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	rs, excluding newborn) bed and newborn days)	Hospi tal	Cost	
I. 00 Ir 2. 00 Ir 3. 00 Pr dc Se 4. 00 Se 5. 00 Tc 6. 00 Tc 7. 00 Tc 3. 00 Tc	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed day npatient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	rs, excluding newborn) bed and newborn days)			
I. 00 Ir 2. 00 Ir 3. 00 Pr dc Se 4. 00 Se 5. 00 Tc 6. 00 Tc 7. 00 Tc 3. 00 Tc	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed day npatient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	bed and newborn days)		1.00	
I. 00 Ir 2. 00 Ir 3. 00 Pr dc Se 4. 00 Se 5. 00 Tc 6. 00 Tc 7. 00 Tc 3. 00 Tc	IPATIENT DAYS npatient days (including private room days and swing-bed day npatient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	bed and newborn days)			
1.00 Ir 2.00 Ir 3.00 Pr dd dd 4.00 Se 5.00 To 6.00 To 7.00 To 8.00 To 7.00 To 8.00 To	npatient days (including private room days and swing-bed day npatient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	bed and newborn days)			
2.00 Ir 3.00 Pr 4.00 Se 5.00 To 5.00 To 7.00 To 8.00 To 7.00 To 7.00 To 7.00 To	patient days (including private room days, excluding swing- rivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b	bed and newborn days)	I	10.505	
3.00 Pr da da 4.00 Se 5.00 Ta 6.00 Ta 7.00 Ta 8.00 Ta 7.00 Ta 7.00 Ta 7.00 Ta	ivate room days (excluding swing-bed and observation bed da o not complete this line. emi-private room days (excluding swing-bed and observation b			42, 505 42, 505	
4.00 Se 5.00 To 5.00 To 6.00 To 7.00 To 8.00 To 7.00 To	o not complete this line. emi-private room days (excluding swing-bed and observation b	iys). Thiyou have only pr	ivate room dave	42, 505	
4.00 Se 5.00 To 5.00 To 5.00 To 7.00 To 8.00 To 8.00 To	emi-private room days (excluding swing-bed and observation b		rvate room days,	0	3.0
5.00 To 7.00 To 7.00 To 8.00 To re	atal owing had CNE type inpatient days (including private re	ed days)		37, 783	4.0
5. 00 To re 7. 00 To 3. 00 To re	otal swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0	5. C
7.00 re 7.00 To 8.00 To re	eporting period				
7.00 To re 3.00 To re	otal swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6. C
3.00 re	eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private roo	m dave) through December	21 of the cost	0	7.0
3.00 To	eporting period	in days) through becember	ST OF THE COST	U	/.0
re	otal swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8.0
9.00 To	eporting period (if calendar year, enter 0 on this line)				
	otal inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 545	9.0
	ewborn days)				
	wing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.0
	nrough December 31 of the cost reporting period (see instruc wing-bed SNF type inpatient days applicable to title XVIII o		noom dave) after	0	11.0
	ecember 31 of the cost reporting period (if calendar year, e		oom days) arter	U	11.0
	wing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.0
tł	nrough December 31 of the cost reporting period	5	3 /		
	wing-bed NF type inpatient days applicable to titles V or XI			0	13.0
	fter December 31 of the cost reporting period (if calendar y				
	edically necessary private room days applicable to the Progr otal nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 1, 889	
	ursery days (title V or XIX only)			77	
	ING BED ADJUSTMENT		I	11	10.0
	edicare rate for swing-bed SNF services applicable to servic	es through December 31 c	f the cost	0.00	17.0
	eporting period	5			
	edicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.0
	eporting period	- three with Desemble 21 of		0.00	10.0
	edicaid rate for swing-bed NF services applicable to service eporting period	es through December 31 of	the cost	0.00	19.0
	edicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.0
	eporting period				
21.00 To	otal general inpatient routine service cost (see instruction	is)		47, 986, 553	21.0
	wing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.0
	x line 17) wing had east applicable to SNE type capilors often December	21 of the cost reporting	a ported (Line (22.0
	<pre>wing-bed cost applicable to SNF type services after December line 18)</pre>	31 OF the Cost reportin	g period (inte o	0	23.0
1	wing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24.0
	x line 19)		ng por ou (r no	J	20
25.00 Sv	wing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.0
	line 20)				
	otal swing-bed cost (see instructions)			0	
	eneral inpatient routine service cost net of swing-bed cost RIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		47, 986, 553	27.0
	eneral inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.0
	rivate room charges (excluding swing-bed charges)		urges)	0	
1	emi-private room charges (excluding swing-bed charges)			0	
	eneral inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	verage private room per diem charge (line 29 ÷ line 3)			0.00	
	verage semi-private room per diem charge (line 30 ÷ line 4)		ti ana)	0.00	
	verage per diem private room charge differential (line 32 mi verage per diem private room cost differential (line 34 x li		tions)	0.00 0.00	
	rivate room cost differential adjustment (line 3 x line 35)	no 31)		0.00	
	eneral inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	47, 986, 553	
	7 minus line 36)			, ,,	
	RT II - HOSPITAL AND SUBPROVIDERS ONLY				1
PA	COGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
PR	djusted general inpatient routine service cost per diem (see			1, 128. 96	
88.00 Ac		0.0)			
PR 38.00 Ac 39.00 Pr	rogram general inpatient routine service cost (line 9 x line edically necessary private room cost applicable to the Progr			1, 744, 243 0	1

REID HOSPITAL & HEALTH CA	ARE SERVICES
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чеат тп	Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	ln Li€	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CO	F	Period: From 01/01/2019 To 12/31/2019		pared:
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	739, 145	1, 889	391.29	77	30, 129	42.00
	Intensive Care Type Inpatient Hospital Units				1		
43.00	INTENSIVE CARE UNIT	9, 576, 096	5, 176	1, 850. 10	213	394, 071	
44.00	CORONARY CARE UNI T						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00							47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (W	kst D-3 col 3	Line 200)			1, 919, 662	48.00
49.00	Total Program inpatient costs (sum of lines			ns)		4, 088, 105	
	PASS THROUGH COST ADJUSTMENTS					.,	1
50.00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	0	50. OC
51.00	Pass through costs applicable to Program in	patient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51.00
	and IV)	50 1 54)					
52.00	Total Program excludable cost (sum of lines	,				0	
53.00	Total Program inpatient operating cost excl		elated, non-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00						0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0.00	•
57.00	Difference between adjusted inpatient opera	ting cost and ta	urget amount (L	ine 56 minus l	ine 53)	0	
58.00	Bonus payment (see instructions)	tring boot and ta	inger amount (i		1110 00)	0	
59.00	Lesser of lines 53/54 or 55 from the cost r	eporting period	ending 1996, u	pdated and com	pounded by the		
	market basket		5				
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin					0	61.00
	which operating costs (line 53) are less th		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ictions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	cost reportir	a period (See	0	64.00
01.00	instructions) (title XVIII only)	Sta through beec				Ŭ	
65.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. OC
	CAH (see instructions)		D 1 01	с. н			1 / 7 . 0.0
67.00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	na costs aftar D	ecomber 31 of	the cost renor	ting period	0	68.00
00.00	(line 13 x line 20)		ecember 31 01	the cost repor	ting period	0	00.00
69.00	1 · ·	routine costs (line 67 + line	68)		0	69.00
'	PART III - SKILLED NURSING FACILITY, OTHER I						1
70.00	Skilled nursing facility/other nursing faci						70.00
71.00	Adjusted general inpatient routine service	cost per diem (I	ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line	,					72.00
73.00	Medically necessary private room cost appli			ne 35)			73.00
74.00	Total Program general inpatient routine ser	•					74.00
75.00	Capital -related cost allocated to inpatient	routine service	e costs (from W	orksheet B, Pa	irt II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.00
77.00	Program capital -related costs (line 9 x lin						77.00
78.00	Inpatient routine service cost (line 74 min						78.00
79.00	Aggregate charges to beneficiaries for exce		rovi der record	s)			79.00
80.00	Total Program routine service costs for com	· · ·		,	ıs line 79)		80.00
B1.00	Inpatient routine service cost per diem lim		,21.01				81.00
82.00	Inpatient routine service cost limitation ()				82.00
02.00	Reasonable inpatient routine service costs		· .				83.00
	Program inpatient ancillary services (see i	•					84.00
83.00 84.00		(ons)				85.00
83.00	Utilization review - physician compensation	(see instructio	,			1	1 0 / 0 /
83. 00 84. 00	Total Program inpatient operating costs (su	m of lines 83 th					86.00
83.00 84.00 85.00 86.00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA	m of lines 83 th SS THROUGH COST					1
83.00 84.00 85.00 86.00 87.00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PAR Total observation bed days (see instruction	m of lines 83 th SS THROUGH COST s)	rough 85)			4, 722	87.00
83.00 84.00 85.00 86.00 87.00 88.00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA	m of lines 83 th SS THROUGH COST s) diem (line 27 ÷	line 2)			4, 722 1, 128. 96 5, 330, 949	87.00 88.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 398, 269	47, 986, 553	0. 09165	5, 330, 949	488, 613	90.00
91.00 Nursing School cost	0	47, 986, 553	0.00000	5, 330, 949	0	91.00
92.00 Allied health cost	0	47, 986, 553	0.00000	5, 330, 949	0	92.00
93.00 All other Medical Education	0	47, 986, 553	0.00000	5, 330, 949	0	93.00

	ATION OF INPATIENT OPERATING COST	TH CARE SERVICES Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet D-1	
	ATTON OF INPATIENT OPERATING COST		From 01/01/2019		
		Component CCN: 15-SO48	To 12/31/2019	Date/Time Prep 6/8/2020 3:16	
		Title XIX	Subprovider -	Cost	- P.II.
	Cost Center Description		I PF		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed da			8, 936	
2.00 3.00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d		rivate room days	8, 936 0	2.0
. 00	do not complete this line.	ays). It you have only pr	rvate room days,	0	0.0
1.00	Semi-private room days (excluding swing-bed and observation			8, 936	4.0
5.00	Total swing-bed SNF type inpatient days (including private r reporting period	room days) through Decembe	er 31 of the cost	0	5.0
5.00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through December	- 31 of the cost	0	7.0
B. 00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			100	
9.00	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	swing-bed and	102	9.0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10. 0
11 00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		non dave) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year,		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12.0
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including privat	e room days)	0	13.0
10.00	after December 31 of the cost reporting period (if calendar			0	15.0
4.00	Medically necessary private room days applicable to the Prog	days)	0		
15.00 16.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	1, 889 77	15.0		
10.00	SWING BED ADJUSTMENT			,,	10.0
17.00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	of the cost	0.00	17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servi	the cost	0.00	18. 0	
9.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	ces through December 31 of	f the cost	0.00	19.0
20.00	reporting period Medicaid rate for swing-bed NF services applicable to servic	as after December 31 of t	he cost	0.00	20.0
0.00	reporting period	Les arter becember 51 01 t	the cost	0.00	20.0
21.00	Total general inpatient routine service cost (see instruction			6, 890, 953	
22.00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	nber 31 of the cost report	ing period (line	0	22.0
23.00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	ng period (line 6	0	23.0
24.00	x line 18) Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.0
26.00	Total swing-bed cost (see instructions)			0	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 890, 953	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ped and observation bed ch	arges)	0	28.0
29.00	Private room charges (excluding swing-bed charges)		lar goo)	0	29.0
80.00	Semi -private room charges (excluding swing-bed charges)			0	30.0
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
3.00	Average semi-private room per diem charge (line 2) : line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x l Private room cost differential adjustment (line 3 x line 35)			0.00 0	35.0 36.0
37.00	General inpatient routine service cost net of swing-bed cost		fferential (line	6, 890, 953	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			
					1
	Adjusted general inpatient routine service cost per diem (se	e instructions)		771.15	
38. 00 39. 00 40. 00		ee instructions) ne 38)		771. 15 78, 657 0	39.00

leal th	Financial Systems REID	HOSPI TAL & HEALT	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-1
	ATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
			Component	CON. 15 5040	From 01/01/2019	Data /Tima Dra	norod
			component	CCN: 15-S048	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
			Titl	e XIX	Subprovider -	Cost	pm
					IPF		
	Cost Center Description	Total	Total	Average Pe		Program Cost	
		Inpatient Cost Ir	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	<u>col.2)</u>	4.00	4)	
42.00	NURSERV (title V & VIX entry)	1.00	2.00	3.00	4.00 00 0	5.00	42.0
+2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		0	0.	00 0	0	42.0
13.00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.0
14.00	CORONARY CARE UNI T		-			-	44.0
45.00	BURN INTENSIVE CARE UNIT						45.0
16.00	SURGICAL INTENSIVE CARE UNIT						46.0
47.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description						
	-					1.00	
18.00	Program inpatient ancillary service cost (Wk					0	
9.00	Total Program inpatient costs (sum of lines	41 through 48)(se	ee instructio	ns)		78, 657	49. C
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing c	anulaas (from	Wkct D cu	m of Dorte L and	0	50.0
0.00	<pre>Information costs appricable to Program The III)</pre>		ervices (110	WKSL. D, SU	III OF PAILS F ANU	0	50.0
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst D	sum of Parts II	0	51.0
	and IV)		23. 1. 303 (11			l U	
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
53.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	0	53.0
	medical education costs (line 49 minus line	52)				L	
	TARGET AMOUNT AND LIMIT COMPUTATION						
4.00	Program di scharges					0	
5.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
6.00 7.00	Difference between adjusted inpatient operat	ing cost and tar	act amount (1	ino 56 minus	lino 52)	0	
8.00	Bonus payment (see instructions)	ing cost and tary	get amount (i	The 50 millios	TTHE 55)	0	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndina 1996 u	indated and c	ompounded by the	0.00	
7.00	market basket	por tring period er	naring 1770, a	puarea ana e	ompounded by the	0.00	57. (
0.00	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the m	arket basket		0.00	60.0
51.00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less that	n expected costs	(lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see	instructions)				l	
52.00	Relief payment (see instructions)					0	
53.00	Allowable Inpatient cost plus incentive paym	ent (see instruc [.]	tions)			0	63.0
	PROGRAM INPATIENT ROUTINE SWING BED COST		04 6 11				1
54.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	its through Decem	ber 31 of the	cost report	ing period (see	0	64.0
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the c	ost reportir	a period (See	0	65.0
	instructions) (title XVIII only)			ost reportin	g period (bee	Ŭ	00.0
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVI	II only). For	0	66.0
	CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·			<i>J</i> ,	-	
57.00	Title V or XIX swing-bed NF inpatient routin	e costs through I	December 31 c	f the cost r	eporting period	0	67.0
	(line 12 x line 19)					l	
58.00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of	the cost rep	orting period	0	68.0
	(line 13 x line 20)			(0)			1 10 0
59.00	Total title V or XIX swing-bed NF inpatient					0	69. C
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70. 0
1.00	Adjusted general inpatient routine service of	2		•	,		71. (
2.00	Program routine service cost (line 9 x line			-,			72.
3.00	Medically necessary private room cost applic	,	(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient				Part II, column		75.0
	26, line 45)	- >					
6.00	Per diem capital-related costs (line 75 ÷ li	,					76.
7.00	Program capital -related costs (line 9 x line	,					77.
8.00	Inpatient routine service cost (line 74 minu		ovidor record				78.
9.00 0.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus Lino 70)		79. 80.
1.00	Inpatient routine service cost per diem limi		st inmidii Off		nus IIIe /7)		80.
2.00	Inpatient routine service cost per drem frim						82.
3.00	Reasonable inpatient routine service cost ()			l	83.
3.00	Program inpatient ancillary services (see in		/				84.
35.00	Utilization review - physician compensation		s)				85.
36.00	Total Program inpatient operating costs (sum						86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
37.00	Total observation bed days (see instructions	·				0	
	Adjusted general innetiont routing cost per		1 :			0.00	88.0
8. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	rine 2)		1		89.0

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S048	From 01/01/2019 To 12/31/2019		
		Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	755, 081	6, 890, 953	0. 10957	6 0	0	90.00
91.00 Nursing School cost	0	6, 890, 953	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	6, 890, 953	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	6, 890, 953	0.00000	0 0	0	93.00

	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES	In Lie	u of Form CMS-2	2552-10
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	Worksheet D-1	
		Component CCN: 15-TO48	From 01/01/2019 To 12/31/2019	Date/Time Prep 6/8/2020 3:16	
		Title XIX	Subprovider -	Cost	рш
	Cost Center Description			1.00	
1	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			4.474	1 00
	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			4, 174	1.00
	Private room days (including private room days, excluding swing-	J <i>i</i>	sivato room dave	4, 174 0	2.00 3.00
. 00	do not complete this line.	ys). Ti you nave only pr	TVate TOOM days,	0	3.00
. 00	Semi-private room days (excluding swing-bed and observation be	ed davs)		4, 174	4.00
. 00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5.00
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	21 of the cost	0	7.00
. 00	reporting period	i days) thi ough becember	ST OF THE COST	0	7.00
. 00	Total swing-bed NF type inpatient days (including private room	m davs) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	5.2			
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	0	9.00
	newborn days)				
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		room days)	0	10.00
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, er		com dayo) ar cor	J	
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12.00
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or XLX			0	13.0
4.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14.0
	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)		
	Nursery days (title V or XIX only)			77	16.00
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.0
0 00	reporting period	a ofter December 21 of	the east	0.00	10.0
8.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es aller December 31 01	the cost	0.00	18.0
9. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19. 0
0.00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of t	the cost	0.00	20. 0
0.00	reporting period	salter becenber 51 01 t	the cost	0.00	20.0
1.00	Total general inpatient routine service cost (see instructions	5)		3, 865, 123	21.0
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.0
	5 x line 17)			-	
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 0
4.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24.0
	7 x line 19)		ng por ou (rino	0	2
5.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.0
	x line 20)			0	24 04
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		0 3, 865, 123	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			3,003,123	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28. 0
9.00	Private room charges (excluding swing-bed charges)			0	29.0
	Semi-private room charges (excluding swing-bed charges)			0	30. 0
	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	32. 0 33. 0
	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	rtions)	0.00	
	Average per diem private room cost differential (line 32 mil			0.00	35.0
	Private room cost differential adjustment (line 3 x line 35)	-		0	36.0
0.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 865, 123	37.0
	27 minus line 36)				
7.00					
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENTS			
7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJL			026 00	28 M
7.00 8.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJL Adjusted general inpatient routine service cost per diem (see	instructions)		926.00 0	
7.00 8.00 9.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJL	instructions) 38)		926.00 0 0	38. 00 39. 00 40. 00

Heal th	Fi nanci al	Systems	
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		HOSPITAL & HEAL				eu of Form CMS-2	
OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0048	Period: From 01/01/2019	Worksheet D-1	
			Component	CCN: 15-T048	To 12/31/2019	Date/Time Pre	
				e XIX	Subprovider -	6/8/2020 3:16 Cost	o pm
			11 (1	e XIX	I RF	031	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Costl	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	C				42.
	Intensive Care Type Inpatient Hospital Units	r		T		1	
3.00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	
4.00 5.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
00	Drogram i proti ont onci ll'ony convice cost (W/		Line 200)			1.00	40
3.00 9.00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ns)		0	
. 00	PASS THROUGH COST ADJUSTMENTS			,113)		<u> </u>	1
0. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	0	50.
~~							
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.
2. 00	Total Program excludable cost (sum of lines !	50 and 51)				0	52.
8.00	Total Program inpatient operating cost exclud		ated, non-phy	sician anest	netist, and	0	53.
	medical education costs (line 49 minus line 5	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION 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 operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period e	nding 1996, i	ipdated and c	ompounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report. upd	ated by the m	narket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines	0					
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o	f the target		
00	amount (line 56), otherwise enter zero (see i	nstructions)				0	62.
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	tions)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST	,					
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	e cost report	ng period (See	0	64.
	instructions)(title XVIII only)	to often Decembe	m 01 of the c	act concrtin	a portiod (Coo		45
6. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after becembe	r 31 01 the c	ost reporting	y period (see	0	65.
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	0	66
	CAH (see instructions)		•	, .	5.		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost r	eporting period	0	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	o costs after De	combor 21 of	the cost rop	orting poriod	0	68.
3. 00	(line 13 x line 20)	e costs arter be		the cost rep	bitting period	0	00.
9.00	Total title V or XIX swing-bed NF inpatient n	0	69.				
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	÷
0. 00	Skilled nursing facility/other nursing facili	2)		70
. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)						71
. 00	5						73
. 00	Total Program general inpatient routine service costs (line 72 + line 73)						74
. 00	Capital -related cost allocated to inpatient i	routine service	costs (from W	lorksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line 76)						77
							78
. 00							79
	Total Program routine service costs for compa		st limitation	n (line 78 mi	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						81
. 00	Reasonable inpatient routine service cost (,					82
. 00	Program inpatient ancillary services (see ins		/				84
. 00	Utilization review - physician compensation	(see instruction					85
. 00	Total Program inpatient operating costs (sum		ough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87
00		,				1 0	10/
7.00 3.00	Adjusted general inpatient routine cost per o		line 2)			0.00	

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T048	From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	574, 325	3, 865, 123	0. 14859	02 0	0	90.00
91.00 Nursing School cost	0	3, 865, 123	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 865, 123	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 865, 123	0.00000	0 0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0048 Period: From 01/01/2019 To 12/31/2019 Worksheet D-3 bate/Time Prepared: To D2/31/2019 Cost Center Description Title XVIII Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS Inpatient Program Costs (Col 1 x col 2) Inpatient Program Costs (Col 1 x col 2) Inpatient Program Costs (Col 1 x col 2) 0.00 03000 ADULTS & PEDIATRICS 26,059,167 30,00 31.00 03100 INTENSIVE CARE UNI T 4,935,663 40,00 41.00 Support 0 0 40,00 43.00 04100 SUBPROVIDER - 1 RF 0 0 4,935,663 41,00 52.00 05200 DELIVERY ROM & LABOR ROM 0.207982 35,534,512 7,390,539 50,00 52.00 05200 DELIVERY ROM & LABOR ROM 0.227984 17,844 4,032 52,50,663 1,734,85 9,943,965 55,54,512 7,390,539 50,00 50.00 05500 DELIVERY ROM & LABOR ROM 0.172263 11,184,430 1,371,245 65,00 60.00 06600 PHSICAL THERAPY 0.122603 11,184,430 1,33	Heal th	Financial Systems RE	ID HOSPITAL & HEALTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
Title XVIII Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Costs (2) Program Charges Inpatient Program Costs (2) Program Costs (2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 30.00 10.00 03000 INTENSIVE CARE UNIT 4,935,683 31.00 40.00 040000 SUBPROVIDER - IPF 4,935,683 31.00 41.00 040000 SUBPROVIDER - IPF 4,935,683 31.00 50.00 05000 OPEATING ROOM 0.207982 35,534,512 7,390,539 50.00 50.00 05000 DELIVERY ROOM & LABOR ROOM 0.22560I 17,844 4,032 52.00 50.00 05000 CARDIA CATHETRER ZATION 0.171495 19,843,956,334,767 60.00 60.00 06000 LABORATORY 0.17239 19,843,436 1,336,598 54.00 50.00 05000 CLARDIA CATHETRER ZATION 0.17239 19,443,430 1,311,246 60.00 60.00 AGOOL ALBORATORY 0.172280 2,861,631,946 7,30,852 60.00			Provi der C	CN: 15-0048	From 01/01/2019	019 019 Date/Time Prepare	
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Costs (col. 1 x col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 26,059,167 30.00 31.00 03000 INTENSIVE CARE UNIT 4,935,683 31.00 41.00 04100 SUBPROVIDER - 1 RF 4,935,683 31.00 50.00 05000 OSUBPROVIDER - 1 RF 9 4,000 41.00 04100 SUBPROVIDER - 1 RF 9 6,00 50.00 05000 OF DELIVERY NOM & LABOR ROM 0.227962 35,534,512 7,390,539 50.00 05000 DELIVERY NOM & LABOR ROM 0.227982 35,534,512 7,390,539 50.00 05000 CARDIAC CATHETER ZATION 0.177245 19,943,956 3,396,598 50.00 06000 CABORATORY 0.177235 19,943,956 3,534,767 60.00 66:00 06600 RESPIRATORY THERAPY 0.126631 11,184,430 1,371,245 65.00 69:00 0900 ELECTROCARDIOLOGY 0.18488 5,624 1,038 70.00 71:00			Ti †l (- XVIII	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS Program (Charges) Program		Cost Center Description	11				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 26,059,167 30.00 10.00 0101 INTENSI VE CARE UNI T 4,935,663 31.00 40.00 04000 SUBPROVI DER - IPF 4,935,663 31.00 41.00 0.00 0 40.00 40.00 43.00 04300 NURSERY 4,935,663 31.00 ANCILLARY SERVICE COST CENTERS 0 43.00 50.00 05000 OPERATING ROOM 0.227961 17,844 4,032 52.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.227961 17,844 4,032 52.00 54.00 05000 RESPI RATORY THERAPY 0.105278 22,861,784 2,406,843 59.00 65.00 06500 RESPI RATORY THERAPY 0.122603 11,84,430 1,371,425 65.00 66.00 06600 PHYSI CAL THERAPY 0.163584 2,655,168 1,730,862 66.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.635892 11,558,495 7.249,955 72.00					Program	Program Costs	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSI VE CARE UNIT 4,935,683 31.00 41.000 SUBBROW DER - 1 FF 0 44.935,683 44.000 41.00 04100 SUBBROW DER - 1 FF 0 41.00 44.032 52.00 50.00 05000 PERATING ROOM 0.225961 7.340,539 50.00 55.034,512 7.390,539 55.039 50.00 05000 DELICERY ROOM & LABOR ROOM 0.225961 7.7.844 4.032 52.00 52.00 05000 CARDI AC CATHETERI ZATION 0.171245 19.943,956 35.34,767 60.00 60.00 06600 LABORATORY 0.1722603 11.184,430 1.371,245 65.00 65.00 06500 RESPI RATORY THERAPY 0.651884 2.655,168 1.730,852 66.00 69.00 06000 LABORATORY 0.11843 3.954,304 438,307 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00					charges		
INPATIENT ROUTINE SERVICE COST CENTERS 26,059,167 30.00 30.00 03000 ADULTS & PEDIATRICS 26,059,167 30.00 31.00 03100 INTENSIVE CARE UNIT 4,935,683 31.00 40.00 04000 SUBPROVIDER - 1 FF 0 0 40.00 4.935,683 31.00 41.00 44.000 SUBPROVIDER - 1 FF 0 0 41.00 43.00 43.00 04300 NURSERY 05000 DPERATING ROM 0.207982 35,534,512 7,390,539 50.00 50.00 05000 DPERATING ROM 0.225961 17,844 4,032 52.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.105278 22,861,784 2,406,843 59.00 50.00 06500 RESPI RATORY THERAPY 0.122603 11,184,430 1,371,245 65.00 66.00 06600 RESPI RATORY THERAPY 0.122603 11,184,430 1,371,245 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.00 65.168				1.00	2.00		
31.00 03100 INTENSI VE CARE UNIT 4,935,683 31.00 40.00 04000 SUBPROVI DER - 1 PF 0 0 41.00 04100 SUBPROVI DER - 1 RF 0 0 A3.00 04300 NURSERY 0 0 0 AMCILLARY SERVICE COST CENTERS 0 25.00 05000 OPERATI NG ROOM 0.227961 17,844 4,032 52.00 54.00 05000 CARDI AC CATHETERI ZATI ON 0.17745 19,943,956 3,396,598 54.00 55.00 065000 CSOR RESPI RATORY 0.177235 19,943,956 3,396,598 59.00 65.00 065000 RESPI RATORY THERAPY 0.177235 19,943,956 3,534,767 60.00 65.00 06600 PHYSI CAL THERAPY 0.61884 2,655,168 1,730,862 66.00 66.00 06000 ELECTROCARDI OLOGY 0.11843 3,954,304 438,307 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0.83663 703,386 60.04,55 74.00 74.00 07400 RENAL DI ALYSI S 0.6358		INPATIENT ROUTINE SERVICE COST CENTERS					
31.00 03100 INTENSI VE CARE UNIT 4,935,683 31.00 40.00 04000 SUBPROVI DER - 1 PF 0 0 41.00 04100 SUBPROVI DER - 1 RF 0 0 A3.00 04300 NURSERY 0 0 0 AMCILLARY SERVICE COST CENTERS 0 25.00 05000 OPERATI NG ROOM 0.227961 17,844 4,032 52.00 54.00 05000 CARDI AC CATHETERI ZATI ON 0.17745 19,943,956 3,396,598 54.00 55.00 065000 CSOR RESPI RATORY 0.177235 19,943,956 3,396,598 59.00 65.00 065000 RESPI RATORY THERAPY 0.177235 19,943,956 3,534,767 60.00 65.00 06600 PHYSI CAL THERAPY 0.61884 2,655,168 1,730,862 66.00 66.00 06000 ELECTROCARDI OLOGY 0.11843 3,954,304 438,307 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 71.00 71.00 07300 DRUGS CHARGED TO PATI ENTS 0.83663 703,386 60.04,55 74.00 74.00 07400 RENAL DI ALYSI S 0.6358	30.00	03000 ADULTS & PEDI ATRI CS			26, 059, 167		30.00
41.00 04100 SUBPROVI DER - 1 RF 0 41.00 43.00 04300 NURSERY 43.00 AMOULLARY SERVICE COST CENTERS 0 0.207982 35, 534, 512 7, 390, 539 50.00 52.00 05000 DELIVERY ROOM & LABOR ROOM 0.207982 35, 534, 512 7, 390, 539 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.171495 19, 805, 816 3, 396, 598 54.00 55.00 05900 CARDI AC CATHETERI ZATI ON 0.105278 22, 861, 784 2, 406, 843 59.00 60.00 06000 LABORATORY 0.177235 19, 943, 956 3, 534, 767 60.00 65.00 06500 RESPI RATORY THERAPY 0.122603 11, 184, 430 1, 371, 245 65.00 66.00 06600 PHYSI CAL THERAPY 0.184588 5, 624 1, 038 70.00 70.00 07100 ELECTROCARDI LOGGY 0.11843 3, 954, 304 438, 307 69.00 70.00 07100 BURGS CHARGED TO PATI ENTS 0.635892 11, 558, 495 7, 349, 955 72.00 72.00 07200 </td <td>31.00</td> <td>03100 INTENSIVE CARE UNIT</td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>	31.00	03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 43.00 50.00 05000 PERATING ROOM 0.207982 35,534,512 7,390,539 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.225961 17,844 4,032 52.00 54.00 05400 RADI OLGGY-DI AGNOSTI C 0.171495 19,805,816 3,396,598 54.00 65.00 05500 CARDI AC CATHETERI ZATI ON 0.105278 22,861,784 2,406,843 59.00 60.00 06000 LABORATORY 0.105278 19,943,956 3,534,767 60.00 65.00 06500 RESPI RATORY THERAPY 0.102603 11,184,430 1,371,245 65.00 64.00 06600 PHSY ICAL THERAPY 0.110843 3,954,304 438,307 69.00 70.00 07000 ELECTROEARDI OLOGY 0.110843 3,954,304 438,307 69.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 071.00 73.00 07300 DRUGA CLARY PATI ENTS 0.342294 2,804,733,86 <t< td=""><td>40.00</td><td>04000 SUBPROVIDER - IPF</td><td></td><td></td><td>0</td><td></td><td>40.00</td></t<>	40.00	04000 SUBPROVIDER - IPF			0		40.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 DPERATING ROOM 0.207982 35, 534, 512 7, 390, 539 50. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0.225961 17, 844 4, 032 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.171495 19, 805, 816 3, 396, 598 54. 00 50. 00 05900 CARDI AC CATHETERI ZATI ON 0.105278 22, 861, 784 2, 406, 843 59. 00 60. 00 06000 LABORATORY 0.172253 11, 184, 430 1, 371, 245 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.122603 11, 184, 430 1, 371, 245 65. 00 60. 00 06000 LECTROCARDI OLOGY 0.118483 3, 954, 304 438, 307 69. 00 1, 038 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0. 184588 5, 624 1, 038 70. 00 70. 00 07200 INPL. DEV. CHARGED TO PATIENTS 0.342294 24, 830, 973 8, 499, 493 73. 00 73. 00 0	41.00	04100 SUBPROVI DER – I RF			0		41.00
50.00 05000 OPERATING ROOM 0.207982 35, 534, 512 7, 390, 539 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.225961 17, 844 4, 032 52.00 54.00 05400 RADI LOGX-DI AGNOSTI C 0.171495 19, 963, 816 3, 396, 598 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.172235 19, 943, 956 3, 534, 767 60.00 66.00 06600 PHYSI CAL THERAPY 0.122603 11, 184, 430 1, 371, 245 65.00 66.00 06600 PHYSI CAL THERAPY 0.651884 2, 655, 168 1, 730, 862 66.00 0.0100 ELECTROCARDI OLOGY 0.110843 3, 954, 304 438, 307 69.00 0.0100 DELICTROCARDI OLOGY 0.184588 5, 624 1, 038 70.00 71.00 00 73.00 0 73.00 0 73.00 73.00 73.00 73.30 60.0455 74.00 74.99, 955 72.00 73.00 73.00 76.00 0.162774 12, 904, 310 2, 100, 486 91.00 60.055 74.00 76.00 76.00 </td <td>43.00</td> <td>04300 NURSERY</td> <td></td> <td></td> <td></td> <td></td> <td>43.00</td>	43.00	04300 NURSERY					43.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.225961 17,844 4,032 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.171495 19,805,816 3,396,598 54.00 59.00 CARDI AC CATHETERI ZATI ON 0.105278 22,861,784 2,406,843 59.00 60.00 06000 LABORATORY 0.177235 19,943,956 3,534,767 60.00 65.00 06500 RESPI RATORY THERAPY 0.122603 11,184,430 1,371,245 65.00 66.00 06600 PHYSI CAL THERAPY 0.610843 3,954,304 438,307 69.00 0.0000 ELECTROCARDI OLOGY 0.110843 3,954,304 438,307 69.00 70.00 O7000 REDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 71.00 71.00 O7100 IMPL. DEV. CHARGED TO PATI ENTS 0.342294 24,830,973 8,499,943 73.00 74.00 O7400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.07 75.00 02000 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.530885				•	÷	*	
54.00 05400 RADI 0L0GY-DI AGNOSTI C 0.171495 19,805,816 3,396,598 54.00 59.00 05000 CARDI AC CATHETERI ZATI 0N 0.105278 22,861,784 2,406,843 59.00 60.00 06000 LABORATORY 0.177235 19,943,956 3,534,767 60.00 65.00 06500 RESPI RATORY THERAPY 0.122603 11,184,430 1,371,245 65.00 66.00 06600 PHYSI CAL THERAPY 0.651884 2,655,168 1,730,862 66.00 69.00 06500 ELECTROCARDI OLOGY 0.110843 3,954,304 438,307 69.00 70.00 O71000 ELECTROENCEPHALOGRAPHY 0.184588 5,624 1,038 70.00 71.00 07100 MEUS CHARGED TO PATI ENTS 0.000000 0 71.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.853663 703,386 600,455 74.00 74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.97 CARDI AC REHABI LI TATION 0.679794 333 226 76.97	50.00			0. 2079	35, 534, 512	7, 390, 539	50.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.105278 22,861,784 2,406,843 59.00 60.00 06000 LABORATORY 0.177235 19,943,956 3,534,767 60.00 65.00 06500 RESPI RATORY THERAPY 0.651884 2,406,843 59.00 66.00 06600 PHYSI CAL THERAPY 0.651884 2,455,168 1,371,245 65.00 67.00 06600 ELECTROCARDI OLOGY 0.61843 3,954,304 438,307 69.00 69.00 06900 ELECTROCARDI OLOGY 0.110843 3,954,304 438,307 69.00 70.00 07000 ELECTROCARDI TO PATI ENTS 0.00000 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.162774 12,904,310 2,100,486 91.00 92.00 09200 OBSEEVATI ON BEDS (NON-DI STI NCT PART) 0.530885	52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2259	51 17, 844	4, 032	52.00
60.00 06000 LABORATORY 0.177235 19,943,956 3,534,767 60.00 65.00 06500 RESPI RATORY THERAPY 0.122603 11,184,430 1,371,245 65.00 66.00 06600 PHYSI CAL THERAPY 0.651884 2,655,168 1,730,862 66.00 69.00 06900 ELECTROCARDI OLOGY 0.110843 3,954,304 438,307 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.184588 5,624 1,038 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.835863 703,386 600,455 74.00 74.00 07400 RENAL DI ALYSI S 0.836363 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.162774 12,904,310 2,100,486 91.00 71.00 07100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 72.00 09200 09250 OBSERVATION BEDS (NON-DI STI NCT PART) 0.530885 1,74	54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1714	95 19, 805, 816	3, 396, 598	54.00
65.00 06500 RESPI RATORY THERAPY 0.122603 11, 184, 430 1, 371, 245 65.00 66.00 06600 PHYSI CAL THERAPY 0.651884 2, 655, 168 1, 730, 862 66.00 69.00 06900 ELECTROCARDIOLOGY 0.110843 3, 954, 304 438, 307 69.00 70.00 O7000 ELECTROENCEPHALOGRAPHY 0.184588 5, 624 1, 038 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.4342294 24, 830, 973 8, 499, 493 73.00 74.00 07400 RENAL DIALYSIS 0.853663 703, 386 600, 455 74.00 76.00 03950 ANCI LLARY - OTHER 0.679794 333 226 76.97 07400 EMAGENCY 0.162774 12,904,310 2,100,486 91.00 71.00 09100 EMERGENCY 0.530885 1,740,235 923,865 92.00 91.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.530885 1,740,235 923,	59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1052	78 22, 861, 784	2, 406, 843	59.00
66.00 06600 PHYSI CAL THERAPY 0.651884 2,655,168 1,730,862 66.00 69.00 06900 ELECTROCARDI OLOGY 0.110843 3,954,304 438,307 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.184588 5,624 1,038 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 76.00 71.00 07400 RENAL DI ALYSI S 0.162774 12,904,310 2,100,486 91.00 79.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 92.00 93.00 04040 FAMI LY PRACTI CE 0.530885 1,740,235 923,865	60.00	06000 LABORATORY		0. 1772	35 19, 943, 956	3, 534, 767	60.00
69.00 06900 ELECTROCARDIOLOGY 0.110843 3,954,304 438,307 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.184588 5,624 1,038 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DIALYSIS 0.853663 703,386 600,455 74.00 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 76.00 76.97 OTAOT CARELAC REHABILITATION 0.679794 333 226 76.97 91.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMILY PRACTICE 0.513842 17,299 8,889 <t< td=""><td>65.00</td><td>06500 RESPI RATORY THERAPY</td><td></td><td>0. 12260</td><td>03 11, 184, 430</td><td>1, 371, 245</td><td>65.00</td></t<>	65.00	06500 RESPI RATORY THERAPY		0. 12260	03 11, 184, 430	1, 371, 245	65.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.184588 5,624 1,038 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DI ALYSI S 0.385663 703,386 600,455 74.00 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 76.00 76.97 ORAPIA CREHABILITATION 0.679794 333 226 76.97 001704 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 91.00 09100 EMERGENCY 0.530885 1,740,235 923,865 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 OtHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 <t< td=""><td>66.00</td><td>06600 PHYSI CAL THERAPY</td><td></td><td>0.6518</td><td>2, 655, 168</td><td>1, 730, 862</td><td>66.00</td></t<>	66.00	06600 PHYSI CAL THERAPY		0.6518	2, 655, 168	1, 730, 862	66.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.600000 0 0 76.00 76.97 ORADI AC REHABI LI TATI ON 0.679794 333 226 76.97 91.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.530885 1,740,235 923,865 92.00 93.00 Od4040 FAMI LY PRACTI CE 0 0 0 96.00 0 0 0 96.00 0 0 0 96.00 0 0 0 0 200.00 201.00 201.00 201.00 201.00 201.00 201.00	69.00	06900 ELECTROCARDI OLOGY		0. 1108	3, 954, 304	438, 307	69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.635892 11,558,495 7,349,955 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 76.00 76.97 76797 CARDI AC REHABILI TATI ON 0.679794 333 226 76.07 00TPATI ENT SERVICE COST CENTERS 0.162774 12,904,310 2,100,486 91.00 91.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 0440 FAMI LY PRACTICE 0.513842 17,299 8,889 93.00 0THER REI MBURSABLE COST CENTERS 1.248292 0 0 0 96.00 0 0 0 0 0 0 0 0 0 0 0 0	70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1845	38 5, 624	1, 038	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.342294 24,830,973 8,499,493 73.00 74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 76.00 76.97 07697 CARDI AC REHABILI TATION 0.679794 333 226 76.97 00100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMILY PRACTICE 0.513842 17,299 8,889 93.00 07HER REI MBURSABLE COST CENTERS 0 0.513842 17,299 8,889 93.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96.00 0 96.00 0 96.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	0 00	0	71.00
74.00 07400 RENAL DI ALYSI S 0.853663 703,386 600,455 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 76.00 76.07 07697 CARDI AC_REHABI LI TATI ON 0.679794 333 226 76.97 0UTPATI ENT SERVICE COST CENTERS 0.162774 12,904,310 2,100,486 91.00 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMI LY PRACTI CE 0.513842 17,299 8,889 93.00 07HER REI MBURSABLE COST CENTERS 0 0.513842 17,299 8,889 93.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 167,718,469 39,757,600 200.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 6358	92 11, 558, 495	7, 349, 955	72.00
76.00 03950 ANCI LLARY - OTHER 0.000000 0 76.00 76.97 07697 CARDI AC_REHABI LI TATI ON 0.679794 333 226 76.97 OUTPATI ENT SERVICE COST CENTERS 0.162774 12,904,310 2,100,486 91.00 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMI LY PRACTI CE 0.513842 17,299 8,889 93.00 04040 FAMI LY PRACTI CE 0 0.513842 17,299 8,889 93.00 04040 FAMI LY PRACTI CE 0 0.513842 17,299 8,889 93.00 05.00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 167,718,469 39,757,600 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3422	24, 830, 973	8, 499, 493	73.00
76.97 07697 CARDI AC REHABILLITATION 0.679794 333 226 76.97 0UTPATI ENT SERVICE COST CENTERS 00170 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 91.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMILLY PRACTI CE 0.513842 17,299 8,889 93.00 0FHER REI MBURSABLE COST CENTERS 0 00 0 0 96.00 0 0 96.00 0 0 96.00 0 0 96.00 0 0 96.00 0 0 0 96.00 0 0 0 96.00 0 0 0 92.00.00 201.00 167,718,469 39,757,600 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 2	74.00	07400 RENAL DI ALYSI S		0.8536	53 703, 386	600, 455	74.00
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMI LY PRACTI CE 0.513842 17,299 8,889 93.00 OTHER REI MBURSABLE COST CENTERS 0 0.513842 17,299 8,889 93.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 167,718,469 39,757,600 201.00	76.00	03950 ANCI LLARY - OTHER		0.0000	0 00	0	76.00
91. 00 09100 EMERGENCY 0.162774 12,904,310 2,100,486 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93. 00 04040 FAMI LY PRACTICE 0.513842 17,299 8,889 93.00 0THER REI MBURSABLE COST CENTERS 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 96.00 96.00 200.00 167,718,469 39,757,600 200.00 201.00 201.00 167,718,469 39,757,600 201.00 201.00 201.00 100 100 201.00 100 201.00 <	76.97	07697 CARDI AC REHABI LI TATI ON		0. 6797	333	226	76.97
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.530885 1,740,235 923,865 92.00 93.00 04040 FAMI LY PRACTI CE 0.513842 17,299 8,889 93.00 0THER REI MBURSABLE COST CENTERS 0 0 96.00 0 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96.00 200.00 167,718,469 39,757,600 200.00 201.00 201.00 167,718,469 39,757,600 201.00 201.00 201.00 0 167,718,469 39,757,600 201.00 201.00 201.00 0 167,718,469 39,757,600 201.00		OUTPATIENT SERVICE COST CENTERS					
93. 00 04040 FAMILY PRACTICE 0.513842 17,299 8,889 93. 00 0THER REI MBURSABLE COST CENTERS 0 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96. 00 96. 00 200. 00 167, 718, 469 39, 757, 600 200. 00 201. 00 201. 00 167, 718, 469 39, 757, 600 201. 00	91.00	09100 EMERGENCY		0. 1627	74 12, 904, 310	2, 100, 486	91.00
OTHER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 167, 718, 469 39, 757, 600 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5308	35 1, 740, 235	923, 865	92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 1.248292 0 0 96. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 167, 718, 469 39, 757, 600 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00	93.00	04040 FAMILY PRACTICE		0. 5138	42 17, 299	8, 889	93.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 167, 718, 469 39, 757, 600 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00		OTHER REIMBURSABLE COST CENTERS					
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	96.00	09600 DURABLE MEDICAL EQUIP-RENTED		1. 2482	92 0	0	96.00
	200.00				167, 718, 469	39, 757, 600	200.00
202.00 Net charges (line 200 minus line 201) 167,718,469 202.00	201.00				0		201.00
	202.00	Net charges (line 200 minus line 201))		167, 718, 469		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-00 Component CCN: 15-5 Title XVIII Cost Center Description Ratio on To Cha	5048	Period: From 01/01/2019 To 12/31/2019 Subprovider - IPF Inpatient	Worksheet D-3 Date/Time Pre 6/8/2020 3:16 PPS	pared:
Cost Center Description Ratio o	5048 -	To 12/31/2019 Subprovi der - I PF	6/8/2020 3:16	
Cost Center Description Ratio o	of Cost	Subprovider -	6/8/2020 3:16	
Cost Center Description Ratio o		. I PF		
Cost Center Description Ratio o		. I PF		
		Innatient	r ¹	
To Cha	arges		Inpati ent	
		Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		0		30.00
31. 00 03100 I NTENSI VE CARE UNI T		0		31.00
40. 00 04000 SUBPROVI DER - I PF		6, 122, 701		40.00
41. 00 04100 SUBPROVIDER - IRF		0		41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
	. 207982			
	. 22596		0	
	. 17149		74, 490	
	. 105278		2, 852	
	. 17723!		134, 495	
	. 122603		76, 486	
	. 651884			
	. 110843		2, 185	
	. 184588		0	
	. 000000		0	
	. 635892		5	72.00
	. 342294			
	. 853663		32, 183	
	. 000000		0	
	. 679794	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		T		
	. 162774		94, 404	
	. 53088		0	92.00
	. 513842	2 284	146	93.00
OTHER REIMBURSABLE COST CENTERS				
	. 248292		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		4, 156, 382	1, 068, 656	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		4, 156, 382		202.00

Health Financial Systems REID	HOSPITAL & HEALTH CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	;
			From 01/01/2019		
	Component	CCN: 15-T048	To 12/31/2019		
	Ti tl c	e XVIII	Subprovider -	6/8/2020 3: 16 PPS	pili
	litie		IRF	PP3	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		l .	Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			3, 006, 025		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS				•	1
50.00 05000 OPERATI NG ROOM		0. 20798	52, 920	11,006	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 22596	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17149	149, 340	25, 611	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10527			
60. 00 06000 LABORATORY		0. 17723			
65. 00 06500 RESPI RATORY THERAPY		0. 12260			
66.00 06600 PHYSI CAL THERAPY		0. 65188			
69. 00 06900 ELECTROCARDI OLOGY		0. 11084			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 18458			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 63589		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 34229		287, 501	•
74.00 07400 RENAL DIALYSIS		0.85366			
76. 00 03950 ANCI LLARY - OTHER		0.00000			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 67979			
OUTPATIENT SERVICE COST CENTERS		0.0777		<u> </u>	/0. //
91. 00 09100 EMERGENCY		0. 16277	20, 870	3, 397	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 53088			
93. 00 04040 FAMILY PRACTICE		0. 51384			
OTHER REIMBURSABLE COST CENTERS		0.0100			1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		1. 24829	02 0	0	96.00
200.00 Total (sum of lines 50 through 94 and 96	6 through 98)		4, 278, 394		
201.00 Less PBP Clinic Laboratory Services-Proc			., 2, 3, 0, 1	2,000,702	201.00
202.00 Net charges (line 200 minus line 201)	g		4, 278, 394		202.00
		I	1,2,3,0,1	I	-02.00

Heal th	Financial Systems	REID HOSPITAL & HEALTH CARE SE	RVICES	In Lie	eu of Form CMS-:	2552-10
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONME	NT Provi dei	- CCN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
		т	itle XIX	Hospi tal	6/8/2020 3: 16	pm
	Cost Center Description		Ratio of Cos		Cost Inpati ent	
	cost center bescription		To Charges		Program Costs	
			10 charges	Charges	(col. 1 x col.	
				charges	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30, 00	03000 ADULTS & PEDIATRICS			2, 425, 610		30.00
	03100 I NTENSI VE CARE UNI T			356, 857		31.00
	04000 SUBPROVIDER - IPF			0		40.00
41.00	04100 SUBPROVIDER - IRF			0		41.00
	04300 NURSERY			382, 079		43.00
	ANCI LLARY SERVICE COST CENTERS		1			
50.00	05000 OPERATI NG ROOM		0. 2079	82 668, 887	139, 116	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2259	61 670, 859	151, 588	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1714			54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1052	78 502, 225	52, 873	59.00
60.00	06000 LABORATORY		0. 1772	35 1, 400, 905	248, 289	60.00
65.00	06500 RESPI RATORY THERAPY		0. 1226	03 562, 407	68, 953	65.00
66.00	06600 PHYSI CAL THERAPY		0. 6518	84 389, 906	254, 173	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 1108	43 158, 767	17, 598	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1845	88 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS	0.0000	00 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 6358	92 81, 802	52, 017	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3422	94 1, 661, 216	568, 624	73.00
74.00	07400 RENAL DIALYSIS		0. 8536	63 46, 460	39, 661	74.00
76.00	03950 ANCI LLARY - OTHER		0.0000	00 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON		0. 6797	94 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				_	
91.00	09100 EMERGENCY		0. 1627	74 831, 142	135, 288	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT P	ART)	0. 5308	85 O	0	92.00
93.00	04040 FAMILY PRACTICE		0. 5138	42 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS					
	09600 DURABLE MEDICAL EQUIP-RENTED		1. 2482		0	
200.00				8, 091, 121	1, 919, 662	
201.00		ces-Program only charges (line 6)	0		201.00
202.00	Net charges (line 200 minus line	201)		8, 091, 121		202.00

Heal th Financial Systems REID HOSPITAL & HEALTH			-		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0048		riod: om 01/01/2019	Worksheet D-3	
	Component	CCN: 15-S048	To		Date/Time Pre	pared:
					6/8/2020 3:16	pm
	Titl	e XIX	S	ubprovider - IPF	Cost	
Cost Center Description	L	Ratio of Cos		Inpati ent	Inpati ent	
		To Charges	5		Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31, 00 03100 NTENSI VE CARE UNI T				0		31.00
40. 00 04000 SUBPROVI DER - I PF				521, 596		40.00
41. 00 04100 SUBPROVIDER - IRF				021,070		41.00
43. 00 04300 NURSERY				0		43.00
ANCI LLARY SERVI CE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM		0. 2079	82	0	0	50. OC
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2259	61	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1714	95	0	0	54. OC
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1052	78	0	0	59. OC
60. 00 06000 LABORATORY		0. 1772	35	0	0	60. OC
65. 00 06500 RESPI RATORY THERAPY		0. 1226	03	0	0	65. OC
66. 00 06600 PHYSI CAL THERAPY		0.6518		0	0	
69. 00 06900 ELECTROCARDI OLOGY		0. 1108	43	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1845	88	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0.6358		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3422		0	0	
74.00 07400 RENAL DIALYSIS		0.8536		0	0	
76. 00 03950 ANCI LLARY - OTHER		0.0000		0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 6797	94	0	0	76.97
OUTPATIENT SERVICE COST CENTERS		0.4407				
91.00 09100 EMERGENCY		0. 1627		0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5308		0	0	
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS		0. 5138	642	0	0	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		1, 2482	02	0	0	96.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 2402	.12	0		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0	0	200.00
202.00 Net charges (line 200 minus line 201)				0		201.00
		1	1	Ч		1202.00

Health Fi	T ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0048	Peri od	4.	Worksheet D-3	2552-1
	ANOTEEART SERVICE COST ATTORTONIMENT		CN. 13 0040		01/01/2019	WOT REFICE TO 5	
		Component	CCN: 15-T048	To 1	12/31/2019	Date/Time Prep 6/8/2020 3:16	
		Titl	e XIX	Subpr	rovider -	Cost	piii
					I RF		
	Cost Center Description		Ratio of Cos		pati ent	Inpatient	
			To Charges		rogram	Program Costs	
				C	harges	(col. 1 x col. 2)	
			1.00		2.00	3.00	
I N	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	000 ADULTS & PEDI ATRI CS				0		30. 0
31.00 03	100 INTENSIVE CARE UNIT				0		31.0
40.00 04	000 SUBPROVI DER – I PF				0	1	40.0
41.00 04	100 SUBPROVI DER – I RF				14, 241	1	41.0
43.00 04	300 NURSERY				0		43.0
AN	CILLARY SERVICE COST CENTERS						
50.00 05	OOO OPERATING ROOM		0. 2079	82	0	0	50.0
52.00 05	200 DELIVERY ROOM & LABOR ROOM		0. 2259	61	0	0	52.0
54.00 05	400 RADI OLOGY-DI AGNOSTI C		0. 1714	95	0	0	54.0
59.00 05	900 CARDI AC CATHETERI ZATI ON		0. 1052	78	0	0	59.0
60.00 06	000 LABORATORY		0. 1772	35	0	0	
	500 RESPI RATORY THERAPY		0. 1226	03	0	0	65.0
	600 PHYSI CAL THERAPY		0.6518		0	0	
	900 ELECTROCARDI OLOGY		0. 1108		0	0	
	000 ELECTROENCEPHALOGRAPHY		0. 1845		0	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	0	
	200 IMPL. DEV. CHARGED TO PATIENT		0.6358		0	0	
	300 DRUGS CHARGED TO PATIENTS		0. 3422		0	0	1 / 0. 0
	400 RENAL DIALYSIS		0.8536		0	0	1
	1950 ANCI LLARY - OTHER		0.0000		0	0	
	7697 CARDI AC REHABI LI TATI ON		0. 6797	94	0	0	76.9
	TPATIENT SERVICE COST CENTERS		0. 1627	74	0	0	91. 0
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1827		0		
	040 FAMILY PRACTICE		0. 5308		0		
	HER REIMBURSABLE COST CENTERS		0.0136	72	0	0	73.0
	600 DURABLE MEDICAL EQUIP-RENTED		1.2482	92	0	0	96.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)				0		200.0
201.00	Less PBP Clinic Laboratory Services-Program only charg	es (line 61)			0	-	201.0
202.00	Net charges (line 200 minus line 201)	(0		202.0

	To 12/31/2019	Date/Time Prep 6/8/2020 3:16	
	Title XVIII Hospital	PPS	
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	0 38, 124, 366	1.00 1.01
. 01	instructions)	30, 124, 300	1.0
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	13, 002, 902	1.02
	instructions)	_	
. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1.04
l	October 1 (see instructions)		
. 00	Outlier payments for discharges. (see instructions)		2.0
. 01 . 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.0 2.0
. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	836, 084	2.0
. 04	outlier payments for discharges occurring on or after October 1 (see instructions)	199, 392	2.0
. 00	Managed Care Simulated Payments	7, 414, 266	3.0
. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	150.06	4.0
00	Indirect Medical Education Adjustment	0.00	FO
. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6.0
1	new programs in accordance with 42 CFR 413.79(e)		
. 00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.0
. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.0
. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0,00	0.0
1	1998), and 67 FR 50069 (August 1, 2002).		
. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8.0
. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 0
02	under § 5506 of ACA. (see instructions)	0.00	0. 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	9.0
0.00	instructions)	0.00	10.0
	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.		10. 0 11. 0
	Current year allowable FTE (see instructions)	0.00	
	Total allowable FTE count for the prior year.	0.00	
4.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	14.0
- 00	otherwise enter zero.	0.00	45 0
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program	0.00 15.47	
	Adjustment for residents displaced by program or hospital closure	0.00	
	Adjusted rolling average FTE count	15.47	
9.00	Current year resident to bed ratio (line 18 divided by line 4).	0. 103092	19. C
	Prior year resident to bed ratio (see instructions)	0. 101230	
	Enter the lesser of lines 19 or 20 (see instructions)	0. 101230 2, 748, 858	
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)	398, 628	
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	,	
3. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 0
1 00	(f)(1)(iv)(C).	0.00	24.0
	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 line 24 (see	0.00 0.00	
J. 00	instructions)	0.00	25.0
6.00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. C
7.00	IME payments adjustment factor. (see instructions)	0.00000	27. C
	IME add-on adjustment amount (see instructions)	0	28. C
	IME add-on adjustment amount - Managed Care (see instructions)	0	28.0
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	2, 748, 858 398, 628	
2.01	Di sproporti onate Share Adjustment	370, 020	27.0
0. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 42	30. C
1.00	Percentage of Medicaid patient days (see instructions)	19. 99	31.0
2.00	Sum of lines 30 and 31	25.41	32. 0 33. 0
	Allowable disproportionate share percentage (see instructions)		

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

CALCUI	Financial Systems REID HOSPITAL & HEALTH			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E	
			From 01/01/2019		
			To 12/31/2019		pare
		T 1.1.1 NO.01.1.1		6/8/2020 3:16	pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		8, 272, 872, 447	8, 350, 599, 096	35.
35.01	Factor 3 (see instructions)		0. 000381928	0. 000381928	35.
35.02	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see	3, 074, 238	891, 518	35.
	instructions)				
35.03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	2, 299, 361	224, 097	35.
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		2, 523, 458		36.
	Additional payment for high percentage of ESRD beneficiary dis		n 46)		00.
10.00	Total Medicare discharges on Worksheet S-3, Part I excluding d		0		40.
+0. 00	652, 682, 683, 684 and 685 (see instructions)	a scharges for mo-blos	0		40.
11 00		2 (04 on (05 (oco	0		11
11.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	55, 064 all 065. (See	0		41.
	instructions)				
11.01	Total ESRD Medicare covered and paid discharges excluding MS-D	אטאכ 52, 582, 683, 684	0		41.
	an 685. (see instructions)				
12.00	Divide line 41 by line 40 (if less than 10%, you do not qualif		0.00		42.
13.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0		43.
	instructions)				
4.00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0.000000		44.
	days)				
15.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.
16.00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46.
17.00	Subtotal (see instructions)		58, 736, 249		47.
18.00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	68, 634, 364		48.
10.00	only. (see instructions)		00, 034, 304		
				Amount	
				1.00	
10.00	Tatal normant for innotions anorating parts (and instructions)				40
19.00	Total payment for inpatient operating costs (see instructions)			69, 032, 992	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			4, 398, 955	50.
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.	· · · · · · · · · · · · · · · · · · ·		0	51.
52.00	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		510, 931	52.
53.00	Nursing and Allied Health Managed Care payment			36, 977	53.
54.00	Special add-on payments for new technologies			0	54.
54.01	Islet isolation add-on payment				
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	2)		0	54.
56.00	Cost of physicians' services in a teaching hospital (see intru				
				0	55.
	Routine service other pass through costs (from Wkst D Pt 11	uctions)	rough 35)	0	55. 56.
	Routine service other pass through costs (from Wkst. D, Pt. II	uctions) I, column 9, lines 30 th	rough 35).	0 0 0	55. 56. 57.
8.00	Ancillary service other pass through costs from Wkst. D, Pt. I	uctions) I, column 9, lines 30 th	rough 35).	0 0 72, 331	55. 56. 57. 58.
58.00 59.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	uctions) I, column 9, lines 30 th	rough 35).	0 0 72, 331 74, 052, 186	55. 56. 57. 58. 59.
57.00 58.00 59.00 50.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195	55. 56. 57. 58. 59. 60.
58.00 59.00 50.00 51.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195 74, 036, 991	55. 56. 57. 58. 59. 60. 61.
58.00 59.00 50.00 51.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195	55. 56. 57. 58. 59. 60.
8.00 9.00 0.00 1.00 2.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195 74, 036, 991	55. 56. 57. 58. 59. 60. 61. 62.
8.00 9.00 0.00 1.00 2.00 3.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872	55. 56. 57. 58. 59. 60. 61.
58.00 59.00 50.00 51.00 52.00 53.00 54.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200)	rough 35).	0 0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629	55. 56. 57. 58. 59. 60. 61. 62. 63.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60)	rough 35).	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65.
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60)	rough 35).	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66.
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions)		0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 65. 67.
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 66. 66.
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 09 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69.
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see (For SCH see instructions)	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
88.00 99.00 90.00 91.00 92.00 93.00 94.00 95.00 96.00 97.00 98.00 99.00 90.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see (For SCH see instructions)	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 09 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70.
88.00 99.00 90.00 91.00 92.00 93.00 94.00 95.00 96.00 97.00 98.00 97.00 98.00 97.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see (For SCH see instructions)	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0	555 566 577 588 599 600 611 62 633 644 655 666 677 688 699 700 700
58.00 59.00 50.00 51.00 52.00 53.00 54.00 55.00 56.00 57.00 58.00 57.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (see (For SCH see instructions)	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70.
38.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 30.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	$\begin{array}{c} 0\\ 0\\ 72, 331\\ 74, 052, 186\\ 15, 195\\ 74, 036, 991\\ 5, 667, 872\\ 57, 629\\ 400, 921\\ 260, 599\\ 196, 409\\ 68, 572, 089\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	555 566 577 588 599 600 611 62 633 644 655 666 677 688 699 700 700 700 700 700
88.00 00 90.00 00 91.00 00 92.00 00 93.00 00 94.00 00 95.00 00 96.00 00 97.00 00 90.00 00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instr	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	$\begin{array}{c} 0\\ 0\\ 72, 331\\ 74, 052, 186\\ 15, 195\\ 74, 036, 991\\ 5, 667, 872\\ 57, 629\\ 400, 921\\ 260, 599\\ 196, 409\\ 68, 572, 089\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 67. 70. 70. 70. 70. 70.
38.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 37.00 38.00 30.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 09 0 0 0 0 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70.
i8.00 i9.00 i0.00 i1.00 i2.00 i3.00 i4.00 i5.00 i6.00 i7.00 i8.00 i9.00 i0.00 i0.00 i0.00 i0.00 i0.00 i0.00 i0.00 i0.00 i0.87 i0.88 i0.89 i0.90 i0.90 i0.91	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	555 566 57 588 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70 70
38.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 37.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 64. 65. 64. 67. 68. 67. 70. 70. 70. 70. 70. 70. 70. 70.
38.00 39.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 39.00 30.00 37.00 38.00 39.00 30.00 70.88 70.88 70.90 70.91 70.92 70.93	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 64. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70
38.00 39.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 37.00	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	uctions) I, column 9, lines 30 th V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (se (For SCH see instructions) ration) adjustment (see in	e instructions)	0 72, 331 74, 052, 186 15, 195 74, 036, 991 5, 667, 872 57, 629 400, 921 260, 599 196, 409 68, 572, 089 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69.

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

ealth Financial Systems REID HOSPITAL & HEALTH	CARE SERVI	CES	III LIE	u of Form CMS-:	2552
ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C		Peri od:	Worksheet E	
			From 01/01/2019 To 12/31/2019		nare
			10 12/01/2017	6/8/2020 3:16	pm
	Title	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70
the corresponding federal year for the period prior to 10/1) . 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70
the corresponding federal year for the period ending on or after			0	0	1 /0
). 98 Low Volume Payment-3				0	70
.99 HAC adjustment amount (see instructions)				0	
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69	9 & 70)			68, 641, 300	71
.01 Sequestration adjustment (see instructions)				1, 372, 826	71
.02 Demonstration payment adjustment amount after sequestration				0	71
2.00 Interim payments				67, 707, 570	
.00 Tentative settlement (for contractor use only)				0	
.00 Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			-439, 096	74
5.00 Protested amounts (nonallowable cost report items) in accordance	Je with			0	75
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1		I	1
0. 00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	F 2 03			0	90
plus 2.04 (see instructions)	2.00			0	^0
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91
00 Operating outlier reconciliation adjustment amount (see instruc	ctions)			0	92
.00 Capital outlier reconciliation adjustment amount (see instructi	ons)			0	93
.00 The rate used to calculate the time value of money (see instruc				0.00	94
.00 Time value of money for operating expenses (see instructions)				0	
0.00 Time value of money for capital related expenses (see instructi	ons)			0	96
			Prior to 10/1		
HSP Bonus Payment Amount			1.00	2.00	
			0	0	1100
0.00 HSP bonus amount (see instructions)			0	0	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0.000000000		
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions))			0. 000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions))		0. 000000000	0. 000000000	101
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 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVRP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instructions) 8.00 HRR adjustment amount for HSP bonus payment (see instruction peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) 6.00 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 	ation) Adju iod under t 49) first year uctions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 206
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare target amount 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare net routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 	ation) Adju iod under t 49) first year uctions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 207 207
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 9.00 Adjustment to Medicare IPPS payments (see instructions) 	ation) Adju iod under t 49) first year uctions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) 4.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Reserved for future use 	ation) Adju iod under t 49) first year uctions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare inpatient routine cost cap (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Reserved for future use 1.00 Medicare Part A inpatient Service costs (from Wkst. E, Pt. A, I 	ation) Adju iod under t 49) first year uctions)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 200 201 202 203 204 205 206 207 208 207 208 209 210
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 0.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instructions) 0.00 Reserved for future use 0.00 Reserved for future use 0.00 Reserved for future use 0.00 Comparision of PPS versus Cost Reimbursement 	ation) Adju iod under t 49) first year uctions) line 59)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210 211
 0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment (see instructions) 3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. A, I 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare Part A IPPS payments (from line 27 	ation) Adju iod under t 49) first year uctions) line 59)	he 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101 102 103 104 200 203 204 205 206 207 208 209 210 211 212
 00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 01.00 HVBP adjustment factor (see instructions) 02.00 HVBP adjustment for HSP Bonus Payment (see instructions) HRR Adjustment for HSP Bonus Payment 03.00 HRR adjustment factor (see instructions) 04.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 02.00 Medicare discharges (see instructions) 03.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjustment factor (see instructions) 04.00 Medicare target amount 05.00 Case-mix adjustment factor (see instructions) 06.00 Medicare target amount 07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, I 09.00 Adjustment to Medicare IPPS payments (see instructions) 00 Medicare Part A inpatient Service costs (from Wkst. E, Pt. A, I 09.00 Adjustment to Medicare IPPS payments (see instructions) 	ation) Adju iod under t 49) First year uctions) Line 59)	of the curren	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	102

 Health Financial Systems
 REID HOSPITAL & HEALTH CARE SERVICES
 In Lieu of Form CMS-2552-10

 CALCULATION OF REIMBURSEMENT SETTLEMENT
 Provider CCN: 15-0048
 Period: From 01/01/2019
 Worksheet E Part B Date/Time Prepared:

			To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	ti ana)		17,665	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	LI ONS)		42, 671, 062 52, 382, 907	
4.00	Outlier payment (see instructions)			31, 461	
4. 01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
5.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
3.00 3.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		162, 931	9.00
	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			17, 665	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
2.00	Ancillary service charges			51, 608	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)			51, 608	14.00
F 00	Customary charges	an mant far aard aas an	a abanga basi a	0	1 15 0
	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
0.00	had such payment been made in accordance with 42 CFR §413.13(e	1 5	a chargebasi s	Ū	10.0
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
	Total customary charges (see instructions)			51,608	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y if line 18 exceeds li	ne 11) (see	33, 943	19.0
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.0
	instructions)	5	, .		
	Lesser of cost or charges (see instructions)			17, 665	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	ructions)		0	22.0 23.0
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			52, 577, 299	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instructions			0	
	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	-		9, 252, 963 43, 342, 001	26.0 27.0
	instructions)			43, 342, 001	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		288, 467	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			43, 630, 468 8, 595	
	Subtotal (line 30 minus line 31)			43, 621, 873	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			1
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			1, 553, 271	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		1, 009, 626 1, 340, 915	
	Subtotal (see instructions)			44, 631, 499	
	MSP-LCC reconciliation amount from PS&R			2, 042	
	OTHER ADJUSTMENTS			0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39.5
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	red devices (see instruc	stions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION		5(10)(3)	0	
	Subtotal (see instructions)			44, 629, 457	
	Sequestration adjustment (see instructions)			892, 589	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractors use only)			43, 751, 853 0	
	Balance due provider/program (see instructions)			-14, 985	
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2				-
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.0
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.0
93.00	Time Value of Money (see instructions)			0	93.00 94.00
	Total (sum of lines 91 and 93)				

ALCULATION OF REIMBURSEMENT SETTLEME		IEALTH CARE SERVICES Provider CCN: 15-0048	Period: From 01/01/2019	u of Form CMS-: Worksheet E Part B	
		Component CCN: 15-SO48	To 12/31/2019		
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEAD				1 047	
00 Medical and other services (se 00 Medical and other services rei		structions)		1, 047 871	
00 OPPS payments				1, 146	
00 Outlier payment (see instructi				0	
01 Outlier reconciliation amount	· · · · · · · · · · · · · · · · · · ·			0	
00 Enter the hospital specific pa 00 Line 2 times line 5	ment to cost ratio (see in	istructions)		0. 000 0	
00 Sum of Lines 3, 4, and 4.01, d	vided by line 6			0.00	
00 Transitional corridor payment	· ,			0	8
00 Ancillary service other pass t	nrough costs from Wkst. D,	Pt. IV, col. 13, line 200		12	
0.00 Organ acquisitions 1.00 Total cost (sum of lines 1 and	10) (coo instructions)			0 1, 047	
COMPUTATION OF LESSER OF COST				1, 047	1''
Reasonabl e charges					
2.00 Ancillary service charges				3, 058	
3.00 Organ acquisition charges (fro		4, line 69)		0	
4.00 <u>Total reasonable charges (sum</u> Customary charges	n Trhes 12 and 13)			3, 058	1 14
5.00 Aggregate amount actually coll	ected from patients liable	for payment for services on	a charge basis	0	15
5.00 Amounts that would have been r			n a chargebasis	0	16
had such payment been made in 7.00 Ratio of line 15 to line 16 (n		3.13(e)		0.00000	17
7.00 Ratio of line 15 to line 16 (n 3.00 Total customary charges (see i				3, 058	
9.00 Excess of customary charges ov	-	e only if line 18 exceeds li	ne 11) (see	2,011	
instructions)					
0.00 Excess of reasonable cost over instructions)	customary charges (complet	e only if line 11 exceeds li	ne 18) (see	0	20
1.00 Lesser of cost or charges (see	instructions)			1, 047	21
2.00 Interns and residents (see ins	-			0	
3.00 Cost of physicians' services i	ö	-		0	
4.00 Total prospective payment (sum COMPUTATION OF REIMBURSEMENT SI		1 9)		1, 158	24
5.00 Deductibles and coinsurance am	•	-		0	
5.00 Deductibles and Coinsurance am	8	•		135	
7.00 Subtotal [(lines 21 and 24 min instructions)	is the sum of lines 25 and	26) plus the sum of lines 22	and 23] (see	2, 070	27
3.00 Direct graduate medical educat	on payments (from Wkst. E-	4, line 50)		0	28
9.00 ESRD direct medical education		9 36)		0	
0.00 Subtotal (sum of lines 27 thro	ıgh 29)			2, 070	
1.00 Primary payer payments 2.00 Subtotal (line 30 minus line 3				0 2, 070	
ALLOWABLE BAD DEBTS (EXCLUDE BA		SERVI CES)		2,070	
3.00 Composite rate ESRD (from Wkst				0	
4.00 Allowable bad debts (see instr				0	
5.00 Adjusted reimbursable bad debt 5.00 Allowable bad debts for dual e	•	instructions)		0	
7.00 Subtotal (see instructions)				2,070	
3.00 MSP-LCC reconciliation amount				0	
9.00 OTHER ADJUSTMENTS (SEE INSTRUC	, , , ,			0	
 9. 50 Pioneer ACO demonstration paym 97 Demonstration payment adjustme 	5	-		0	39
9.98 Partial or full credits receiv	•		tions)	0	
9. 99 RECOVERY OF ACCELERATED DEPREC				0	39
0.00 Subtotal (see instructions)				2, 070	
 0.01 Sequestration adjustment (see 0.02 Demonstration payment adjustme 		on		41	
1.00 Interim payments	anount arter sequesti att	0.1		1, 501	
2.00 Tentative settlement (for cont	ractors use only)			0	42
3.00 Balance due provider/program (-			528	
4.00 Protested amounts (nonallowabl §115.2	e cost report items) in acc	cordance with CMS Pub. 15-2,	cnapter 1,	0	44
TO BE COMPLETED BY CONTRACTOR					1
0.00 Original outlier amount (see i	nstructions)			0	90
1.00 Outlier reconciliation adjustm	-	ons)		0	
2.00 The rate used to calculate the				0.00	
3.00 Time Value of Money (see instr 4.00 Total (sum of lines 91 and 93)					93

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	In Lie Period: From 01/01/2019	Worksheet E Part B	
		Component CCN: 15-T048	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title XVIII	Subprovider -	PPS	pin
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions)	ati ana)		118	
	Medical and other services reimbursed under OPPS (see instrue OPPS payments	ctions)		39 101	
	Outlier payment (see instructions)			0	
	Outlier reconciliation amount (see instructions)			0	4
	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
	Transitional corridor payment (see instructions)			0.00	
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
	Organ acqui si ti ons			0	
	Total cost (sum of lines 1 and 10) (see instructions)			118	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
	Ancillary service charges			344	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)			13
	Total reasonable charges (sum of lines 12 and 13)			344	14
	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	1 15
	Amounts that would have been realized from patients liable for	1 3	5	0	
	had such payment been made in accordance with 42 CFR §413.13				
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)	nly if line 10 evenede li	no 11) (coo	344 226	
. 00	Excess of customary charges over reasonable cost (complete or instructions)	III y II IIIle 18 exceeds II	lie II) (See	220	19
. 00	Excess of reasonable cost over customary charges (complete of	nly if line 11 exceeds li	ne 18) (see	0	20
	instructions)				
	Lesser of cost or charges (see instructions)			118	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			101	
	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instruction	-		0	
	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	-		0 219	
	instructions)	prus the sum of fries 22		217	2'
	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	
	Subtotal (sum of lines 27 through 29)			219	
	Primary payer payments Subtotal (line 30 minus line 31)			0 219	
•	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		217	
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
	Subtotal (see instructions)			219	
	MSP-LCC reconciliation amount from PS&R			0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39
	Pioneer ACO demonstration payment adjustment (see instruction	-		_	39
	Demonstration payment adjustment amount before sequestration		tions)	0	
	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aceu uevices (see instruc	u 0115 <i>)</i>	0	
	Subtotal (see instructions)			219	
. 01	Sequestration adjustment (see instructions)			4	40
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments Tentative settlement (for contractors use only)			209 0	
	Balance due provider/program (see instructions)			6	
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) 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)				93
	Total (sum of lines 91 and 93)				94

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prep 6/8/2020 3:16	pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A		tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		67, 634, 5	70 0	43, 465, 853 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					
01	ADJUSTMENTS TO PROVIDER	04/24/2019	73, 00	00 04/24/2019	110, 100	3.
02				0 07/27/2019	175, 900	
03				0	0	3
04 05				0	0	
05	Provider to Program	<u> </u>		0	0	1 3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	
54 99	Subtatal (sum af lines 2.01.2.40 minus sum af lines		72.00	0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		73, 00		286, 000	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)		67, 707, 5	70	43, 751, 853	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
11	Program to Provider	I		0		_
)1)2	TENTATI VE TO PROVI DER			0	0	5
)2)3				0	0	
	Provider to Program	· · ·				1
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
7	5. 50-5. 98)			U III	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROGRAM		439, 09	8	14, 985	
00	Total Medicare program liability (see instructions)		67, 268, 47		43, 736, 868	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1, 00	2.00	-

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0048 CCN: 15-S048	Period: From 01/01/2019 To 12/31/2019		parec
		Title	XVIII	Subprovider -	PPS	-1-
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 875, 3	83 0	1, 501 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
)5	Describer to Descrean			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
50 51	ADJUSTIVIENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
	3. 50-3. 98)					
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)		4, 875, 3	83	1, 501	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	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
0	Provider to Program			0		
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
92 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
)0	5.50-5.98) Determined net settlement amount (balance due) based on					6
-	the cost report. (1)					
)1	SETTLEMENT TO PROVIDER		64, 4	18	528	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		4, 939, 8		2, 029	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8

NALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0048 CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019		pared:
		Ti tl e	XVIII	Subprovider -	PPS	-
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 548, 5	73 0	209 0	1.00 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0	0	3.01
02				0	0	3.02
03				0	0	3.03
04				0	0	3.04
05	Provider to Program			0	0	3.0
50	ADJUSTMENTS TO PROGRAM			0	0	3.5
51				0	0	3.5
52				0	0	3.5
53				0	0	3.5
54				0	0	3.5
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.9
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) TO BE COMPLETED BY CONTRACTOR		4, 548, 5	73	209	4.0
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.0
01	TENTATI VE TO PROVIDER			0	0	5.0
02				0	0	5.0
03				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5.5
51				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. 9
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
01	SETTLEMENT TO PROVIDER		0. F	0	6	6.0
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		26, 5 4, 522, 0		0 215	6.0 7.0
00	Total medicale program manifity (see instructions)		4, 522, 0	Contractor	NPR Date	1.0
				Number	(Mo/Day/Yr)	
				Trumbor	(

Heal th	Financial Systems REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0048	Peri od:	Worksheet E-	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title XVIII	Hospi tal	PPS) pili
			nospi tai	113	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
	Calculation of the HIT incentive payment (see instructions)				8.00
	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				_
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	is)		32.00

alth Financial Systems LCULATION OF REIMBURSEMEN ⁻		& HEALTH CARE SERVICES Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2019	Part II	
		Component CCN: 15-S048	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
PART II - MEDICARE PA	RT A SERVICES - IPF PPS				
00 Net Federal IPF PPS F	ayments (excluding outlier, ECT,	and medical education payments)		5, 587, 738	1
00 Net IPF PPS Outlier F	5			28, 023	2
00 Net IPF PPS ECT Payme				0	3
15, 2004. (see instru		·		0.00	4
	unweighted intern and resident losure, that would not be counted			0.00	4
CFR §412.424(d)(1)(ii	i)(F)(1) or (2) (see instruction	ns)			
	adjustment. (see instructions)			0.00	5
	hted FTE count of I&R excluding	FIEs in the new program growth p	eriod of a "new	0.00	6
teaching program" (se 00 Current year's unweid	e instuctions) hted I&R FTE count for residents	within the new program growth p	eriod of a "new	0.00	7
teaching program" (se		within the new program growth p		0.00	'
51 5 1	ount for IPF PPS medical education	on adjustment (see instructions)		0.00	8
00 Average Daily Census				24. 482192	ç
õ j	actor {((1 + (line 8/line 9)) rai	ised to the power of .5150 -1}.		0.00000	
	line 1 multiplied by line 10).			0	1
	Payments (sum of lines 1, 2, 3 a			5, 615, 761	12
	alth Managed Care payment (see in	nstruction)		0	13
.00 Organ acquisition (DC	ervices in a teaching hospital (see instructions)		0	
00 Subtotal (see instruc				5, 615, 761	
00 Primary payer payment				0,010,701	1
00 Subtotal (line 16 les				5, 615, 761	18
00 Deductibles				290, 292	1
.00 Subtotal (line 18 mir	us line 19)			5, 325, 469	
00 Coinsurance				350, 583	
00 Subtotal (line 20 min		al convisco) (coo instructions)		4, 974, 886	
	exclude bad debts for professiona bad debts (see instructions)	al services) (see instructions)		98, 679 64, 141	
3	or dual eligible beneficiaries (see instructions)		86, 156	
00 Subtotal (sum of line	0			5, 039, 027	
-	al education payments (from Wkst.	. E-4, line 49)		0,007,027	2
00 Other pass through co	1 3			1, 586	28
00 Outlier payments reco				0	29
00 OTHER ADJUSTMENTS (SE	, , ,			0	30
	tion payment adjustment (see ins			0	30
	adjustment amount before seques			0 E 040 613	
	to the provider (see instructions ent (see instructions)	5)		5, 040, 613 100, 812	
	adjustment amount after sequest	ration		100, 812	
00 Interim payments				4, 875, 383	
. 00 Tentative settlement	(for contractor use only)			0	33
	program (line 31 minus lines 31.0	01, 31.02, 32 and 33)		64, 418	34
.00 Protested amounts (no §115.2	nallowable cost report items) in	accordance with CMS Pub. 15-2,	chapter 1,	0	35
TO BE COMPLETED BY CO	NTRACTOR				
5	nt from Worksheet E-3, Part II,			28, 023	50
	n adjustment amount (see instruc	tions)		0	51
.00 The rate used to calc	ulate the Time Value of Money			0.00	52 53

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-TO48	From 01/01/2019 To 12/31/2019	Part III Date/Time Pre 6/8/2020 3:16	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			4, 374, 161	
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0175	
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			118, 540	3.
. 00	Outlier Payments			160, 954	4.
. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period en	aing on or prior	0.00	5.
. 01	Cap increases for the unweighted intern and resident FTE cou	nt for residents that wer	e displaced by	0.00	5.
	program or hospital closure, that would not be counted witho	ut a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8.
00	teaching program" (see instructions)	atment (and instructions)		0.00	
00	Intern and resident count for IRF PPS medical education adju	stment (see instructions)		0.00	
0.00	Average Daily Census (see instructions) Teaching Adjustment Factor (see instructions)			11. 435616 0. 000000	
2.00	Teaching Adjustment (see instructions)			0.000000	
3.00	Total PPS Payment (see instructions)			4, 653, 655	
4.00	Nursing and Allied Health Managed Care payments (see instruc	tion		4,000,000	
5.00	Organ acquisition (DO NOT USE THIS LINE)			0	15
6.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
7.00	Subtotal (see instructions)			4, 653, 655	
8.00	Primary payer payments			0	
9.00	Subtotal (line 17 less line 18).			4, 653, 655	
0. 00	, , ,			15,004	
1.00	Subtotal (line 19 minus line 20)			4, 638, 651	21
2.00				26, 598	22
3.00	Subtotal (line 21 minus line 22)			4, 612, 053	23
4.00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		2, 704	24
5.00	Adjusted reimbursable bad debts (see instructions)			1, 758	25
6. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		1, 364	
7.00	Subtotal (sum of lines 23 and 25)			4, 613, 811	
8.00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	
9.00				545	
0.00	Outlier payments reconciliation			0	
1.00		>		0	31
1.50	Pioneer ACO demonstration payment adjustment (see instruction			0	31
1.99	Demonstration payment adjustment amount before sequestration			0	
2.00 2.01	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			4, 614, 356 92, 287	
2.01					32
3.002	1 5 5 1			4, 548, 573	
4.00	Tentative settlement (for contractor use only)			4, 548, 575	
5.00	Balance due provider/program (line 32 minus lines 32.01, 32.	02 33 and 34)		-26, 504	
6. 00	Protested amounts (nonallowable cost report items) in accord		chapter 1,	20, 304	
	§115.2 TO BE COMPLETED BY CONTRACTOR				-
0. 00				160, 954	50
1.00	0			00, 734	
2.00	5			0.00	
	Time Value of Money (see instructions)				53

CULA	Financial Systems REID HOSPITAL & HEALTH CA TTION OF REIMBURSEMENT SETTLEMENT Pr	RE SERVICES ovider CCN: 15-0048	In Lie Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Pre 6/8/2020 3:16	pared:
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR X	IX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES		4 000 105		1.0
	Inpatient hospital/SNF/NF services Medical and other services		4, 088, 105	3, 696, 728	2.0
	Organ acquisition (certified transplant centers only)		0	3, 090, 720	3.0
	Subtotal (sum of lines 1, 2 and 3)		4, 088, 105	3, 696, 728	4.0
	Inpatient primary payer payments		1, 000, 100	0,070,720	5.0
	Outpatient primary payer payments			0	6.0
	Subtotal (line 4 less sum of lines 5 and 6)		4, 088, 105	3, 696, 728	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES		, , , , , , , , , , , , , , , , ,		
	Reasonabl e Charges				1
0	Routi ne servi ce charges		0		8.0
0	Ancillary service charges		8, 091, 121	15, 444, 229	9.0
00	Organ acquisition charges, net of revenue		0		10.0
	Incentive from target amount computation		0		11.0
- H	Total reasonable charges (sum of lines 8 through 11)		8, 091, 121	15, 444, 229	12.0
	CUSTOMARY CHARGES				
	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13.0
	basi s				
	Amounts that would have been realized from patients liable for pa		n O	0	14.0
	a charge basis had such payment been made in accordance with 42 (FR 9413.13(e)	0, 000000	0, 000000	15.0
	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		8, 091, 121	15, 444, 229	
	Excess of customary charges over reasonable cost (complete only i	fling 16 exceeds	4, 003, 016	11, 747, 501	17.0
	line 4) (see instructions)	T THE TO EXCEEds	4,003,010	11, 747, 301	17.0
	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds lir	ie 0	0	18.0
	16) (see instructions)		-	-	
	Interns and Residents (see instructions)		0	0	19.0
00	Cost of physicians' services in a teaching hospital (see instruct	i ons)	0	0	20.0
00	Cost of covered services (enter the lesser of line 4 or line 16)		4, 088, 105	3, 696, 728	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provi	ders.		
	Other than outlier payments		0	0	22.0
	Outlier payments		0	0	23.0
	Program capital payments		0		24. C
	Capital exception payments (see instructions)		0	-	25.0
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	27.0 28.0
	Titles V or XIX (sum of lines 21 and 27)		4, 088, 105	0 3, 696, 728	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		4,000,100	3, 090, 720	29.0
	Excess of reasonable cost (from line 18)		0	0	30.0
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4, 088, 105	3, 696, 728	
	Deducti bl es		4,000,100	0,070,720	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	-	35.0
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	4, 088, 105	3, 696, 728	36.0
	TO ZERO OUT MEDICAID		-4, 088, 105	-3, 696, 728	
	Subtotal (line 36 ± line 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0		39.
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.
00	Interim payments		0	0	41. (
	Balance due provider/program (line 40 minus line 41)		0	0	42.
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	0	0	43.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2019	Worksheet E-3 Part VII	
		Component CCN: 15-SO48	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pare
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		78, 657		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0	_	3
00	Subtotal (sum of lines 1, 2 and 3)		78, 657	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		70 (57	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		78, 657	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				+
00	Reasonable Charges Routine service charges		0		8
00	Ancillary service charges		0	0	
00	Organ acquisition charges, net of revenue		0	0	10
00	Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		0	0	
00	CUSTOMARY CHARGES				1
00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13
	basi s	5			
00	Amounts that would have been realized from patients liable for	r payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with 4				
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
00	Total customary charges (see instructions)		0	0	
00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	0	0	17
~~	line 4) (see instructions)		70 (57	0	
00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds lin	e 78, 657	0	18
00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 2		0	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	2
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		25
00	Routine and Ancillary service other pass through costs		0	0	26
00	Subtotal (sum of lines 22 through 26)		0	0	27
00	Customary charges (title V or XIX PPS covered services only)		0	0	28
00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		78, 657	0	
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	0	
00			0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	34
00	Utilization review Subtotal (sum of lines 21, 24 and 25 minus sum of lines 22 and	4 22)	0	0	
00 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 337	0	0	
00	Subtotal (line 36 ± 1 ine 37)		0	0	
00	Direct graduate medical education payments (from Wkst. E-4)		0	0	30
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments		0	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2	0	0	
	chapter 1, §115.2			Ũ	1

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII	
		component ccn: 15-1048	10 12/31/2019	Date/Time Pre 6/8/2020 3:16	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1 1
0	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0	1	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable Charges				1.
00	Routine service charges		0	0	8
00	Ancillary service charges		0	0	9
00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		0	0	
00	CUSTOMARY CHARGES		V	0	1 '2
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1 13
	basi s			-	
00	Amounts that would have been realized from patients liable for	payment for services or	0 ו	0	14
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	15
00	Total customary charges (see instructions)		0	0	
00	Excess of customary charges over reasonable cost (complete onl)	y if line 16 exceeds	0	0	17
~~	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete onl) 16) (see instructions)	y IT IINE 4 exceeds IINE	e 0	0	18
00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	23
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		25
00	Routine and Ancillary service other pass through costs		0	0	26
00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
00	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	I	39
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40
00	Interim payments		0	0	41
00	Balance due provider/program (line 40 minus line 41)		0	0	42
		ce with CMS Pub 15-2,	0		43

	Financial Systems REID HOSPITAL & HEALT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO	CN: 15-0048	Period:	u of Form CMS-2 Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2019 To 12/31/2019	Date/Time Prep 6/8/2020 3:16	
		Title	XVIII	Hospi tal	PPS	- p
				-	1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	0.00	1. C
. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	P 113 70(a)(1) (see instr	uctions)	0.00	2.0
. 00	Amount of reduction to Direct GME cap under section 422 of MM		i) (see misti		0.00	3.0
. 01	Direct GME cap reduction amount under ACA §5503 in accordance		§413.79 (m).	(see	0.00	3.0
00	instructions for cost reporting periods straddling 7/1/2011)			to a Madi anna	0.00	
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a medicare	0.00	4.0
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	ng periods	0.00	4.0
	straddling 7/1/2011)				0.00	
. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.0
. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus l	ines 4.01 and	0.00	5.0
	4.02 plus applicable subscripts	c		C .	45 47	
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	15.47	6.0
. 00	Enter the lesser of line 5 or line 6				0.00	7.
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2.00 7 0.00	<u>3. 00</u> 15. 47	8.
. 00	program for the current year.	atin o	10.1	, 0.00	10.17	0.
. 00	If line 6 is less than 5 enter the amount from line 8, otherw		0.0	0 0.00	0.00	9.
	multiply line 8 times the result of line 5 divided by the amo 6.	ount on line				
0. 00	Weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10.
0. 01	Unweighted dental and podiatric resident FTE count for the cu	irrent year		0.00		10.
1.00	Total weighted FTE count		0.0			11. 12.
2.00	Total weighted resident FTE count for the prior cost reportin instructions)	iy year (see	0.0	0 0.00		12.
3.00	Total weighted resident FTE count for the penultimate cost re	porti ng	0.0	0 0.00		13.
4.00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	(h) 2)	0.0	0.00		14.
5.00	Adjustment for residents in initial years of new programs	1 by 5).	15.4			15.
5. 01	Unweighted adjustment for residents in initial years of new p	rograms	15.4	7 0.00		15.
6. 00	Adjustment for residents displaced by program or hospital clo		0.0			16.
6. 01	Unweighted adjustment for residents displaced by program or h	iospi tal	0.0	0 0.00		16.
7.00	closure Adjusted rolling average FTE count		15.4	7 0.00		17.
8.00	Per resident amount		85,000.0			18.
9.00	Approved amount for resident costs		1, 314, 95	0 0	1, 314, 950	19.
				-	1.00	
0. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	0.00	20.
1 00	Sec. 413.79(c)(4)	ati ana`			45 47	21
1.00 2.00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr				15. 47 0. 00	
3.00	Enter the locality adjustment national average per resident a		nstructions)		85,000.00	
1.00	Multiply line 22 time line 23		,		0	24.
5.00	Total direct GME amount (sum of lines 19 and 24)				1, 314, 950	25.
			Inpatient Par	t Managed care		
			1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
6.00	Inpatient Days (see instructions)		29, 82			26.
7.00 3.00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		56, 26 0. 53008			27. 28.
9.00 9.00	Program direct GME amount		697, 03			28. 29.
	Reduction for direct GME payments for Medicare Advantage		077,03	16, 845		30.
0.00						

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0048	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2019 To 12/31/2019	Date/Time Pre	arod
			10 12/31/2019	6/8/2020 3: 16	
		Title XVIII	Hospi tal	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, Tines 74	0	32.00
22.00	and 94)		74	1 104 700	22.00
33.00 34.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. Ratio of direct medical education costs to total charges (lin		74 and 94)	1, 184, 700 0, 000000	
34.00	Medicare outpatient ESRD charges (see instructions)	e 32 ÷ 11ne 33)		0.000000	34.00 35.00
36.00	Medicare outpatient ESRD direct medical education costs (line	34 v line 35)		0	36.00
50.00	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII			0	30.00
	Part A Reasonable Cost	ONET			
37.00	Reasonable cost (see instructions)			75, 902, 375	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38,00
39.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39.00
40.00	Primary payer payments (see instructions)			15, 195	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)		75, 887, 180	41.00
	Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)			42, 853, 745	
43.00	Primary payer payments (see instructions)			8, 595	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			42, 845, 150	
45.00	Total reasonable cost (sum of lines 41 and 44)			118, 732, 330	
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin			0.639145	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 360855	47.00
40.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RIB		700, 200	40.00
48.00 49.00	Total program GME payment (line 31)	(and instructions)		799, 398 510, 931	48.00 49.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) Part B Medicare GME payment (line 47 x 48) (title XVIII only)	. ,		288, 467	
50.00	Irai to medicale GME payment (THE 47 x 40) (LITE XVIII ONLY)	(See THSTINCTIONS)	I	200, 407	50.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019		pare
		General Fund	Specific Purpose Func			
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	44, 535, 838		0 0	0	1.
00	Temporary investments	316, 214, 676		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	139, 079, 903		0 0	0	4
00	Other receivable	451, 725, 089		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-71, 780, 924		0 0	0	
00	Inventory	7, 651, 836		0 0	0	
00	Prepaid expenses	5, 390, 731		0 0	0	
00 . 00	Other current assets Due from other funds	100		0 0	0	
. 00	Total current assets (sum of lines 1-10)	892, 817, 249		0 0	0	
. 00	FIXED ASSETS	072,017,247		<u> </u>	0	1
. 00	Land	16, 281, 439		0 0	0	12
. 00	Land improvements	13, 517, 691		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	14
. 00	Bui I di ngs	311, 331, 989		0 0	0	15
. 00	Accumulated depreciation	-155, 901, 003		0 0	0	
. 00	Leasehold improvements	12, 979, 130		0 0	0	
. 00	Accumulated depreciation	-5, 923, 221		0 0	0	
	Fixed equipment	2, 180, 808		0 0	0	
. 00 . 00	Accumulated depreciation Automobiles and trucks	-1, 628, 181 0		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
	Major movable equipment	172, 254, 105		0 0	0	
. 00	Accumulated depreciation	-139, 291, 865		0 0	0	
. 00	Minor equipment depreciable	0		0 0	0	25
. 00	Accumulated depreciation	0		0 0	0	26
. 00	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	
. 00	Minor equipment-nondepreciable	0		0 0	0	
. 00	Total fixed assets (sum of lines 12-29)	225, 800, 892		0 0	0	30
. 00	OTHER ASSETS Investments	0		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	
. 00	Due from owners/officers	0		0 0	0	
. 00	Other assets	73, 383, 344		0 0	0	
. 00	Total other assets (sum of lines 31-34)	73, 383, 344		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	1, 192, 001, 485		0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	21, 723, 763		0 0	0	
	Salaries, wages, and fees payable	15, 303, 102		0 0	0	
. 00	Payroll taxes payable	0		0 0	0	
. 00	Notes and Loans payable (short term)	9, 843, 148		0 0	0	
. 00 . 00	Deferred income Accelerated payments	3, 283, 592		0 0	0	41
. 00	Due to other funds	3, 203, 372		0 0	0	
. 00	Other current liabilities			0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	50, 153, 605		0 0		
	LONG TERM LIABILITIES		1	-1 -1	-	
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	235, 798, 109		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	48
. 00	Other long term liabilities	3, 000, 229		0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	238, 798, 338		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	288, 951, 943		0 0	0	51
00	CAPITAL ACCOUNTS	002 040 542				1 6 2
00	General fund balance	903, 049, 542		0	1	52
. 00	Specific purpose fund Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - restricted			0		55
. 00	Governing body created - endowment fund balance			0	1	56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				-	
		903, 049, 542	1	0 0	0	59
. 00 . 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1, 192, 001, 485		0 0	0	

STATE	Financial Systems REID MENT OF CHANGES IN FUND BALANCES	HOSPITAL & HEAL	Provider CC	CN: 15-0048	Period: From 01/01/2019 To 12/31/2019		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00 787,785,815	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		206, 394, 683				2.00
3.00	Total (sum of line 1 and line 2)		994, 180, 498		0		3.00
4.00	Additions (credit adjustments) (specify)	0	,,		0	0	
5.00		0			0	0	
5.00		0			0	0	6.00
7.00		0			0	0	7.00
3.00		0			0	0	
9.00		0			0	0	
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		994, 180, 498		0		11.0
12.00 13.00	Deductions (debit adjustments) (specify) AMOUNTS INCLUDED IN HO COST REPORT	01 120 05(0	0	12.0
14.00	AMOUNTS INCLUDED IN HU CUST REPORT	91, 130, 956			0	0	
14.00		0			0	0	
16.00		0			0	0	16.0
17.00		0			0	0	17.00
18.00	Total deductions (sum of lines 12-17)		91, 130, 956		0		18.00
19.00	Fund balance at end of period per balance		903, 049, 542		0		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4.0
5.00 5.00			0				5.0
7.00			0				7.0
3.00			0				8.0
7.00			0				9.0
0.00	Total additions (sum of line 4-9)	0			0		10.0
1.00	Subtotal (line 3 plus line 10)	0			0		11.0
2.00	Deductions (debit adjustments) (specify)		0				12.0
3.00	AMOUNTS INCLUDED IN HO COST REPORT		0				13.0
14.00			0				14.0
			0				15.00
15.00			0				16.00
15. 00 16. 00				1	1		17.00
15. 00 16. 00 17. 00	Tatal deductions (our of Linco 12, 17)		0		0		10 00
15. 00 16. 00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance	0	0		0		18.00

ATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0048		: 1/01/2019 2/31/2019		pared
	Cost Center Description		Inpati ent	0ut	pati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
00	Hospi tal		61, 030, 6	21		61, 030, 621	1. (
00	SUBPROVIDER - IPF		9, 860, 6	48		9, 860, 648	2.0
00	SUBPROVIDER - IRF		4, 688, 7	30		4, 688, 780	3.
00	SUBPROVI DER						4.
00	Swing bed - SNF			0		0	5.
00	Swing bed - NF			0		0	6.
00	SKILLED NURSING FACILITY						7.
00	NURSING FACILITY						8.
00	OTHER LONG TERM CARE						9.
), 00	Total general inpatient care services (sum of lines 1-9)		75, 580, 0	49		75, 580, 049	10.
	Intensive Care Type Inpatient Hospital Services						
. 00	INTENSIVE CARE UNIT		11, 777, 2	95		11, 777, 295	111.
2.00	CORONARY CARE UNI T						12.
3.00	BURN INTENSIVE CARE UNIT						13.
1.00	SURGI CAL I NTENSI VE CARE UNI T						14.
	OTHER SPECIAL CARE (SPECIFY)						15.
	Total intensive care type inpatient hospital services (sum of l	ines	11, 777, 2	95		11, 777, 295	
	11-15)						
. 00	Total inpatient routine care services (sum of lines 10 and 16)		87, 357, 3	44		87, 357, 344	17.
3. 00	Ancillary services		285, 895, 3		4, 700, 792		
	Outpatient services		22, 648, 2		1, 235, 447	93, 883, 705	
). 00	RURAL HEALTH CLINIC			0	0		
. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		
2.00	HOME HEALTH AGENCY			-	-	-	22.
3.00	AMBULANCE SERVICES						23.
1.00	CMHC						24.
5.00	AMBULATORY SURGICAL CENTER (D. P.)						25.
5.00	HOSPICE			0	5, 420, 528	5, 420, 528	
7.00	OTHER		3, 132, 3		1, 748, 061	4, 880, 382	
3.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst	399, 033, 2		3, 104, 828		
. 00	G-3, line 1)	o mor	077,000,2	, 0 00	0, 101, 020	/02, 100, 101	20.
	PART II - OPERATING EXPENSES	I				I	
9.00	Operating expenses (per Wkst. A, column 3, line 200)			28	1, 251, 567		29.
). 00	ADD (SPECIFY)			0			30.
. 00				0			31.
2.00				0			32.
3.00				0			33.
1.00				0			34.
5.00				0			35.
5.00	Total additions (sum of lines 30-35)				0		36.
7.00	DEDUCT (SPECIFY)			0	Ū		37.
. 00 3. 00				0			38.
00				0			39.
. 00				0			40.
. 00				0			41.
2.00	Total deductions (sum of lines 37–41)			J	0		41.
2.00 3.00		(transfor		20	1 251 547		42.
b. UU	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(cranster		28	1, 251, 567		43.

	Financial Systems REID HOSPITAL & HEALT			u of Form CMS-2	
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0048	Period: From 01/01/2019	Worksheet G-3	
			To 12/31/2019		pared:
				6/8/2020 3:16	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		962, 138, 101	1.00
2.00	Less contractual allowances and discounts on patients' accounts			541, 733, 194	2.00
3.00	Net patient revenues (line 1 minus line 2)			420, 404, 907	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		281, 251, 567	
5.00	Net income from service to patients (line 3 minus line 4)			139, 153, 340	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			55, 170, 508	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			396, 923	13.00
14.00	Revenue from meals sold to employees and guests			3, 940, 191	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			20, 000	17.00
18.00	Revenue from sale of medical records and abstracts			300	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			68, 434	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			13, 739	21.00
22.00	Rental of hospital space			6, 294, 493	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			1, 336, 755	24.00
25.00	Total other income (sum of lines 6-24)			67, 241, 343	25.00
	Total (line 5 plus line 25)			206, 394, 683	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			206, 394, 683	29.00

Heal	th	Fi	nan	ci al	Sys	tems	
ΔΝΔΙ	VS	15	OF	HUCD		-BASED	HUSDI CE

REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048 Period:

In Lieu of Form CMS-2552-10 Worksheet O

ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CC		eriod:	Worksheet 0	
				I FI	rom 01/01/2019		
			Hospi ce CCN			Date/Time Pre 6/8/2020 3:16	
					Hospi ce I		
		SALARI ES		SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FIXT*		900	900	- 900	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		2, 126	2, 126	0	2, 126	2.00
3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT* ADMINISTRATIVE & GENERAL*	0 608, 933	72, 284 36, 241	72, 284 645, 174	24, 836 14, 629	97, 120 659, 803	3.0 4.0
5.00	PLANT OPERATION & MAINTENANCE*	000, 935	30, 241	043, 174	14, 02 9	037,003	5.0
6.00	LAUNDRY & LINEN SERVICE*	0	o	0	0	0	6.00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7.00
8.00	DI ETARY*	0	2, 782	2, 782	0	2, 782	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	101, 294	101, 294	0	101, 294	12.00
13.00 14.00	VOLUNTEER SERVICE COORDINATION* PHARMACY*	0	0 108, 447	0 108, 447	0	0 108, 447	13.00 14.00
14.00	PHARMACT PHYSICIAN ADMINISTRATIVE SERVICES*	0	106, 447	106, 447	0	108, 447	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	, i i i i i i i i i i i i i i i i i i i	Ĵ	0	Ū	Ũ	17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSI CI AN SERVI CES**	0	186, 702	186, 702	0	186, 702	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGI STERED NURSE**	206, 011	0	206, 011	192, 903	398, 914	28.00
29.00		63, 551	0	63, 551	76, 549	140, 100	29.00
30. 00 31. 00	PHYSI CAL THERAPY** OCCUPATI ONAL THERAPY**	0	0	0	0	0	30.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	31.00 32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG**	0	0	0	0	0	35.0
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	84, 419	0	84, 419	56, 136	140, 555	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	I MAGI NG SERVI CES**	0	0	0	0	0	40.00
41.00	LABS & DI AGNOSTI CS**	0	141 004	141 004	0	0	41.0
42.00 42.50	MEDICAL SUPPLIES-NON-ROUTINE** DRUGS CHARGED TO PATIENTS**	0	141, 094	141, 094	24, 486	165, 580 0	42.00
42.50	OUTPATIENT SERVICES**	0	0	0	0	0	42.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	526, 772	526, 772	0	526, 772	46.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	
62.00	FUNDRAI SI NG*	0	0	0	0	0	62.0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00 65.00	PALLI ATI VE CARE PROGRAM* OTHER PHYSI CI AN SERVI CES*	0	0	0	0	0	64.0 65.0
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.0
67.00	ADVERTI SI NG*	0	0	0	0	0	67.0
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	
69. 00	THRI FT_STORE*	0	0	0	0	0	69.0
70.00	NURSING FACILITY ROOM & BOARD*	0	o	0	Ő	0	70.0
	OTHER NONREI MBURSABLE (SPECI FY)*	0	0	0	0	0	71.0
				2, 141, 556	388, 639		100.00

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Heal th	Fi	nar	ici al	Sys	tems		
ANIAL VS	15	OF	HUCD	ΙΤΛΙ	-BASED	HUSDI	CE

In Lieu of Form CMS-2552-10

IALYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0048	Period: From 01/01/2019	Worksheet O
			Hospi ce CCN:	15-1524	To 12/31/2019	Date/Time Prepare 6/8/2020 3:16 pm
					Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5			
		6.00	<u>± col. 6)</u> 7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
00	CAP REL COSTS-BLDG & FIXT*	0	0			1.
00	CAP REL COSTS-DEDG & TTXT	0				2.
00	EMPLOYEE BENEFITS DEPARTMENT*	-717	96, 403			3.
00	ADMI NI STRATI VE & GENERAL*	0	659, 803			4.
00	PLANT OPERATION & MAINTENANCE*	0	037,003			5.
00	LAUNDRY & LINEN SERVICE*	0	Ő			6.
00	HOUSEKEEPING*	0	0			7.
00	DI ETARY*	0	2, 782			8.
. 00	NURSI NG ADMI NI STRATI ON*	0	0			9.
0. 00	ROUTINE MEDICAL SUPPLIES*	0	0			10.
1.00	MEDI CAL RECORDS*	0	0			11.
2.00	STAFF TRANSPORTATION*	0	101, 294			12.
3.00	VOLUNTEER SERVICE COORDINATION*	0	0			13.
4.00	PHARMACY*	0	108, 447			14.
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15.
6. 00	OTHER GENERAL SERVICE*	0	0			16.
7.00	PATIENT/RESIDENTIAL CARE SERVICES					17.
	DIRECT PATIENT CARE SERVICE COST CENTERS					
5.00	INPATIENT CARE-CONTRACTED**	0	0			25.
6.00	PHYSICIAN SERVICES**	0	186, 702			26.
7.00	NURSE PRACTITIONER**	0	0			27.
8.00	REGI STERED NURSE**	0	398, 914			28.
9.00	LPN/LVN**	0	140, 100			29.
0.00	PHYSI CAL THERAPY**	0	0			30.
1.00	OCCUPATIONAL THERAPY**	0	0			31.
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0			32.
3.00	MEDICAL SOCIAL SERVICES**	0	0			33.
4.00	SPIRITUAL COUNSELING**	0	0			34.
5.00	DI ETARY COUNSELI NG**	0	0			35.
6.00	COUNSELING - OTHER**	0				36.
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	140, 555			37.
8.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0			38.
9.00	PATIENT TRANSPORTATION**	0	0			39.
0.00	I MAGI NG SERVI CES** LABS & DI AGNOSTI CS**	5	0			40.
1.00 2.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	165, 580			41. 42.
2.00	DRUGS CHARGED TO PATIENTS**	0	105, 560			42.
3.00	OUTPATIENT SERVICES**	0	0			42.
4.00	PALLIATIVE RADIATION THERAPY**	0	0			43.
5.00	PALLIATIVE CHEMOTHERAPY**	0	0			44.
6.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0				45.
0.00	NONREI MBURSABLE COST CENTERS		020///2			
0. 00	BEREAVEMENT PROGRAM *	0	0			60.
1.00	VOLUNTEER PROGRAM *	0	0			61.
2.00	FUNDRAI SI NG*	0	0			62.
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0			63.
4.00	PALLIATIVE CARE PROGRAM*	0	0			64.
	OTHER PHYSICIAN SERVICES*	0	0			65.
6.00	RESI DENTI AL CARE*	0	0			66.
7.00	ADVERTI SI NG*	0	o			67.
B. 00	TELEHEALTH/TELEMONI TORI NG*	0	o			68.
9.00	THRI FT STORE*	0	0			69.
	NURSING FACILITY ROOM & BOARD*	0	0			70.
1. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0			71.
00 00	TOTAL	-717	2, 529, 478			100.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

		HOSPI TAL & HEAL				u of Form CMS-:	
	S OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E ROUTINE HOME	Provider CO	CN: 15-0048	Peri od:	Worksheet 0-2	
CARE			Hospi ce CCI	N: 15-1524	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	IRECT PATIENT CARE SERVICE COST CENTERS						
	NPATIENT CARE-CONTRACTED						25.00
	PHYSI CI AN SERVI CES	0	186, 702	186, 70	02 0	186, 702	
	JURSE PRACTITIONER	0	0		0 0	0	
	REGI STERED NURSE	206, 011	0	206, 0		206, 011	28.00
	_PN/LVN	63, 551	0	63, 5	51 0	63, 551	
	PHYSI CAL THERAPY	0	0		0 0	0	
	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	
	IEDI CAL SOCI AL SERVI CES	0	0		0 0	0	00.00
	SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
	DI ETARY COUNSELING	0	0		0 0	0	00.00
	COUNSELING - OTHER	0	0		0 0	0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	84, 419	0	84, 4	19 0	84, 419	
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
	MAGI NG SERVI CES	0	0		0 0	0	40.00
	ABS & DIAGNOSTICS	0	0		0 0	0	41.00
	IEDI CAL SUPPLI ES-NON-ROUTI NE	0	141, 094	141, 04		141, 094	
10 50 0	NDUCS CHADCED TO DATLENTS		0		0	<u>م</u>	10 5

42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	141,094	141, 094	0	141, 094	42.00		
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50		
43.OC	OUTPATI ENT SERVICES	0	0	0	0	0	43.00		
44. OC	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00		
45.OC	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00		
46. OC	OTHER PATIENT CARE SERVICES (SPECIFY)	0	526, 772	526, 772	0	526, 772	46.00		
100. C	O TOTAL *	353, 981	854, 568	1, 208, 549	0	1, 208, 549	100.00		
* Tra	* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.								

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
-	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25.0
26.00	PHYSI CI AN SERVI CES	0	186, 702	26.0
27.00	NURSE PRACTITIONER	0	0	27.0
28.00	REGI STERED NURSE	0	206, 011	28.0
29.00	LPN/LVN	0	63, 551	29.0
30.00	PHYSI CAL THERAPY	0	0	30.0
31.00	OCCUPATIONAL THERAPY	0	0	31.0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.0
33.00	MEDICAL SOCIAL SERVICES	0	0	33. 0
34.00	SPI RI TUAL COUNSELI NG	0	0	34.0
35.00	DI ETARY COUNSELI NG	0	0	35. 0
36.00	COUNSELING - OTHER	0	0	36.0
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	84, 419	37.0
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.0
39.00	PATI ENT TRANSPORTATI ON	0	0	39.0
40.00	I MAGI NG SERVI CES	0	0	40. 0
41.00	LABS & DIAGNOSTICS	0	0	41. C
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	141, 094	42.0
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.5
43.00	OUTPATI ENT SERVICES	0	0	43.0
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. C
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. C
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	526, 772	
100.00	TOTAL *	0	1, 208, 549	100. C

Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Health Financial Systems	REID HOSPITAL & HEAL				u of Form CMS-	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS F	OR HOSPICE INPATIENT	Provider CCN		Period:	Worksheet 0-3	
RESPI TE CARE		Hospice CCN:		From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
			10 1021	12/01/2017	6/8/2020 3:16	
				Hospi ce I		
	SALARI ES	OTHER S	UBTOTAL (col.	RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CE	NTERS					
25.00 INPATIENT CARE-CONTRACTED		0	(0 0	0	
26.00 PHYSI CI AN SERVI CES	0	0	(0 0	0	26.00
27.00 NURSE PRACTITIONER	0	0	(0 0	0	27.00
28.00 REGI STERED NURSE	0	0	(23, 997		28.00
29.00 LPN/LVN	0	0	(9, 523	9, 523	29.00
30. 00 PHYSI CAL THERAPY	0	0	(0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0	(0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	(0 0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0	(0 0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0	(0 0	0	34.00
35.00 DI ETARY COUNSELI NG	0	0	(0 0	0	35.00
36.00 COUNSELING - OTHER	0	0	(0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	(6, 983	6, 983	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	(o o	0	38.00
39.00 PATIENT TRANSPORTATION	0	0	(0 0	0	39.00
40.00 I MAGI NG SERVI CES	0	O	(0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	(o o	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	(3, 046	3, 046	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	42.50
43.00 OUTPATIENT SERVICES	0	0	(0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	(0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	(0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIF	Y) 0	0	(0 0	0	46.00
100.00 TOTAL *	0	0	(43, 549	43, 549	100.00
* Transfer the amount in column 7 to Wkst.	0-5. column 1. line 52	•				

		ADJUSTMENTS	TOTAL (col. 5		
		(00	± col. 6)		
		6.00	7.00		
	DI RECT PATIENT CARE SERVICE COST CENTERS	1	1		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	23, 997		28.00
29.00	LPN/LVN	0	9, 523		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE ALDE & HOMEMAKER SERVICES	0	6, 983		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39,00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	0		41.00
	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	3, 046		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0,010		42.50
43.00	OUTPATI ENT SERVICES	0	0		43.00
	PALLIATIVE RADIATION THERAPY		0		44.00
	PALLI ATI VE CHEMOTHERAPY		0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)				45.00
	TOTAL *		43, 549		48.00
			43, 549		00.00
* Iran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52.			

26.00 PHYSICIAN SERVICES 0 0 0 0 26.00 27.00 NURSE PRACTITIONER 0 0 0 27.00 28.00 REGISTERED NURSE 0 0 0 168,906 28.00 29.00 LPN/LVN 0 0 0 67.026 67.026 29.00 30.00 PHYSICAL THERAPY 0 0 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 33.00 33.00 MEDICAL SERVICES 0 0 0 0 33.00 34.00 SPIRITUAL COUNSELING 0 0 0 0 34.00 35.00 DIETARY COUNSELING 0 0 0 0 35.00 37.00 HOSPICE ALDE & HOMEMAKER SERVICES 0 0 0 36.00 38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN 0 0 0 0 37.00 38.00 DURABLE MEDICAL	Heal th	Financial Systems REID	HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
International Hospice CN: 15-1524 To 12/31/2019 Date/Time Prepared 6/8/2020 3: 16 pm SALARI ES OTHER SUBTOTAL Col. RECLASSI FI- CATIONS SUBTOTAL 1.00 2.00 3.00 4.00 5.00 25.00 INPATIENT CARE SERVICE COST CENTERS 0 0 0 0 25.00 26.00 PHYSI CI AN SERVI CES 0 0 0 0 27.00 26.00 PHYSI CI AN SERVI CES 0 0 0 0 27.00 29.00 LPN/LVN 0 0 0 0 0 27.00 29.00 LPN/LVN 0 0 0 0 0 0 30.00 31.00 OCUPATIONAL THERAPY 0 0 0 0 0 30.00 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 30.00 31.00 32.00 33.00 33.00 33.00 33.00 33.00 33.00			E GENERAL	Provider C	CN: 15-0048			
Constraint Constraint <thconstraint< th=""> Constraint Constrai</thconstraint<>	I NPATI	ENT CARE		Hospice (()	N· 15_1524			nared
DIRECT PATIENT CARE SERVICE COST CENTERS SALARI ES OTHER SUBTOTAL (col. 1 + col. 2) RECLASSIFI- CATIONS SUBTOTAL 25.00 INPATIENT CARE-CONTRACTED 0 0 0 0 0 0 25.00 26.00 PHYSICIAN SERVICES 0 0 0 0 0 27.00 28.00 REGISTERED NURSE 0 0 0 0 27.00 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 27.00 0 0 0 0 0 27.00 0 0 0 27.00 0 0 0 0 0 0 0 0 0 0 0 0 0 <					N. 10 1024	10 12/31/2017	6/8/2020 3: 16	parea.
DIRECT PATIENT CARE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 25.00 INPATIENT CARE SERVICE COST CENTERS 0 0 0 0 25.00 26.00 PHYSICIAN SERVICES 0 0 0 0 25.00 26.00 PHYSICIAN SERVICES 0 0 0 0 27.00 28.00 REGISTERED NURSE 0 0 0 0 27.00 29.00 LPM/LWN 0 0 0 0 0 27.00 30.00 PHYSICAL THERAPY 0 0 0 0 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 0 0 30.00 31.00 0 0 0 0 33.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 0 33.00 33.00 MEDI CAL SOCI AL SERVICES 0 0 0 33.00 35.00 DI ETARY COUNSELI NG <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
DI RECT PATI ENT CARE SERVI CE COST CENTERS 0 1.00 2.00 3.00 4.00 5.00 25.00 INPATI ENT CARE-CONTRACTED 0 0 0 0 25.00 26.00 PHYSI CI AN SERVI CES 0 0 0 0 26.00 26.00 PHYSI CI AN SERVI CES 0 0 0 0 26.00 27.00 NURSE PRACTI TI ONER 0 0 0 0 27.00 0 66.906 28.00 REGI STERED NURSE 0 0 0 0 27.02 0 18.906 168.906 28.00 29.00 19.11VLN 0			SALARI ES	OTHER			SUBTOTAL	
DI RECT PATI ENT CARE SERVICE COST CENTERS 25.00 INPATI ENT CARE-CONTRACTED 0 0 0 25.00 26.00 PHYSI CI AN SERVICES 0 0 0 0 26.00 26.00 PHYSI CI AN SERVICES 0 0 0 0 26.00 27.00 NURSE PRACTI TI ONER 0 0 0 0 27.00 28.00 REGI STERED NURSE 0 0 0 0 27.00 29.00 LPN/LVN 0 0 0 67.026 67.026 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 31.00 0 0 0 31.00 0 0 0 0 31.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 0 34.00 35.00 0 0 0 0 0								
25.00 INPATIENT CARE-CONTRACTED 0 0 0 0 25.00 26.00 PHYSI CIAN SERVICES 0 0 0 0 26.00 27.00 NURSE PRACTITIONER 0 0 0 0 27.00 28.00 REGISTERED NURSE 0 0 0 0 27.00 29.00 LPN/LVM 0 0 0 67.026 67.026 29.0 30.00 PHYSI CAL THERAPY 0 0 0 0 30.0 31.00 OCCUPATIONAL THERAPY 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 31.00 33.00 MEDI CAL SOCIAL SERVICES 0 0 0 32.0 34.00 SPI RI TUAL COUNSELING 0 0 0 33.0 35.00 DI ETARY COUNSELING 0 0 0 35.0 36.00 COUNSELING 0 0 0 0 36.00 37.00 HOBEN & HOMEMAKER SERVICES 0 0 0 0<		Γ	1.00	2.00	3.00	4.00	5.00	
26.00 PHYSI CI AN SERVI CES 0 0 0 0 26.00 27.00 NURSE PRACTI TI ONER 0 0 0 0 27.00 28.00 REGI STERED NURSE 0 0 0 168,906 168,906 28.00 29.00 LPN/LW 0 0 0 67,026 67,026 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 30.0 31.00 OCUPATIONAL THERAPY 0 0 0 31.00 31.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 33.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 33.00 34.00 SPI RI TUAL COUNSELING 0 0 0 33.00 0 34.00 35.00 0 0 0 0 35.00 0 0 0 0 0 36.00 0 0 0 36.00 0 0 0 0 37.00 0 0 0			II		1			
27.00 NURSE PRACTITIONER 0 0 0 27.00 28.00 REGISTERED NURSE 0 0 168,906 28.00 29.00 LPN/LVN 0 0 67,026 67,026 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 0 0 31.00 32.00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 32.00 33.00 MEDI CAL SOCIAL SERVI CES 0 0 0 33.00 33.00 33.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 35.00 0 0 0 0 35.00 0 0 0 0 35.00 0 36.00 0 0 0 36.00 36.00 0 0 0 36.00 0 0 0 36.00 0 0 0 36.00 0 0 0 37.00 38.00 0 0 0<				0)	0 0	-	
28.00 REGISTERED NURSE 0 0 168,906 168,906 28.0 29.00 LPN/LVN 0 0 67,026 67,026 29.0 30.00 PHYSICAL THERAPY 0 0 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 33.0 34.00 SPI RI TUAL COUNSELI NG 0 0 0 0 33.0 35.00 DI ETARY COUNSELI NG 0 0 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 0 0 35.00 0 37.00 40591 CE AL EQUI PMENT/OXYGEN 0 0 0 38.00 37.00 39.00 PATI ENT TRANSPORTATION 0 0 0 39.00 9.00 PATI ENT TRANSPORTATION <td></td> <td></td> <td>0</td> <td>0</td> <td>)</td> <td>0 0</td> <td>-</td> <td></td>			0	0)	0 0	-	
29.00 LPN/LVN 0 0 67,026 67,026 29.0 30.00 PHYSI CAL THERAPY 0 0 0 30.0 31.00 OCCUPATI ONAL THERAPY 0 0 0 30.0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 31.0 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 31.0 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 33.0 34.00 SPIRI TUAL COUNSELI NG 0 0 0 34.0 35.00 DI ETARY COUNSELI NG 0 0 0 35.0 36.00 COUNSELI NG - OTHER 0 0 0 36.0 37.00 HOESPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 38.0 0LRABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 38.0 0LMABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 39.0 37.00 IMAGI NG SERVICES 0 0 0 0 39.0 38.00 DUR			0	0		0 0	-	
30.00 PHYSI CAL THERAPY 0 0 0 0 30.00 31.00 OCCUPATI ONAL THERAPY 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 33.00 34.00 SPI RI TUAL COUNSELING 0 0 0 0 34.00 35.00 DI ETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 35.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 38.00 0 0 0 38.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 39.00 40.00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 42.00 MEDI CAL SUPPLI ES-			0	0)			
31.00 OCCUPATIONAL THERAPY 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 33.0 34.00 SPI RI TUAL COUNSELI NG 0 0 0 33.0 35.00 DI ETARY COUNSELI NG 0 0 0 34.0 35.00 DI ETARY COUNSELI NG 0 0 0 34.0 36.00 COUNSELI NG - OTHER 0 0 0 35.0 36.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 36.0 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 38.0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38.0 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 40.00 IMAGI NG SERVI CES 0 0 0 0 40.0 41.00 LABS & DI AGNOSTI CS 0 0 0 0 41.0			0	0		0 67, 026	67, 026	
32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32.00 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 0 35.00 36.00 COUNSELI NG - OTHER 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 38.00 40.00 IMAGI NG SERVI CES 0 0 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 42.00 43.00 OUTPAT ENT SERVI CES 0 0 0			0	0		0 0	0	
33.00 MEDI CAL SOCI AL SERVICES 0 0 0 33.00 34.00 SPI RI TUAL COUNSELI NG 0 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 0 34.00 35.00 DI ETARY COUNSELI NG 0 0 0 35.00 36.00 COUNSELI NG 0 0 0 35.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 38.00 40.00 IMAGI NG SERVI CES 0 0 0 0 0 39.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 42.00 43.00 OUTPATI ENT SERVI CES 0 0 0 0 0 42.00 43.00 OUTPATI ENT SERVI CES 0<	31.00	OCCUPATIONAL THERAPY	0	0)	0 0	0	31.00
34.00 SPIRITUAL COUNSELING 0 0 0 34.00 34.00 35.00 DI ETARY COUNSELING 0 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 49,153 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 38.00 40.00 IMAGI NG SERVI CES 0 0 0 0 38.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 42.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 42.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42.00 43.00 OUTPATI ENT SERVI CES 0 0 0 0 42.50	32.00		0	0)	0 0	0	32.00
35.00 DI ETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 36.00 37.00 HOSPI CE AIDE & HOMEMAKER SERVI CES 0 0 0 49,153 37.0 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 38.0 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 38.0 40.00 IMAGI NG SERVI CES 0 0 0 0 39.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 0 40.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 41.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 42.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 43.00 45.00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 44.00	33.00	MEDICAL SOCIAL SERVICES	0	0)	0 0	0	33.00
36.00 COUNSELING - OTHER 0 0 0 36.00 36.00 36.00 36.00 36.00 37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 0 49,153 37.00 37.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 39.00 240.00 IMAGING SERVICES 0 0 0 0 39.00 240.00 1MAGING SERVICES 0 0 0 0 39.00 240.00 1MAGING SERVICES 0 0 0 0 39.00 240.00 240.00 240.00 240.00 240.00 240.00 241.00 21,440 21,440 21,440 21,440 22.50 21,440 21,440 21,440 22.50 23.00 0 0 0 0 24.55 24.50 24.50 24.50 24.50 24.00 24.50 24.00 24.50 24.50 24.00 24.50 24.00 24.50 24.50 24.50	34.00	SPI RI TUAL COUNSELI NG	0	0)	0 0	0	34.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 0 49,153 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 38.00 40.00 IMAGING SERVICES 0 0 0 0 39.00 41.00 LABS & DI AGNOSTICS 0 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42.50 21,440 21,440 42.50 43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 42.50 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00	35.00	DI ETARY COUNSELING	0	0		0 0	0	35.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 38.00 39.00 PATIENT TRANSPORTATION 0 0 0 0 39.00 40.00 IMAGING SERVICES 0 0 0 0 0 39.00 41.00 LABS & DI AGNOSTICS 0 0 0 0 40.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 21,440 21,440 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 44.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
39.00 PATIENT TRANSPORTATION 0 0 0 39.00 40.00 IMAGING SERVICES 0 0 0 0 40.00 41.00 LABS & DIAGNOSTICS 0 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 21,440 21,440 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 42.01 43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 43.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 49, 153	49, 153	37.00
40.00 IMAGING SERVICES 0 0 0 0 40.00 41.00 LABS & DIAGNOSTICS 0 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 21,440 21,440 42.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 0 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 42.00 43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 44.00 45.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 45.00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
41.00 LABS & DI AGNOSTICS 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 21,440 21,440 42.00 42.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 42.50 43.00 OUTPATI ENT SERVICES 0 0 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 44.00 45.00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATI ENT CARE SERVICES (SPECI FY) 0 0 0 0 46.00	39.00	PATIENT TRANSPORTATION	0	0		0 0	0	39.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 21,440 21,440 42.0 42.50 DRUGS CHARGED TO PATI ENTS 0 0 0 0 42.5 43.00 OUTPATI ENT SERVICES 0 0 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 44.00 45.00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATI ENT CARE SERVICES (SPECI FY) 0 0 0 0 46.00	40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
42.50 DRUGS CHARGED TO PATIENTS 0 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 44.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	41.00	LABS & DIAGNOSTICS	0	0		0 0	0	41.00
43.00 OUTPATIENT SERVICES 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 21, 440	21, 440	42.00
44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	43.00	OUTPATI ENT SERVICES	0	0		0 0	0	43.00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 0 46. 0	44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
	45.00	PALLIATIVE CHEMOTHERAPY	0	0)	0 0	0	45.00
100. 00 TOTAL * 0 0 0 306, 525 306, 525 100. 0	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0)	0 0	0	46.00
	100.00	TOTAL *	0	0		0 306, 525	306, 525	100.00
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.	* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1. line 53.					

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	-
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	168, 906	28.00
29.00	LPN/LVN	0	67, 026	29.00
30.00	PHYSI CAL THERAPY	0	C	30.00
31.00	OCCUPATIONAL THERAPY	0	C	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	C	34.00
35.00	DI ETARY COUNSELI NG	0	C	35.00
36.00	COUNSELING - OTHER	0	C	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	49, 153	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	21, 440	
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	C	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	306, 525	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 53.		

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0048	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION		N 15 1504	From 01/01/2019		
		Hospi ce CC	N: 15-1524	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
-				Hospi ce I	0/0/2020 3.10	pin
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
) EXPENSES FROM	1 + 2)	
				WKST B PART I	, ,	
				(see		
				instructions)		
	1		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 10, 893		1
2.00	CAP REL COSTS-MVBLE EQUIP		2, 1			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		96, 4			3.00
4.00	ADMINISTRATIVE & GENERAL		659, 8			4.00
5.00	PLANT OPERATION & MAINTENANCE			0 0		5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	-	6.00
7.00	HOUSEKEEPING			0 57, 182		1
8.00	DI ETARY		2, 7			8.00
9.00	NURSI NG ADMI NI STRATI ON			0 0	-	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 627		10.00
11.00	MEDICAL RECORDS		101.0	0 700		11.00
12.00	STAFF TRANSPORTATION		101, 2		101, 294	12.00
13.00	VOLUNTEER SERVICE COORDINATION		100 4	0	0	13.00
14.00			108, 4			14.00
15. 00 16. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE			0 0	0	15.00 16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			52, 193		
17.00	LEVEL OF CARE			52, 175	52, 175	17.00
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPI CE ROUTI NE HOME CARE		1, 208, 5		1, 208, 549	
52.00	HOSPICE INPATIENT RESPITE CARE		43, 5		43, 549	1
53.00	HOSPICE GENERAL INPATIENT CARE		306, 5		306, 525	1
00100	NONREI MBURSABLE COST CENTERS		000,0	-0	000,020	00.00
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00	RESI DENTI AL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRI FT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99.00	NEGATIVE COST CENTER			0	0	99.00
100.00	II I I I I I I I I I I I I I I I I I I		2, 529, 4	78 1, 186, 610	3, 716, 088	100.00

COST A	LLOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	SERVICE COSTS	Provider CC Hospice CCN		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part I Date/Time Prep 6/8/2020 3:16	pared:
	Descriptions	TOTAL EXPENSES	FLX	EQUI P	Hospi ce I E EMPLOYEE BENEFI TS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10, 893	10, 893				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 126		2, 12	26		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	355, 987	0		0 355, 987		3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 318, 327	10, 893		0 170, 343	1, 499, 563	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	57, 182	0		0 0	57, 182	7.00
8.00	DI ETARY	2, 782	0		0 0	2, 782	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	627	0		0 0	627	10.00
11.00	MEDI CAL RECORDS	700	0		0 0	700	11.00
12.00	STAFF TRANSPORTATION	101, 294	0		0 0	101, 294	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	255, 354	o		0 0	255, 354	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0	52, 193	
	LEVEL OF CARE		- 1		-	,	
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 208, 549			96, 700	1, 305, 249	
52.00	HOSPICE INPATIENT RESPITE CARE	43, 549	0	26		54, 877	
53.00	HOSPICE GENERAL INPATIENT CARE	306, 525	0	1, 86		386, 267	
00.00	NONREI MBURSABLE COST CENTERS	000,020		.,		000/20/	00.00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	
62.00	FUNDRALSING	0	0		0 0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD		0			0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)		_		0 0	0	
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00
17.00	INCOMENTE COST CENTER	U	0		<u> </u>		77.00

	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0048 N: 15-1524			Worksheet 0-6 Part I Date/Time Pre 6/8/2020 3:16	pared: pm
			DLANT		1	Hospi ce I		
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00		7.00	8.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL	1, 499, 563						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C	D				5.00
6.00	LAUNDRY & LINEN SERVICE	0	C	D	0			6.00
7.00	HOUSEKEEPING	38, 686	C	D		95, 868		7.00
8.00	DI ETARY	1, 882	C	D		0	4, 664	8.00
9.00	NURSING ADMINISTRATION	0	C			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	424	C			0		10.00
11.00	MEDI CAL RECORDS	474	C	D		0		11.00
12.00	STAFF TRANSPORTATION	68, 529	C	D		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C	D		0		13.00
14.00	PHARMACY	172, 757	C	D		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C	D		0		15.00
16.00	OTHER GENERAL SERVICE	0	C	D		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	35, 311	0	0		0		17.00
	LEVEL OF CARE			1				
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	883, 050						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	37, 126			0	11, 849	580	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	261, 324		ון	0	84, 019	4, 084	53.00
(0.00	NONREI MBURSABLE COST CENTERS							10.00
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00		0				0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	(0		63.00
64.00	PALLIATIVE CARE PROGRAM	0				0		64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			~	0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	0	66.00
67.00	ADVERTI SI NG	0				0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0				0		68.00
69.00	THRIFT STORE	0	C	1		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		· · · · · · · · · · · · · · · · · · ·		0	_	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	0	
99.00	NEGATIVE COST CENTER	0	l L	4	U	0	0	99.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CO Hospice CCI		Peri od: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part I Date/Time Pre 6/8/2020 3:16	pared:
					Hospi ce I		
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1, 051				10.00
11.00	MEDI CAL RECORDS	0		1, 1			11.00
12.00	STAFF TRANSPORTATION	0			169, 823		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00		0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00 17.00	OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	0			0	0	16.00 17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 169, 823	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	985			0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	8		9 0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	58		64 0		53.00
	NONREI MBURSABLE COST CENTERS			1			
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0			0	0	
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00
100.00	IOIAL	0	1, 051	1, 1	74 169, 823	0	100.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider C		Period: From 01/01/2019	Worksheet 0-6 Part I	
			Hospi ce CC	N: 15-1524	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA		TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
		14.00	SERVI CES	1/ 00	CARE SERVICES	10.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-BEDG & FIXT						2.00
2.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
	ADMINISTRATIVE & GENERAL						
4.00							4.00
5.00	PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE						5.00
6.00 7.00							6.00 7.00
	HOUSEKEEPI NG DI ETARY						1
8.00 9.00	NURSING ADMINISTRATION						8.00 9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES						9.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
12.00	VOLUNTEER SERVICE COORDINATION						12.00
14.00	PHARMACY	428, 111					14.00
14.00	PHYSICIAN ADMINISTRATIVE SERVICES	420, 111	0				15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0			87, 504		17.00
17.00	LEVEL OF CARE		I	I	07, 304		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0	169, 823	50.00
51.00	HOSPICE ROUTINE HOME CARE	401, 327			0	2, 591, 712	1
52.00	HOSPICE INPATIENT RESPITE CARE	3, 331			0 10, 882	118, 662	1
53.00	HOSPICE GENERAL INPATIENT CARE	23, 453	-		0 76,622	835, 891	1
	NONREI MBURSABLE COST CENTERS		-				
60.00	BEREAVEMENT PROGRAM	0			0	C	60.00
61.00	VOLUNTEER PROGRAM	0			0	C	
62.00	FUNDRAI SI NG	0			0	C	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	C	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	C	1
65.00	OTHER PHYSICIAN SERVICES	0			0	0	1
66.00	RESI DENTI AL CARE	0	l a		0 0	C	1
67.00	ADVERTI SI NG	0			0	Ő	1
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	
69.00	THRI FT STORE	0			0	C	69.00
70.00	NURSING FACILITY ROOM & BOARD					C	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	c		0 0	C	71.00
00 00	NEGATIVE COST CENTER				0 0	0	99.00
99.00	NEGATIVE COST CENTER	0	0		0 0	0	77.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERA	RELD HOSPITAL & HEAL	Provi der CO		Peri od:	u of Form CMS-2 Worksheet 0-6	
	TICAL BASIS	L SERVICE COSTS			From 01/01/2019	Part II	
			Hospi ce CCN	N: 15-1524	To 12/31/2019	Date/Time Pre 6/8/2020 3:16	
					Hospi ce I	0/0/2020 3.10	рш
	Cost Center Descriptions	CAP REL BLDG &		EMPLOYEE	RECONCI LI ATI ON		
		FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
		1.00	2.00	SALARIES)	4A	4.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4A	4.00	
. 00	CAP REL COSTS-BLDG & FIXT	400					1 1.
. 00	CAP REL COSTS-MVBLE EQUIP		445				2.
. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1, 303, 13	31		3.
. 00	ADMI NI STRATI VE & GENERAL	400	0	623, 56		2, 216, 525	4.
. 00	PLANT OPERATION & MAINTENANCE	0	0		0 0	0	5.
. 00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.
. 00	HOUSEKEEPING	0	0		0 0	57, 182	7.
. 00	DIETARY	0	0		0 0	2, 782	
. 00	NURSING ADMINISTRATION	0	0		0 0	0	9.
0.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	627	10.
1.00	MEDI CAL RECORDS	0	0		0 0	700	11.
2.00	STAFF TRANSPORTATION	0	0		0 0	101, 294	12.
3.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.
4.00	PHARMACY	0	0		0 0	255, 354	14.
5.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.
6.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.
7.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	52, 193	17.
	LEVEL OF CARE						
0. 00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.
1.00	HOSPICE ROUTINE HOME CARE			353, 98	31 0	1, 305, 249	51.
2.00	HOSPICE INPATIENT RESPITE CARE	0	55	40, 50	03 0	54, 877	52.
3.00	HOSPICE GENERAL INPATIENT CARE	0	390	285, 08	35 0	386, 267	53.
	NONREI MBURSABLE COST CENTERS						
0.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.
1.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.
2.00	FUNDRAI SI NG	0	0		0 0	0	62.
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.
4.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.
5.00	OTHER PHYSI CI AN SERVI CES	0	0		0 0	0	65.
6.00	RESIDENTIAL CARE	0	0		0 0	0	66.
7.00	ADVERTI SI NG	0	0		0 0	0	67.
8.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.
9.00	THRIFT STORE NURSING FACILITY ROOM & BOARD	0	0		0	0	69.
0.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	70.
	NEGATIVE COST CENTER	0	0		0	0	99.
	COST TO BE ALLOCATED (per Wkst. 0-6, Par	t I) 10, 893	2, 126	355, 98	77	1, 499, 563	
	UNIT COST MULTIPLIER	27. 232500	4. 777528			0. 676538	
01.00	UNIT GOUT MULTIFLIER	27.232300	4. ///320	0.2/31	, u	0.070000	por.

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS	Provider C	CN: 15-0048	Period:	Warkahaat 0 (
STATI STI CAL BASI S				Worksheet 0-6	
	lloopi oo CC	N. 15 1504	From 01/01/2019	Part II	norod.
	Hospi ce CC	N: 15-1524	To 12/31/2019	Date/Time Prep 6/8/2020 3:16	
			Hospi ce I	0/0/2020 3.10	_piii
Cost Center Descriptions PLANT	LAUNDRY &	HOUSEKEEPIN		NURSI NG	
OPERATION &	LINEN SERVICE			ADMI NI STRATI ON	
MAINTENANCE	(IN-FACILITY		DAYS)		
(SQUARE FEET)	DAYS)			(DIRECT NURS.	
· · · ·	, í			HRS.)	
5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
3.00 EMPLOYEE BENEFITS DEPARTMENT					3.00
4. 00 ADMI NI STRATI VE & GENERAL					4.00
5.00 PLANT OPERATION & MAINTENANCE					5.00
6.00 LAUNDRY & LINEN SERVICE					6.00
7.00 HOUSEKEEPING		4	45		7.00
8. 00 DI ETARY			0 1, 166		8.00
9. 00 NURSI NG ADMI NI STRATI ON			0	0	9.00
10. 00 ROUTI NE MEDI CAL SUPPLI ES			0	0	10.00
11. 00 MEDICAL RECORDS			0	0	11.00
12. 00 STAFF TRANSPORTATION			0	0	12.00
13. 00 VOLUNTEER SERVICE COORDINATION			0	0	13.00
14. 00 PHARMACY			0	0	14.00
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES			0	0	15.00
16. 00 OTHER GENERAL SERVICE CE			0	0	16.00
17. 00 PATIENT/RESIDENTIAL CARE SERVICES			0	0	17.00
LEVEL OF CARE	1		0		17.00
50. 00 HOSPICE CONTINUOUS HOME CARE	1			0	50.00
51. 00 HOSPICE ROUTINE HOME CARE				0	51.00
52. 00 HOSPICE INPATIENT RESPITE CARE	c		55 145		52.00
53. 00 HOSPICE GENERAL INPATIENT CARE			90 1, 021	0	53.00
NONREI MBURSABLE COST CENTERS	<u>/</u>	<u>/</u> 3`	70 1,021	0	55.00
60. 00 BEREAVEMENT PROGRAM		1	0	0	60.00
61. 00 VOLUNTEER PROGRAM			0	0	61.00
62. 00 FUNDRAISING			0	0	62.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64. 00 PALLIATI VE CARE PROGRAM			0	0	64.00
65. 00 OTHER PHYSICIAN SERVICES			0	0	65.00
66. 00 RESIDENTIAL CARE	o c		0 0	0	66,00
67. 00 ADVERTI SI NG			0 0	0	67.00
			0	0	68,00
68. 00 TELEHEALTH/TELEMONI TORI NG C 69. 00 THRI FT STORE C			0	0	69.00
70.00 NURSING FACILITY ROOM & BOARD				0	70.00
			0	0	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY) C 99.00 NEGATIVE COST CENTER	0 0		0 0	0	99.00
			40 4 4 4 4		99.00 100.00
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 0.000000	۳ ۱	1010			
101. 00junti 0031 MULTIPLIEK 0. 000000	η 0.00000	ן ∠וט. 43370	4.00000	0.00000	101.00

	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part II Date/Time Pre 6/8/2020 3:16	pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (1 (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATI O (MI LEAGE)	VOLUNTEER N SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS			•			
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE PATIENT/RESIDENTIAL CARE SERVICES	18, 637	18, 637	1, 00	0 0 0 0 0 0 0 0 0	18, 637 0 0	15.00
	LEVEL OF CARE			1		-	
50.00 51.00 52.00 53.00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREI MBURSABLE COST CENTERS	0 17, 471 145 1, 021	0 17, 471 145 1, 021		0 0 0 0 0 0 0 0	17, 471 145	51.00 52.00
	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER D COST TO BE ALLOCATED (per Wkst. 0-6, Part 1) D UNIT COST MULTIPLIER) 1, 051 0. 056393	1, 174 0. 062993	169, 82		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00

COST A	Financial Systems REID LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI		Provider C		Peri od:	u of Form CMS Worksheet O-	
	TI CAL BASI S		Hospi ce CCI		From 01/01/2019 To 12/31/2019	Part II Date/Time Pr 6/8/2020 3:1	repared
					Hospi ce I	0,0,2020 0.1	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT	Y		
		15.00	1/ 00	DAYS)			
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00			-
1.00	CAP REL COSTS-BLDG & FIXT						1.0
2.00	CAP REL COSTS-MVBLE EQUIP						2.0
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.0
4.00	ADMI NI STRATI VE & GENERAL						4.0
5.00	PLANT OPERATION & MAINTENANCE						5.0
5.00	LAUNDRY & LINEN SERVICE						6. C
. 00	HOUSEKEEPING						7.0
. 00	DI ETARY						8.0
. 00	NURSING ADMINISTRATION						9.0
0.00	ROUTI NE MEDI CAL SUPPLI ES						10. (
1.00	MEDI CAL RECORDS						11. (
2.00	STAFF TRANSPORTATION						12. (
3.00	VOLUNTEER SERVICE COORDINATION						13. (
4.00	PHARMACY						14. 0
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	18, 637					15.0
6.00	OTHER GENERAL SERVICE		0				16.0
7.00	PATIENT/RESIDENTIAL CARE SERVICES			1, 1	66		17.0
	LEVEL OF CARE	1		1			_
50.00	HOSPICE CONTINUOUS HOME CARE	0	0				50.0
51.00	HOSPICE ROUTINE HOME CARE	17, 471	0				51.0
52.00	HOSPICE INPATIENT RESPITE CARE	145	0		45		52.0
3.00	HOSPICE GENERAL INPATIENT CARE	1, 021	0	1, 0	21		53. (
0.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM		0				60. (
1.00	VOLUNTEER PROGRAM		0				61.0
2.00	FUNDRAI SI NG		0				62.
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.
4.00	PALLIATIVE CARE PROGRAM		0				64.0
5.00	OTHER PHYSICIAN SERVICES		0				65.0
6.00	RESI DENTI AL CARE	0	0		0		66. (
7.00	ADVERTI SI NG		0		-		67.0
8.00	TELEHEALTH/TELEMONI TORI NG		0				68. 0
9.00	THRI FT STORE		0				69. (
0.00	NURSING FACILITY ROOM & BOARD						70.0
1.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.
9.00	NEGATIVE COST CENTER						99. (
00.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	87, 5	04		100.0
101 00	UNIT COST MULTIPLIER	0. 000000	0. 000000	75.0463	12		101.0

near th	Financial Systems REID	HOSPI TAL & HEALT	H CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
	ONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV		Provider CC		Peri od:	Worksheet 0-7	
LEVEL C	DF CARE		Hospi ce CCN	l: 15-1524	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/8/2020 3:16	pared:
					Hospi ce I		
				Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Cc		HCHC	HRHC	HI RC	
		Part I, Col. 9 line	Ratio				
		0	1.00	2.00	3.00	4.00	
	ANCI LLARY SERVI CE COST CENTERS	II					
1.00	PHYSI CAL THERAPY	66.00	0. 651884		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 342294		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1. 248292		0 0	0	5.00
	LABORATORY	60.00	0. 177235		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 000000		0 0	0	7.00
	FAMILY PRACTICE	93.00	0.513842		0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00					9.00
10.00	ANCI LLARY - OTHER	76.00	0. 000000		0 0	0	10.00
10.97	CARDI AC REHABI LI TATI ON	76.97	0. 679794		0 0	0	10.97
11.00	Totals (sum of lines 1–11)						11.00
		Charges by LOC		Shared Servi	ice Costs by LOC		
		(from Provider					
		Records)					
	Cost Center Descriptions	HGI P HC			xHIRC (col. 1 x		
			col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVI CE COST CENTERS	T					
	PHYSI CAL THERAPY	0	0		0 0	0	
	OCCUPATIONAL THERAPY						2.00
	SPEECH PATHOLOGY						3.00
	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
	LABORATORY	0	0		0 0	0	6.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	FAMILY PRACTICE	0	0		0 0	0	
	RADI OLOGY-THERAPEUTI C						9.00
	ANCI LLARY - OTHER	0	0		0 0	0	
	CARDIAC REHABILITATION	0	0		0 0	0	
	Totals (sum of lines 1-11)	1 1	0		0 0	0	11.00

ALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider C	CN: 15-0048	Peri od:	worksheet 0-8	
		Hospi ce CCI	N: 15-1524	From 01/01/2019 To 12/31/2019		
				Hospi ce I	0/0/2020 3.10	piii
			TITLE XVIII		TOTAL	
			MEDI CARE	MEDI CAI D	TOTAL	
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0	-7, col. 6,			169, 823	1.00
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.0
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	3.0
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, li	ne 10)		0 0		4.0
. 00	Program cost (line 3 times line 4)			0 0		5.0
	HOSPICE ROUTINE HOME CARE					
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0	-7, col. 7,			2, 591, 712	6. C
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 471	7.0
. 00	Total average cost per diem (line 6 divided by line 7)				148.34	8.0
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, I	ine 11)	14, 0			9.0
0.00	Program cost (line 8 times line 9)		2, 091, 2	97 114, 964		10.0
	HOSPICE INPATIENT RESPITE CARE				1	
1. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0	-7, col. 8,			118, 662	11.0
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.0
3.00	Total average cost per diem (line 11 divided by line 12)				818.36	
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, I	ine 12)		22 1		14.0
5.00	Program cost (line 13 times line 14)		99, 8	40 818		15.0
(00	HOSPICE GENERAL INPATIENT CARE Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0	7 col 0			835, 891	1 16. C
6.00	lline 11)	-7, COL. 9,			835, 891	10.0
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				1, 021	17. C
7.00 3.00	Total average cost per diem (line 16 divided by line 17)				818.70	
	Unduplicated program days (Wkst. S-9, col. as appropriate, I	ine 13)	7	95 49		19.0
	Program cost (line 18 times line 19)	110 10)	, 650, 8			20.0
0.00	TOTAL HOSPICE CARE		0.00, 0	0, 110	1	20.0
1.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 716, 088	21 0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				18, 637	
	Average cost per diem (line 21 divided by line 22)		1		199.39	

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0048 Peri od: Worksheet L From 01/01/2019 Parts I-II Date/Time Prepared: То 12/31/2019 6/8/2020 3:16 pm Title XVIII Hospi tal PPS 1.00 PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 4, 106, 324 1.00 Model 4 BPCI Capital DRG other than outlier 1.01 Ο 1 01 2.00 Capital DRG outlier payments 140, 286 2.00 Model 4 BPCI Capital DRG outlier payments 2.01 0 2.01 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 119.81 3.00 4.00 Number of interns & residents (see instructions) 15.47 4.00 5.00 Indirect medical education percentage (see instructions) 3.71 5.00 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 152, 345 6.00 1.01) (see instructions) 7 00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 0.00 7 00 30) (see instructions) 0.00 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 9.00 Sum of lines 7 and 8 0.00 9.00 Allowable disproportionate share percentage (see instructions) 0.00 10.00 10.00 Disproportionate share adjustment (see instructions) 11.00 0 11.00 12.00 Total prospective capital payments (see instructions) 4, 398, 955 12.00 1 00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 0 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 3 00 Total inpatient program capital cost (line 1 plus line 2) 3 00 0 4.00 Capital cost payment factor (see instructions) 0 4.00 Total inpatient program capital cost (line 3 x line 4) 0 5.00 5.00 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 1.00 0 1.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 2 00 2 00 0 3.00 Net program inpatient capital costs (line 1 minus line 2) 0 3.00 Applicable exception percentage (see instructions) 0.00 4.00 4.00 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 5.00 6.00 0.00 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 7.00 Capital minimum payment level (line 5 plus line 7) 8.00 0 8.00 9.00 Current year capital payments (from Part I, line 12, as applicable) 0 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 10.00 10.00 0 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00 11.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 0 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 13.00 0

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 14.00

0 15.00

0 17.00

0 16.00

15.00 Current year allowable operating and capital payment (see instructions) 16.00 Current year operating and capital costs (see instructions)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

14.00