This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0048 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2023 Time: 11:46 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX				
	1	2	SI GNATURE STATEMENT			
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1		
2	Signatory Printed Name			2		
3	Signatory Title			3		
4	Date			4		

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
PART III -	SETTLEMENT SUMMARY						
1. 00 HOSPI TAL		0	-43, 215	805, 013	0	0	1.00
2. 00 SUBPROVI DER	: - IPF	0	63, 267	2		0	2.00
3. 00 SUBPROVI DER	: - IRF	0	8, 525	1		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	28, 577	805, 016	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1401 CHESTER BOULEVARD 1.00 PO Box: 1.00 State: IN 2.00 City: RICHMOND Zip Code: 47374 County: WAYNE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REID HOSPITAL & HEALTH 150048 99915 07/01/1966 Ν 0 3.00 1 CARE SERVICES Subprovi der - IPF SUBPROVI DER 99915 01/01/2001 4.00 15S048 4 Ν 0 4.00 5.00 Subprovi der - IRF REHAB UNIT 15T048 99915 5 01/01/2003 Р 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSPI CE 14.00 151524 99915 11/03/1993 14.00 Hospital -Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October

1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 956 640 508 103 8, 505 112 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 94 10 47 428 25.00 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 01/01/2022 12/31/2022 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N Ν N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Y 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Υ 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11: 46 am XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 60.01 23 00 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA Ν 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

<u>Heal th</u>	Financial Systems	REID HOSPITA	L & HEALTH	CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION D	ATA	Provi der CO		Period: From 01/01/2022 To 12/31/2022		pared:
					Unwei ghted FTEs Nonprovi der Si te	·	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ar FTF Pasidants in N	Johnnovi der	Sattings_	1.00	2.00	3. 00	
	period that begins on or after				- IIII's base yea	ai is your cost	reporting	
64. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	mber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	on-primary n all nonpr ed non-prim n column 3	care ovider ary care the ratio	0.0	0. 00	0. 000000	64.00
		Program Name		am Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2.	00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	65.00
	Soction EEOA of the ACA Current	Voor ETE Docidents i	n Nonnrovi	dor Cotting	1.00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n wonprovi	der Setting	JSEITECTIVE	Tor Cost report	ing periods	
66.00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (col	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	provider se ary care re 3 the rati	ttings. sident o of	0. (0. 00	0. 000000	66.00
		Program Name	Progra	am Code	Unwei ghted	Unwei ghted	Ratio (col.	
					FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
/7.00	[Fata : a and one 1 the arrange	1. 00		00	3.00	4.00	5.00	1 (7 00
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MED	1350		2.0	14. 34	0. 124007	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your Ν 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 0 76.00 Ν Ν 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adjustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES In Lieu of For

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		Peri od:	Worksheet S	-2
			From 01/01/2022 To 12/31/2022		
			V	5/23/2023 1 XIX	1:46 am
			1.00	2.00	
8.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y column 1 for title V, and in column 2 for title XIX.			Y	Y	98. 0
8.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98.0
8.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for ye	Y	Y	98. (
for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for a creimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.				N	98.
3.04 Does title V or XIX follow Medicare (title XVIII) for a C outpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	N	98.
8.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no i column 2 for title XIX.				Y	98.
8.06 Does title V or XIX follow Medicare (title XVIII) when co Pts. I through IV? Enter "Y" for yes or "N" for no in col column 2 for title XIX.			Y	Y	98.
Rural Providers			NI NI		105
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the a for outpatient services? (see instructions)	I-inclusive me	thod of paymen	t N		105. 106.
07.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in col Column 2: If column 1 is Y and line 70 or line 75 is Y,	N		107.		
approved medical education program in the CAH's excluded Enter "Y" for yes or "N" for no in column 2. (see instru 08.00 s this a rural hospital qualifying for an exception to t	N		108.		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	DI		C	D	
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	y
09.00 f this hospital qualifies as a CAH or a cost provider, a		N N	N N	N N	109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
				1 00	
for yes or "N" for no for each therapy.	tal Demonstrati	r "N" for no.	410A If yes,	1. 00 N	110.
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and	tal Demonstrati	r "N" for no.	410A If yes, ugh 215, as	N	110.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable.	tal Demonstratic "Y" for yes on Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in	Community period? Enter enter the column 2.	410A If yes, ugh 215, as		
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for	tal Demonstratic "Y" for yes on Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services.	tal Demonstrati - "Y" for yes of Worksheet E-2, I The Frontier (cost reporting column 1 is Y, participating in additional beds	Community period? Enter enter the column 2.	410A If yes, ugh 215, as	N	111.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began partidemonstration. In column 3, enter the date the hospital	tal Demonstration "Y" for yes on Worksheet E-2, In the Frontier Cost reporting column 1 is Y, participating in additional bedseed the Model reporting column 1 is cipating in the	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	111.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Health Acc Transformation (CHART) model for any portion of the currereporting period? Enter "Y" for yes or "N" for no.	tal Demonstratic "Y" for yes of Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in additional bedset alth Model reporting column 1 is cipating in the ceased ess and Rural	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	111.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Health Acc Transformation (CHART) model for any portion of the curre reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information	tal Demonstration "Y" for yes on Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in additional bedsealth Model reporting column 1 is cipating in the ceased less and Rural and cost	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	111.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Health Acc Transformation (CHART) model for any portion of the currer reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car	tal Demonstration "Y" for yes on Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in additional bedsets and Rural to cost "N" for no B, or E only) "93" percent (includes)	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	111.
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 1.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 2.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. 3.00 Did this hospital participate in the Community Health Acc Transformation (CHART) model for any portion of the currer reporting period? Enter "Y" for yes or "N" for no. Mi scellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car psychiatric, rehabilitation and long term hospitals provi the definition in CMS Pub. 15-1, chapter 22, §2208.1.	tal Demonstration of the Frontier of the Frontier of cost reporting column 1 is Y, participating in additional bedsets and Rural of the cost of the co	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	110. 1111. 112. 113.
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Ente complete Worksheet E, Part A, lines 200 through 218, and applicable. 11.00 If this facility qualifies as a CAH, did it participate i Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is Enter all that apply: "A" for Ambulance services; "B" for for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural H (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. 13.00 Did this hospital participate in the Community Health Acc Transformation (CHART) model for any portion of the curre reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term car psychiatric, rehabilitation and long term hospitals provi	tal Demonstratic "Y" for yes of Worksheet E-2, In the Frontier (cost reporting column 1 is Y, participating in additional beds and the cost "N" for no B, or E only) "93" percent (includes ders) based on "" for yes or	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	N 2. 00	111.

142.00Street. 1100 KLID FAKKWAT	ILO DOY.					1142.00
143.00 City: RICHMOND	State:	I N	Zi p Code:	4737	4	143.00
	·					
					1. 00	
144.00 Are provider based physicians' co	sts included in Wor	ksheet A?			Υ	144.00
				1. 00	2. 00	
145.00 If costs for renal services are c	laimed on Wkst. A,	line 74, are the	costs for	Υ		145.00
inpatient services only? Enter "Y	" for yes or "N" fo	or no in column 1.	. If column 1 is			
no, does the dialysis facility in			cost reporting			
period? Enter "Y" for yes or "N"	for no in column 2	<u>)</u> .				
146.00 Has the cost allocation methodolo				N		146. 00
Enter "Y" for yes or "N" for no i			pter 40, §4020) If			
yes, enter the approval date (mm/	dd/yyyy) in column	2.				

2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home

(see instructions)

140. 00

141.00

142 00

3.00

Contractor's Number: 08101

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,

office and enter the home office contractor name and contractor number.

are claimed, enter in column 2 the home office chain number.

1.00

141.00 Name: REID HOME OFFICE

142 00 Street 1100 REID PARKWAY

chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs

PO Box

Contractor's Name: WPS

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CO	CN: 15-0048	From (f: 01/01/2022 12/31/2022		epared:
						1.00	4
147.00 Was there a change in the statist	ical basis2 Enter "V" for	ves or "N" for	. no			1. 00 N	147.00
148.00 Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif				for no.		N	149.00
· · · · · · · · · · · · · · · · · · ·		Part A	Part		Title V	Title XIX	
		1.00	2.00)	3. 00	4.00	1
Does this facility contain a prov							
or charges? Enter "Y" for yes or	"N" for no for each compo	nent for Part A	and Part	B. (See	42 CFR §41		
155. 00 Hospi tal		N	N		N	N	155. 00
156. 00 Subprovi der - IPF		N	N N		N	N	156.00
157. 00 Subprovi der - IRF		N	N		N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N.			N	N.	158. 00 159. 00
160. OOHOME HEALTH AGENCY		N N	N N		N N	N N	160.00
161. OO CMHC		IN	N N		N	N N	161.00
TOT: OO CWITE			14			- IV	101.00
						1. 00	1
Mul ti campus							
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more camp	ouses in d	ifferent (CBSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	0 166. 00
						1. 00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Rei nves	tment Act			4,,,,,,,
167.00 s this provider a meaningful use 168.00 of this provider is a CAH (line 1	O5 is "Y") and is a meanir	ngful user (lin			er the	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user, doe	es Íhis provide			rdshi p		168. 01
exception under §413.70(a)(6)(ii)							01/0 00
169.00 If this provider is a meaningful transition factor. (see instruction		u is not a CAH	(Tine 105	IS N),	enter the	9. 9	9169.00
transition ractor. (See Instructi	JIIS)					Fardi are	_

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting

171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

period respectively (mm/dd/yyyy)

Endi ng

2.00

2.00

170.00

0171.00

Begi nni ng 1.00

1.00

Ν

105PI I.	Financial Systems REID HOSPITAL & HEALTH CARL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Pro		CN: 15-0048	Peri od: From 01/01/2022 To 12/31/2022		epared:
				Y/N	Date	
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT (General Instruction: Enter Y for all YES responses. Enter N for a mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the begineporting period? If yes, enter the date of the change in column	nning of 12. (see	the cost instructions	N 5)		1.0
		` `	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare Program yes, enter in column 2 the date of termination and in column 3, voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, including man- contracts, with individuals or entities (e.g., chain home office or medical supply companies) that are related to the provider or officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other sim relationships? (see instructions)	es, drug its board	Y			3. C
	rerationships: (see Thati detrons)		Y/N	Type	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Certified Accountant? Column 2: If yes, enter "A" for Audited, "C" for Color "R" for Reviewed. Submit complete copy or enter date available column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different	ompiled, e in	Y N	A	04/20/2023	4. C
	those on the filed financial statements? If yes, submit reconcil	iation.				
				Y/N	Legal Oper.	
	Annual of Chinadianal Activities			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: I the Legal operator of the program?		s the provide	er N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see instruc	ti ons.		Y		7.0
. 00	Were nursing programs and/or allied health programs approved and cost reporting period? If yes, see instructions.	l/or rene	wed during th	y Y		8.0
. 00	Are costs claimed for Interns and Residents in an approved gradu program in the current cost report? If yes, see instructions.	ate medi	cal education	Y		9.0
	Was an approved Intern and Resident GME program initiated or rencost reporting period? If yes, see instructions.	newed in	the current	Y		10.0
0. 00		in an Apı	proved	N		11.0
0. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions.					
	Are GME cost directly assigned to cost centers other than I & R				Y/N	
1. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions.				Y/N 1.00	
1. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions. Bad Debts		hi ana		1.00	10.5
1. 00 2. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions. Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see	einstruc		rost roperting	1. 00 Y	
1. 00 2. 00	Are GME cost directly assigned to cost centers other than I & R Teaching Program on Worksheet A? If yes, see instructions. Bad Debts	einstruc		cost reporting	1.00	12. C 13. C

	That detrons:					
	Bed Complement					
15.00	Did total beds available change from the prior cost report	ing period? If	yes, see instr	ructions.	N	15.00
		Par	t A	Pa	rt B	
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
47.00	date of the PS&R Report used in columns 2 and 4 (see instructions)		0.4.400.40000	.,	0.4.400.400.00	17.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2023	Y	04/03/2023	17.00
18. 00	,	N		N		18.00
19. 00	cost report? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems REID HOSPITAL & HEA	ALTH CARE SERV	CES	In Lie	u of Form CMS	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0048 F	Peri od:	Worksheet S			
				rom 01/01/2022 o 12/31/2022		renared.		
			'	0 12/31/2022	5/23/2023 1			
			i pti on	Y/N	Y/N			
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00		
20.00	Report data for Other? Describe the other adjustments:			IN	IN	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	CEPT CHILDRENS	HOSPI TALS)		1.00			
	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	e due to apprai	sals made duri	ng the cost	N	23.00		
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	and into during	this cost ron	orting poriod?	N	24. 00		
24.00	If yes, see instructions	ed Titto dall'ing	till's cost rep	or tring perrous	IN	24.00		
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period?	If yes, see	N	25.00		
	instructions.		0 .					
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period? If	yes, see	N	26. 00		
27 00	instructions.		na noriod2 lf	voo oubmi+	N	27.00		
27. 00	Has the provider's capitalization policy changed during th copy.	ie cost reporti	ng perrou? II	yes, subilli t	IN	27.00		
	Interest Expense							
28.00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	ring the cost	reporti ng	N	28.00		
	period? If yes, see instructions.		-					
29. 00	Did the provider have a funded depreciation account and/or		ebt Service Re	serve 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		dobt2 If you	500	Υ	30.00		
30.00	instructions.	see	ĭ	30.00				
31.00	Has debt been recalled before scheduled maturity without i	see	N	31.00				
	i nstructi ons.							
	Purchased Services							
32. 00			ed through con	tractual	Υ	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		ng to competit	ive hidding? If	Y	33.00		
33.00	no, see instructions.	ppireu pertaini	ng to competit	ive bruding: in	'	33.00		
	Provi der-Based Physi ci ans							
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-ba	sed physicians?	N	34.00		
	If yes, see instructions.							
35.00	If line 34 is yes, were there new agreements or amended ex		ents with the p	rovi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see i	IISTI UCTI OIIS.		Y/N	Date			
				1. 00	2. 00			
	Home Office Costs							
	Were home office costs claimed on the cost report?			Y		36.00		
37. 00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Υ		37.00		
20 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fica diffarant	from that of	N		38.00		
30.00	the provider? If yes, enter in column 2 the fiscal year er			IN		38.00		
39. 00	If line 36 is yes, did the provider render services to other			N		39.00		
2.700	see instructions.	oompe		[
40.00	If line 36 is yes, did the provider render services to the	e home office?	If yes, see			40.00		
	i nstructi ons.	1						
		1	00	2	00			
	Cost Report Preparer Contact Information 2.00							
41.00	Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00		
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	Enter the employer/company name of the cost report	FORVI S				42.00		
12 00	preparer. Enter the telephone number and email address of the cost	2172024000		KERRY. BEJARANO	@EUDVIS COM	12 00		
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834000		NLKKI. DEJAKANU	⊯IUKVIS. CUW	43.00		
	proport preparer in corumns rand z, respectivery.	1		ĺ		II		

Health Financial Systems REID HOSPITAL & HE			LTH CARE SERV	/I CES	In Lieu of Form CMS-2552-10			
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUEST	I ONNAI RE	Provi der		Peri od:	Worksheet S-2		
					From 01/01/2022			
					To 12/31/2022	Date/Time Pre 5/23/2023 11:		
	· · · · · · · · · · · · · · · · · · ·					5/23/2023 11:	46 alli	
		-						
				3. 00				
	Cost Report Preparer Contact Information						1	
41.00) Enter the first name, last name and the title/	position [DI RECTOR				41.00	
	held by the cost report preparer in columns 1,	2, and 3,						
	respectively.							
42.00	Enter the employer/company name of the cost rep	port					42.00	
	preparer.							
43 00	Enter the telephone number and email address of	f the cost					43.00	
.0. 00	report preparer in columns 1 and 2, respectivel						.5. 66	
	proport proparer in cordinas i and 2, respectives	· y ·			1		I	

Heal th Fi nancial SystemsREID HOSPITALHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | Date/Time | Prepared: | Provider CCN: 15-0048

				To	o 12/31/2022	Date/Time Pre 5/23/2023 11:	
						I/P Days /	
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.	2.00	Available	4.00	F 00	
	PART I - STATISTICAL DATA	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	153	55, 845	0.00	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	100	33, 643	0.00	U	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		153	55, 845	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	30	10, 950	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00	ŀ	44 705	0.00	0	13.00
14. 00 15. 00	Total (see instructions) CAH visits		183	66, 795	0. 00	0	14. 00 15. 00
16. 00	SUBPROVIDER - IPF	40. 00	0	9, 408		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00				0	17. 00
18. 00	SUBPROVI DER	41.00	20	7,300		O	18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00	0	0			24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	l e			0	26. 25
27. 00	Total (sum of lines 14-26)		203				27.00
28. 00	Observation Bed Days					0	28. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
30.00	Employee discount days (see Instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 00	Total ancillary labor & delivery room		0				32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00	o	0		0	34.00
	· · · · · · · · · · · · · · · · · · ·	•			'	'	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0048

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

5/23/2023 11:46 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6. 00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA 14, 946 36, 117 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 759 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 8, 287 9, 756 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 506 1.344 4.00 787 579 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 C Total Adults and Peds. (exclude observation 7.00 14.946 759 7.00 36, 117 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 1,904 101 5,037 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11 00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 96 1, 417 13.00 14.00 Total (see instructions) 16,850 956 42, 571 16. 37 1,561.64 14.00 15.00 ${\sf CAH}\ {\sf visits}$ 15.00 16.00 SUBPROVIDER - IPF 1,864 215 4,631 0.00 31.47 16.00 SUBPROVIDER - IRF 17.00 3, 810 0.00 21.30 17.00 1,643 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 1, 735 24.00 HOSPI CE 1, 390 33 0.00 27.67 24.00 HOSPICE (non-distinct part) 24.10 24.10 C 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26 25 0 Ω 0 26 25 Total (sum of lines 14-26) 1, 642. 08 27.00 16.37 27.00 28.00 Observation Bed Days 234 7, 155 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 30 00 30.00 436 31.00 Employee discount days - IRF 39 31.00 32.00 Labor & delivery days (see instructions) 0 112 175 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 0 LTCH non-covered days 33 00 33 00 33. 01 LTCH site neutral days and discharges 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0048

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

5/23/2023 11:46 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12. 00 13.00 14. 00 15.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 4,604 243 10,834 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 1, 926 2, 483 2.00 3.00 HMO IPF Subprovider 3.00 56 HMO IRF Subprovider 4 00 40 4 00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7 00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8 00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 NURSERY 13.00 13.00 Total (see instructions) 4,604 14.00 0.00 0 10,834 14.00 243 15.00 CAH visits 15 00 16.00 SUBPROVIDER - IPF 0.00 191 511 16.00 17.00 SUBPROVIDER - IRF 0.00 133 0 263 17.00 SUBPROVI DER 18.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 24.00 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0.00 26.25 Total (sum of lines 14-26) 27 00 0 00 27 00 Observation Bed Days 28.00 28.00 29.00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31 00 31 00 32.00 Labor & delivery days (see instructions) 32.00 32.01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.00 0 33.01 LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00

Provider CCN: 15-0048

Peri od:

Health Financial Systems

HOSPITAL WAGE INDEX INFORMATION

In Lieu of Form CMS-2552-10 Worksheet S-3

From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 110, 917, 961 1.00 Total salaries (see 110, 917, 961 3, 454, 965. 87 32.10 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 3 00 Non-physician anesthetist Part C 0 00 0 00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 5.00 Physician and Non C 0 0.00 0.00 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 2, 004, 328 2, 004, 328 7.00 21.00 39, 462, 79 50.79 7.00 0 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 SNF 44.00 0.00 0 00 9 00 10.00 Excluded area salaries (see 7, 484, 913 781,830 8, 266, 743 255, 237. 22 32.39 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 12, 548, 243 12, 548, 243 164, 806. 03 76. 14 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 442, 438 0 442, 438 2, 788. 25 158. 68 13.00 A - Administrative 14.00 Home office and/or related 0 0.00 0.00 14.00 0 organization salaries and wage-related costs 14.01 Home office salaries 22, 020, 964 22, 020, 964 674, 622. 05 32. 64 14.01 Related organization salaries 0.00 14.02 14.02 0.00 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 30, 895, 237 30, 895, 237 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 2, 495, 273 2, 495, 273 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 21.00 0 22.00 Physician Part A -О 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 23.00 0 23 00 24.00 Wage-related costs (RHC/FQHC) 0 24.00 25.00 Interns & residents (in an 385, 795 385, 795 25.00 approved program) 25.50 Home office wage-related 3, 932, 543 0 3, 932, 543 25.50 (core) 25.51 Related organization 0 0 25.51 wage-related (core) Home office: Physician Part A 25.52 0 0 25.52 - Administrative wage-related (core)

42.00

Social Service

43.00 Other General Service

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 234, 865 234, 865 8, 408. 00 27. 93 26.00 27.00 Administrative & General 5.00 10, 181, 587 268, 876 10, 450, 463 442, 002. 37 23.64 27.00 28. 00 6, 951, 077 6, 951, 077 102, 990. 96 67.49 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 0.00 0.00 30.00 Laundry & Linen Service 8.00 615, 011 519, 475 29, 048. 16 17. 88 31.00 31.00 -95, 536 32.00 Housekeepi ng 148, 600. 85 19. 35 32.00 9.00 2, 875, 641 2, 875, 641 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 3, 588, 455 34.00 Dietary 10.00 -2, 410, 409 1, 178, 046 59, 520. 62 19. 79 34.00 Dietary under contract (see 5, 347. 00 35.00 387, 693 387, 693 72.51 35.00 instructions) 36.00 Cafeteri a 11.00 2, 410, 409 2, 410, 409 120, 842. 68 19. 95 36.00 0.00 37.00 Maintenance of Personnel 12.00 0 0.00 37.00 Nursing Administration 13.00 323, 913 2, 080. 00 38.00 38.00 323, 913 155. 73 39.00 Central Services and Supply 14.00 609, 997 609, 997 32, 194. 01 18. 95 39.00 126, 964. 74 38.00 40.00 Pharmacy 15.00 4, 824, 693 0 4, 824, 693 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0.00 0.00 41.00

5, 086, 701

0

5, 086, 701

140, 180. 93

0.00

36. 29 42. 00

0.00 43.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

29. 43

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2022 To 12/31/2022 Part III Date/Time Prepared: 5/23/2023 11:46 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Salaries in Sal ari es 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see 1.00 118, 256, 731 -2, 004, 328 116, 252, 403 3, 523, 841. 04 32. 99 1.00 instructions) 2.00 Excluded area salaries (see 7, 484, 913 781, 830 8, 266, 743 255, 237. 22 32.39 2.00 instructions) 3.00 Subtotal salaries (line 1 110, 771, 818 -2, 786, 158 107, 985, 660 3, 268, 603. 82 33.04 3.00 minus line 2) 4.00 35, 011, 645 35, 011, 645 842, 216. 33 41.57 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs 34, 827, 780 34, 827, 780 0.00 5.00 32. 25 (see inst.) 6.00 Total (sum of lines 3 thru 5) 180, 611, 243 177, 825, 085 43. 26 6.00 -2, 786, 158 4, 110, 820. 15

35, 355, 720

497, 253

35, 852, 973

1, 218, 180. 32

Health Financial Systems
HOSPITAL WAGE RELATED COSTS REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048

		5/23/2023 11:	46 am_
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	233, 361	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	4, 133, 619	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	_	
8. 00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	18, 775, 281	8. 02
8. 03	Heal th Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	76, 055	
10.00	Dental, Hearing and Vision Plan	652, 574	
11. 00	Life Insurance (If employee is owner or beneficiary)	150, 508	
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	375, 877	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	816, 676	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	010, 070	16.00
10.00	Noncumulative portion)		10.00
	TAXES		
17 00	FICA-Employers Portion Only	8, 315, 464	17 00
18. 00	Medicare Taxes - Employers Portion Only	0,010,101	
19. 00	Unempl oyment Insurance	0	19.00
	State or Federal Unemployment Taxes	0	20.00
20.00	OTHER	U	20.00
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
21.00	instructions))		21.00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tui ti on Rei mbursement	246, 890	
	Total Wage Related cost (Sum of lines 1 -23)	33, 776, 305	
24.00	Part B - Other than Core Related Cost	33, 770, 303	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	TOTHER WIND REDITED GOOTS (GLEGTT)		25.00

Health Financial Systems REID HOSPITAL & HE	ALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0048	Peri od:	Worksheet S-3	
		From 01/01/2022 To 12/31/2022		nared·
		10 12/01/2022	5/23/2023 11:	
Cost Center Description		Contract	Benefit Cost	
		Labor		
DART M. O. Lovel I. Lovel I. D. Ci I. O. I.		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital -Based Component Identification:		10 540 040	22 77/ 205	1 00
1.00 Total facility's contract labor and benefit cost 2.00 Hospital		12, 548, 243		1.00 2.00
2. 00 Hospi tal 3. 00 SUBPROVI DER - I PF		12, 548, 243	31, 281, 032 840, 408	3.00
4. 00 SUBPROVIDER - IRF		0	611, 591	4.00
5.00 Subprovider - (Other)		0	011, 371	5. 00
6. 00 Swing Beds - SNF		0	0	6.00
7. 00 Swing Beds - NF		0	0	7. 00
8.00 SKILLED NURSING FACILITY			_	8.00
9. 00 NURSING FACILITY				9.00
10.00 OTHER LONG TERM CARE I				10.00
11.00 Hospi tal -Based HHA				11.00
12.00 AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00 Hospi tal -Based Hospi ce		0	780, 771	13.00
14.00 Hospital-Based Health Clinic RHC				14.00
15.00 Hospital-Based Health Clinic FQHC				15.00
16.00 Hospi tal -Based-CMHC				16. 00
17. 00 RENAL DIALYSIS I		0	0	17. 00
18.00 Other		0	262, 503	18. 00

Heal th	ı Financial Systems	REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION			Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-9 PARTS I THROU	GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	NG BEFORE OCT	DBER 1, 2015			
1. 00 2. 00 3. 00 4. 00	Hospice Continuous Home Care Hospice Routine Home Care Hospice Inpatient Respite Care Hospice General Inpatient Care							1.00 2.00 3.00 4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1, 2015			
6. 00	Number of patients receiving hospice care							6. 00
7. 00	Total number of unduplicated Continuous Care hours billable to Medicare							7. 00
8. 00	Average Length of Stay (line 5 / line 6)							8. 00
9. 00	Unduplicated census count			<u> </u>				9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of	
					col s. 1	
					through 3)	
		1. 00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGIN	NNING ON OR AFT	ER OCTOBER 1,	2015		
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11. 00	Hospice Routine Home Care	17, 310	86	1, 685	19, 081	11.00
12.00	Hospi ce Inpati ent Respi te Care	150	0	16	166	12.00
13.00	Hospice General Inpatient Care	1, 240	33	296	1, 569	13.00
14.00	Total Hospi ce Days	18, 700	119	1, 997	20, 816	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15. 00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16. 00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-0048	Period: From 01/01/2022 To 12/31/2022		epared			
				1. 00	\vdash			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colur	nn 8)	0. 297406	1. C			
	Medicaid (see instructions for each line)			(1.2(2.425	4			
2.00	Net revenue from Medicaid			61, 362, 425				
3.00	Did you receive DSH or supplemental payments from Medicaid?	nto from Modi	ani dO	N	3.0			
1. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Media		cai d?	0	4.0			
5. 00 5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 0 5. Medicaid charges 232,661,267 6.							
7. 00		Medical d charges Medical d cost (line 1 times line 6) 69, 194, 857						
3. 00	Difference between net revenue and costs for Medicaid program (line 7)	ninus sum of li	nes 2 and 5: if					
5. 00	<pre>< zero then enter zero)</pre>	III IIus suii 01 11	nes 2 and 5, 11	7,032,432	0. (
	Children's Health Insurance Program (CHIP) (see instructions for each I	ine)		1				
. 00	Net revenue from stand-alone CHIP	,		0	9.			
0. 00	Stand-alone CHIP charges			0				
1.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.			
2.00	Difference between net revenue and costs for stand-alone CHIP (line 11	minus line 9;	if < zero then	0	12.			
	enter zero)							
	Other state or local government indigent care program (see instructions							
3.00	Net revenue from state or local indigent care program (Not included on			0				
4. 00	Charges for patients covered under state or local indigent care program	n (Not included	d in lines 6 or	0	14.			
F 00	10)							
5.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indigent ca	one present (1)	no 15 minuo lin	0				
6.00	13; if < zero then enter zero)	are program (ri	THE TO IIII HUS TITH	Ŧ U	10.			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and s	ate/Local indi	gent care progra	ams (see				
	instructions for each line)		gont out o progra	u (000				
7. 00	Private grants, donations, or endowment income restricted to funding cl	narity care		0	17.			
8. 00	Government grants, appropriations or transfers for support of hospital	operati ons		0	18.			
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indiger 8, 12 and 16)	nt care progran	ns (sum of lines	7, 832, 432	19.			
	·	Uni nsured	Insured	Total (col. 1				
		pati ents	pati ents	+ col . 2)				
		1.00	2. 00	3. 00				
	Uncompensated Care (see instructions for each line)				4			
0. 00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1, 885, 2	01 2, 731, 332	4, 616, 533	20.			
1. 00	Cost of patients approved for charity care and uninsured discounts (sec instructions)	560, 6	70 2, 731, 332	3, 292, 002	21.			
2. 00	Payments received from patients for amounts previously written off as charity care		0 0	0	22.			
3.00	Cost of charity care (line 21 minus line 22)	560, 6	70 2, 731, 332	3, 292, 002	23			

imposed on patients covered by Medicaid or other indigent care program?

Total bad debt expense for the entire hospital complex (see instructions)

27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)

Non-Medicare bad debt expense (see instructions)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0

16, 833, 673

2, 338, 357

3, 597, 472

13, 236, 201

5, 195, 641

8, 487, 643

16, 320, 075 31. 00

25.00

26.00

27.00

27.01

28.00

29.00

30.00

25.00

26.00

stay limit

	FINANCIAL SYSTEMS REID SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HUSPITAL & HEAL	Provi der Co		Peri od:	Worksheet A	2332-10
RECEAS	STITCATION AND ADSOSTMENTS OF TRIAL DALANCE O	I LAFLINGLS	Frovider Co	F	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	To din
		1.00			,	col . 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		0	(,	22, 448, 378	1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE		0	(7, 994, 001	7, 994, 001	1. 01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	234, 865	0 30, 439	265, 30 ⁴	0	0 262, 191	2. 00 4. 00
5. 01	00540 NONPATIENT TELEPHONES	234, 603	30, 439	203, 302	-3, 113	202, 191	1
5. 02	00550 DATA PROCESSING	230, 277	2, 755, 249	2, 985, 526		2, 985, 526	1
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	75, 178 5, 930, 442	14, 695 2, 537, 038	89, 873 8, 467, 480		89, 873 8, 452, 287	1
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	268, 712	268, 712		104, 568	1
5.06	00590 OTHER A&G	3, 945, 690	22, 739, 159			26, 673, 707	5.06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 615, 011	0 629, 462	1, 244, 473	0 3 -178, 743	0 1, 065, 730	
9. 00	00900 HOUSEKEEPING	2, 875, 641	1, 081, 001	3, 956, 642		3, 956, 642	
10.00	01000 DI ETARY	3, 588, 455	4, 331, 706		-5, 295, 571	2, 624, 590	10.00
11.00	01100 CAFETERI A	0	0	(5, 294, 675	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	609, 997	5, 766, 011	6, 376, 008		323, 913 6, 376, 008	
15.00	01500 PHARMACY	4, 824, 693	40, 423, 579	45, 248, 272		45, 236, 758	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	4 000 100	0	0	
17. 00 17. 01	01700 SOCIAL SERVICE 01701 NSERVICE EDUCATION	3, 657, 098 1, 429, 603	625, 035 1, 779, 378	4, 282, 133 3, 208, 981		4, 282, 133 3, 208, 981	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	3, 200, 70		2, 089, 254	•
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRV	2, 102, 498	628, 433			641, 677	•
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	285, 110	55, 339	340, 449	9 0	340, 449	23.00
30. 00	03000 ADULTS & PEDIATRICS	25, 576, 622	13, 614, 720	39, 191, 342	-916, 328	38, 275, 014	30.00
31.00	03100 INTENSIVE CARE UNIT	4, 378, 887	2, 495, 759			6, 874, 646	1
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	2, 256, 259 1, 641, 909	376, 258 392, 860			2, 632, 517 2, 034, 769	
43.00	04300 NURSERY	599, 946	134, 931	734, 877		2, 034, 769 734, 877	1
	ANCILLARY SERVICE COST CENTERS						1
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	1, 850, 204 635, 566	53, 376, 762 289, 799			42, 388, 417 924, 445	
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 613, 073	12, 394, 544	21, 007, 617		20, 915, 260	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 221, 045	13, 056, 795	15, 277, 840	-6, 531, 538	8, 746, 302	59.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	5, 329, 975	11, 896, 662 1, 628, 414	17, 226, 637 3, 414, 982		17, 175, 518 3, 414, 045	
66.00	06600 PHYSI CAL THERAPY	1, 786, 568 8, 504, 540	2, 759, 340			11, 012, 255	1
69. 00	06900 ELECTROCARDI OLOGY	1, 440, 272	1, 643, 438	3, 083, 710	o	3, 083, 710	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	459, 280 0	154, 552 0	613, 832 (613, 088 0	1
	07200 IMPL. DEV. CHARGED TO PATTENTS	0	0	(
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(o	0	73. 00
74. 00 76. 00	07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER	532	932, 852	933, 384	0	933, 384 0	1
	07697 CARDI AC REHABI LI TATI ON	512, 214	117, 699	629, 913	-18, 854	611, 059	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	O	0	(0	0	77. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	9, 250, 890	5, 465, 466	14, 716, 356	-955, 880	13, 760, 476	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 230, 670	3, 403, 400	14, 710, 330	- 755, 660	13, 700, 470	92.00
93. 00		1, 863, 561	545, 089	2, 408, 650	-87, 405	2, 321, 245	93.00
96 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	290, 425	492, 464	782, 889	9 0	782, 889	96 00
	10200 OPI OI D TREATMENT PROGRAM	270, 429	472, 404	702,00			102.00
	SPECIAL PURPOSE COST CENTERS					_	
	11300 I NTEREST EXPENSE 11600 HOSPI CE	1, 410, 225	8, 730, 057 1, 352, 655				113.00
118.00	1 1	109, 026, 551	215, 516, 352				
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 12, 072, 334	12, 072, 33 ²		0 5, 089, 343	190.00
	07950 RENTAL SPACE	o	18, 190, 679	18, 190, 679		5, 928, 712	
	07951 FOUNDATI ON	155, 142	183, 996	339, 138		339, 138	1
	207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES	168, 485 0	25, 333 0	193, 818 (193, 818 178, 743	1
	107954 REID PHYSICIAN ASSOC.	o	ol	(0		194. 03
194. 05	07955 CONNERSVILLE LOCATION	О	1, 939, 882	1, 939, 882		1, 457, 299	194. 05
	07956 VACANT SPACE 07957 HOME OFFICE	0	756, 946	756, 94 <i>6</i>	5 -516, 387 0 0	240, 559 0	194. 06 194. 07
194.08	07958 CAMBRI DGE RHC	0	0				194.07
	07959 REID HEALTH PAVILION - RES	1, 567, 783	301, 594	1, 869, 377		1, 863, 806	

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2022		
				To 12/31/2022		
					5/23/2023 11:	46 am_
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
200.00 TOTAL (SUM OF LINES 118 through 199)	110, 917, 961	248, 987, 116	359, 905, 07	7 0	359, 905, 077	200. 00

Heal th FinancialSystemsREID HOSPITAL & HEALTH CARE SERVICESRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CCN: 1

Provi der CCN: 15-0048

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am

			5/23/2023 11	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
	6. 00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	1, 399, 633	23, 848, 011		1.00
1.01 O0101 NEW CAP BLDG & FLXT - OFFSITE	0	7, 994, 001		1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	0			2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	21, 452, 656	21, 714, 847		4.00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG	16, 618, 868	19, 604, 394		5. 01 5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	10, 010, 000			5. 02
5. 04 00570 ADMI TTI NG	-22	1		5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-104, 568			5. 05
5. 06 00590 OTHER A&G	13, 281, 521	39, 955, 228		5. 06
7. 00 00700 OPERATION OF PLANT	0	-		7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	-137, 804			8.00
9. 00 00900 HOUSEKEEPI NG	-879			9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	-256, 161 -3, 530, 850	2, 368, 429 1, 763, 825		10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-5, 550, 650			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	-8	1		14.00
15. 00 01500 PHARMACY	-137, 196			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		16.00
17. 00 01700 SOCIAL SERVICE	4, 064	1		17. 00
17. 01 01701 I NSERVI CE EDUCATI ON	-624, 736	1		17. 01
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0			21.00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM	-331, 341 -57, 602	310, 336 282, 847		22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-37,002	202, 047		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	-6, 315, 663	31, 959, 351		30.00
31.00 03100 INTENSIVE CARE UNIT	0			31.00
40. 00 04000 SUBPROVI DER - 1 PF	-28	2, 632, 489		40.00
41. 00 04100 SUBPROVI DER - RF	-151, 434			41.00
43. 00 04300 NURSERY	-1, 999	732, 878		43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	-10, 786, 339	31, 602, 078		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-10, 780, 337			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-943, 765			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-1, 010			59.00
60. 00 06000 LABORATORY	-1, 433, 644	15, 741, 874		60.00
65. 00 06500 RESPIRATORY THERAPY	-630			65.00
66. 00 06600 PHYSI CAL THERAPY	-160, 749	1		66.00
69. 00 06900 ELECTROCARDI OLOGY	-43, 422			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-520 0	1		70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o o			73.00
74.00 07400 RENAL DIALYSIS	0	933, 384		74.00
76.00 03950 ANCILLARY - OTHER	0	0		76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0			76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
91. 00 O9100 EMERGENCY	-2, 679, 628	11, 080, 848		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-2,079,020	11,000,040		92.00
93. 00 04040 FAMILY PRACTICE	-12, 843	2, 308, 402		93.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-467, 462			96. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				112 00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	-40, 593	0 3, 506, 277		113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)				118.00
NONREI MBURSABLE COST CENTERS	21,000,770	007,117,107		110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
194.00 07950 RENTAL SPACE	0	5, 928, 712		194. 00
194. 01 07951 FOUNDATI ON	0	339, 138		194. 01
194. 02 07952 RETAIL SERVICES	0	193, 818		194. 02
194. 03 07953 REID CONTRACTED SERVICES 194. 04 07954 REID PHYSICIAN ASSOC.	0	178, 743		194. 03 194. 04
194. 04 07954 REID PHYSICIAN ASSOC. 194. 05 07955 CONNERSVILLE LOCATION				194. 04
194.06 07956 VACANT SPACE				194.05
194. 07 07957 HOME OFFICE	0	0		194. 07
194. 08 07958 CAMBRI DGE RHC	0	0		194. 08
194.09 07959 REID HEALTH PAVILION - RES	0	,		194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	24, 535, 778	384, 440, 855		200. 00

	Financial Systems	REI D	HOSPITAL & HEA				of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der (CCN: 15-0048	Peri od: From 01/01/2022	Worksheet A-6
						To 12/31/2022	Date/Time Prepared: 5/23/2023 11:46 am
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2.00 A - CAPITAL EXPENSE RECLASS	3.00	4. 00	5. 00			
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	o	13, 421, 794			1.00
2. 00	NEW CAP BLDG & FIXT -	1. 01	Ö	7, 554, 218			2.00
	OFFSI TE						
3. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	78, 333			3.00
4. 00	NEW CAP BLDG & FIXT - OFFSITE	1. 01	0	437, 403			4. 00
5. 00	CAP REL COSTS-BLDG & FIXT	1. 00	o	218, 194			5. 00
6. 00	NEW CAP BLDG & FIXT -	1. 01	o	2, 380			6.00
	OFFSI TE						
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0.00	o	0			11. 00
12.00		0.00	o	0			12.00
13.00		0.00	0	0			13.00
14.00		0. 00	0	0			14.00
15.00		0.00	0	0			15.00
16. 00 17. 00		0. 00 0. 00	0	0			16. 00 17. 00
18.00		0.00	0	0			18.00
19. 00		0.00	0	0			19. 00
20.00		0.00	Ö	0			20.00
21.00		0.00	0	0			21.00
22. 00		0.00	•	0			22.00
	B - CAFETERIA RECLASS		0	21, 712, 322			
1. 00	CAFETERIA RECLASS	11. 00	2, 410, 409	2, 884, 266			1.00
1.00	0		2, 410, 409	2, 884, 266			1.00
	C - LAUNDRY RECLASS						
1.00	REI D CONTRACTED SERVICES	194.03	9 <u>5, 5</u> 36	8 <u>3, 2</u> 07			1.00
	O NUMBER NO ME DECLACE		95, 536	83, 207			
1. 00	D - NURSING VP RECLASS NURSING ADMINISTRATION	13.00	323, 913	0			1.00
1.00	0	13.00	323, 913	— — <u> </u>			1.00
	E - OCCUPATIONAL MEDICINE RE	CLASS	020, 7.0				
1.00	OTHER A&G	5.06	592, 789	<u>354, 866</u>			1.00
	0	100	592, 789	354, 866			
1. 00	F - IMPLANTABLE DEVICES RECLIMPL. DEV. CHARGED TO	ASS 72.00	0	19, 381, 532			1 00
1.00	PATIENTS	72.00	U	19, 381, 532			1.00
2.00		0.00	O	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	•	0			4.00
	O LINTEDECT DECLACE		0	19, 381, 532			
1. 00	G - INTEREST RECLASS CAP REL COSTS-BLDG & FIXT	1.00	ol	8, 730, 057			1.00
1.00	0		— — — ŏ	8, 730, 057			1.00
	J - INTERN AND RESIDENT			51.551.55.			
1.00	I &R SERVI CES-SALARY &	21. 00	2, 004, 328	84, 926			1.00
	FRI NGES APPRV	 					
	0 N - HOSPI CE		2, 004, 328	84, 926			
1. 00	HOSPICE	116. 00	686, 294	99, 346			1.00
1. 50	0	110.00	686, 294	99, 346			1.00
500.00	Grand Total: Increases		6, 113, 269	53, 330, 522			500.00
		•	·				•

	Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERV	/I CES	In Lieu	of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0048	Peri od:	Worksheet A-	-6
						From 01/01/2022 To 12/31/2022	Date/Time Pr	epared:
							5/23/2023 11	
		Decreases				1		
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6.00	7. 00	8. 00	9. 00	10.00			
1 00	A - CAPITAL EXPENSE RECLASS	4 00	ما	0.110				1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMITTING	4. 00 5. 04	0	3, 113 15, 193				1.00
3. 00	CASHI ERI NG/ACCOUNTS	5. 05	o	164, 144		l .		3. 00
3.00	RECEI VABLE	5.05	o o	104, 142	+ 13			3.00
4. 00	OTHER A&G	5. 06	o	634, 884	1 13			4.00
5. 00	DI ETARY	10. 00	o	896		1		5. 00
6. 00	PHARMACY	15. 00	0	11, 514		l .		6.00
7. 00	ADULTS & PEDIATRICS	30.00	o	130, 688		l e		7. 00
8. 00	OPERATING ROOM	50.00	0	12, 809		ł .		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	69, 023		l .		9. 00
10.00	LABORATORY	60.00	o	51, 119		l .		10.00
11. 00	RESPIRATORY THERAPY	65. 00	o	937				11.00
12.00	PHYSI CAL THERAPY	66. 00	o	251, 625				12.00
13.00	ELECTROENCEPHALOGRAPHY	70. 00	O	744				13.00
14.00	CARDIAC REHABILITATION	76. 97	O	18, 854				14.00
15.00	EMERGENCY	91.00	o	8, 225				15.00
16.00	FAMILY PRACTICE	93. 00	o	87, 405				16.00
17.00	HOSPI CE	116. 00	0	1, 650				17.00
18.00	PHYSICIANS' PRIVATE OFFICES	192. 00	O	6, 982, 991	1			18.00
19.00	RENTAL SPACE	194. 00	0	12, 261, 967	7 C			19.00
20.00	CONNERSVILLE LOCATION	194. 05	0	482, 583	3			20.00
21.00	VACANT SPACE	194. 06	0	516, 387	7 C			21.00
22.00	REID HEALTH PAVILION - RES	194. 09	O	5, 571	1 C			22.00
	0 — — — — —			21, 712, 322	2			
	B - CAFETERIA RECLASS							
1.00	DI ETARY	1000	<u>2, 410, 4</u> 09	<u>2, 884, 2</u> 66				1.00
	0		2, 410, 409	2, 884, 266	5			
	C - LAUNDRY RECLASS				1			
1. 00	LAUNDRY & LINEN SERVICE		9 <u>5, 5</u> 36	8 <u>3, 2</u> 07		0		1.00
	0		95, 536	83, 207	/			
	D - NURSING VP RECLASS	5.0/	200 010					4
1. 00	OTHER A&G		323, 913	;) 		1.00
	E - OCCUPATIONAL MEDICINE REC	1 100	323, 913		<u> </u>			
1. 00	EMERGENCY	91. 00	592, 789	354, 866	5 0	N .		1.00
1.00	0	71.00	592, 789	354, 866		1		1.00
	F - IMPLANTABLE DEVICES RECLA	ASS	372, 107	334, 000	21	1		
1. 00	OPERATI NG ROOM	50.00	0	12, 825, 740	O C			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52.00	o	920		ł .		2.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	23, 334		ł		3.00
4. 00	CARDI AC CATHETERI ZATI ON	59. 00	o	6, 531, 538		1		4.00
	0		— — 	19, 381, 532		1		
	G - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113. 00	0	8, 730, 057	711			1.00
	0		0	8, 730, 057				
	J - INTERN AND RESIDENT				_			
1.00	I&R SERVICES-OTHER PRGM	22. 00	2, 004, 328	84, 926	5)		1.00
	COSTS APPRV					1		
	0		2, 004, 328	84, 926	5	L		_
	N - HOSPI CE				. T			
1. 00	ADULTS & PEDI ATRI CS	30. 00	686, 294	99, 346		<u> </u>		1.00
F00 57	0		686, 294	99, 346		4		F00 05
500.00	Grand Total: Decreases		6, 113, 269	53, 330, 522	<u>4</u>	I		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

HIT designated Assets

10.00 Total (line 8 minus line 9)

Reconciling Items

Subtotal (sum of lines 1-7)

7.00

8.00

9.00

Provider CCN: 15-0048

0

0

0

0

Peri od:

7.00

8.00

9.00

10.00

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 18, 100, 042 Land 617, 354 617, 354 1.00 0 Land Improvements 11, 502, 205 2.00 618, 849 2.00 3.00 Buildings and Fixtures 333, 565, 568 11, 039, 181 11, 039, 181 0 3.00 0 4.00 Building Improvements 13, 645, 110 0 4.00 Fi xed Equi pment 2, 222, 588 14, 510 0 5.00 14, 510 0 5.00 6.00 Movable Equipment 208, 123, 269 0 6.00 12, 676, 460 12, 676, 460 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 587, 158, 782 24, 347, 505 24, 347, 505 618, 849 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 24, 347, 505 618, 849 587, 158, 782 O 24, 347, 505 10.00 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 18, 717, 396 0 1.00 2.00 0 2.00 Land Improvements 10, 883, 356 344, 604, 749 3.00 Buildings and Fixtures 0 3.00 4.00 Building Improvements 13, 645, 110 0 4.00 5.00 Fixed Equipment 2, 237, 098 0 5.00 Movable Equipment 0 6.00 220, 799, 729 6.00

610, 887, 438

610, 887, 438

2.00

3.00

CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

2.00

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0048 Peri od: Worksheet A-7 From 01/01/2022 Part II Date/Time Prepared: 5/23/2023 11:46 am 12/31/2022 SUMMARY OF CAPITAL Interest Taxes (see Cost Center Description Depreciation Lease Insurance instructions) (see instructions) 9. 00 10.00 13.00 11.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE 1.00 0 0 1.00 0 0 1.01 0 0 1.01 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 2.00 Total (sum of lines 1-2) 0 0 3.00 3.00 SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) Capital-Relat (sum of cols. ed Costs (see 9 through 14) instructions) 15. 00 14.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT 1.00 1.00 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 0 0

0

0

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				From 01/01/2022		
				To 12/31/2022	Date/Time Prep 5/23/2023 11:4	
	COME	PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	to alli
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						
1. 00 CAP REL COSTS-BLDG & FIXT	390, 087, 709	0	,			1.00
1. 01 NEW CAP BLDG & FIXT - OFFSITE	0	0		0.000000	0	1. 01
2. 00 CAP REL COSTS-MVBLE EQUIP	220, 799, 729		220, 799, 72		0	2. 00
3.00 Total (sum of lines 1-2)	610, 887, 438		610, 887, 43			3. 00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	OF CAPITAL	
Coot Conton Doponintian	Toyon	Other	Total (sum of	Depreciation	Lanca	
Cost Center Description	Taxes	Capi tal -Rel at		Depreciation	Lease	
		ed Costs	through 7)			
	6, 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7. 00	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	0		23, 551, 484	218, 194	1.00
1. 01 NEW CAP BLDG & FIXT - OFFSITE	0	0		7, 554, 218		1. 01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00 Total (sum of lines 1-2)	0	0		31, 105, 702	220, 574	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)			9 through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C			70.00		00 040 044	
1. 00 CAP REL COSTS-BLDG & FLXT	0	_			.,	1.00
1. 01 NEW CAP BLDG & FIXT - OFFSITE	0	0	437, 40		, , , , , , ,	1. 01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	1	0		2.00
3.00 Total (sum of lines 1-2)	0	0	515, 73	6 0	31, 842, 012	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

Provi der CCN: 15-0048

					From 01/01/2022 To 12/31/2022	Date/Time Pre	
				Expense Classification of To/From Which the Amount is		5/23/2023 11:	46 am
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3. 00	4. 00	Ref. 5. 00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
1. 01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter 2)			NEW CAP BLDG & FIXT - OFFSITE	1. 01	0	1. 01
2. 00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)	В		PURCHASING RECEIVING AND STORES	5. 03	0	4. 00
5. 00	Refunds and rebates of		0	OT ONE O	0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -16, 717, 903		0.00	0	9. 00 10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Rel ated organization	A-8-1	85, 107, 439			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others	В	-2, 793, 255 0	CAFETERI A	11. 00 0. 00	0	1
16. 00	Sale of medical and surgical supplies to other than patients	В		PURCHASING RECEIVING AND STORES	5. 03	0	16. 00
17. 00	Sale of drugs to other than	В	-137, 196	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and abstracts	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00 21. 00	books, etc.) Vending machines Income from imposition of interest, finance or penalty charges (chapter 21)	В	-256, 161 0	DI ETARY	10. 00 0. 00	0	20. 00 21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FLXT Depreciation - NEW CAP BLDG &		0	NEW CAP BLDG & FIXT -	1. 01	0	26. 01
27. 00	FIXT - OFFSITE Depreciation - CAP REL			OFFSITE CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00	0	28. 00 29. 00

Provider CCN: 15-0048

Peri od:

Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 30.00 Adjustment for occupational A-8-3 0 *** Cost Center Deleted *** 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30.99 Hospice (non-distinct) (see 30.00 30.99 instructions) Adjustment for speech 0 *** Cost Center Deleted *** 31.00 A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest MISCELLANEOUS INCOME -109, 638 EMPLOYEE BENEFITS DEPARTMENT В 4.00 33.00 33. 01 MISCELLANEOUS INCOME -803, 492 DATA PROCESSING 33.01 В 5.02 MISCELLANEOUS INCOME OPURCHASING RECEIVING AND 33.02 В 5.03 33.02 STORES 33.03 MISCELLANEOUS INCOME В -5 ADMITTING 5.04 33.03 33.04 MISCELLANEOUS INCOME В -104, 568 CASHI ERI NG/ACCOUNTS 5.05 33.04 RECEI VABLE -28,000 OTHER A&G 33.05 MISCELLANEOUS INCOME В 33.05 5.06 0 33.06 MISCELLANEOUS INCOME -137, 804 LAUNDRY & LINEN SERVICE 8.00 0 33.06 В 33.07 MISCELLANEOUS INCOME В -737, 595 CAFETERI A 11.00 33.07 MISCELLANEOUS INCOME 4, 886 SOCIAL SERVICE 33.08 33.08 В 17.00 MISCELLANEOUS INCOME 33 09 В -49, 846 I NSERVI CE EDUCATI ON 17.01 33.09 33. 10 MISCELLANEOUS INCOME В -57, 193 PARAMED ED PRGM 23.00 33.10 33. 11 MISCELLANEOUS INCOME В -26, 132 ADULTS & PEDIATRICS 30.00 33.11 -498 OPERATING ROOM MISCELLANEOUS INCOME 50.00 0 33.12 33. 12 В MISCELLANEOUS INCOME -213, 765 RADI OLOGY-DI AGNOSTI C 33.13 В 54.00 33.13 MISCELLANEOUS INCOME -24, 785 LABORATORY 60.00 33.14 В 33.14 33. 15 MISCELLANEOUS INCOME В 220 ELECTROCARDI OLOGY 69.00 33.15 -148, 466 PHYSI CAL THERAPY MISCELLANEOUS INCOME 33, 16 33.16 В 66.00 0 33.17 MISCELLANEOUS INCOME В -2, 535 EMERGENCY 91.00 33.17 MISCELLANEOUS INCOME -465, 702 DURABLE MEDICAL EQUIP-RENTED 33. 18 В 96.00 33.18 MISCELLANEOUS INCOME -39, 830 HOSPI CE 33.19 В 116.00 33.19 -3, 801, 940 CAP REL COSTS-BLDG & FIXT 11 33.20 INTEREST INCOME В 1.00 33.20 33. 21 UNNECESSARY BORROWING -4, 928, 117 CAP REL COSTS-BLDG & FIXT 1.00 11 33.21 Α -8, 188, 108 EMPLOYEE BENEFITS DEPARTMENT 33. 22 SELF INSURANCE ADJUSTMENT 4.00 0 33.22 Α MARKETI NG/ADVERTI SI NG 33.23 Δ -144, 539 OTHER A&G 5.06 0 33.23 33.24 MARKETI NG/ADVERTI SI NG Α O DI ETARY 10.00 0 33.24 MARKETI NG/ADVERTI SI NG -4, 134 INSERVICE EDUCATION 33. 25 Α 17.01 33.25 MARKETI NG/ADVERTI SI NG -541 &R SERVICES-OTHER PRGM 33.26 33. 26 Α 22.00 COSTS APPRV MARKETI NG/ADVERTI SI NG 33.27 Α -250 PARAMED ED PRGM 23.00 33.27 33. 28 MARKETI NG/ADVERTI SI NG -3,077 ADULTS & PEDIATRICS 30.00 33.28 Α 33, 29 MARKETI NG/ADVERTI SI NG Α -79 SUBPROVI DER - I PF 40.00 33.29 MARKETI NG/ADVERTI SI NG -2, 953 SUBPROVI DER - I RF 41.00 33.30 33 30 Α 33. 31 MARKETI NG/ADVERTI SI NG -1, 999 NURSERY 43.00 33.31 Α MARKETI NG/ADVERTI SI NG -733 OPERATING ROOM 50.00 33.32 Α 33.32 33. 33 MARKETI NG/ADVERTI SI NG -66 RADI OLOGY-DI AGNOSTI C 54.00 0 33.33 Α -1, 010 CARDI AC CATHETERI ZATI ON 59.00 MARKETI NG/ADVERTI SI NG 33.34 Α 33.34 33. 35 MARKETI NG/ADVERTI SI NG -10, 061 PHYSI CAL THERAPY 66.00 33.35 Α 33.36 MARKETI NG/ADVERTI SI NG Α -520 ELECTROENCEPHALOGRAPHY 70.00 33.36 MARKETI NG/ADVERTI SI NG -435 EMERGENCY 33.37 91.00 33.37 O Α MARKETI NG/ADVERTI SI NG -10, 726 FAMILY PRACTICE 0 33 38 Α 93.00 33 38 33.39 MARKETI NG/ADVERTI SI NG Α -1, 666 DURABLE MEDICAL EQUIP-RENTED 96.00 33.39 33. 40 MARKETI NG/ADVERTI SI NG -618 HOSPI CE 116.00 33.40 Α NON-ALLOWABLE EXPENSES -17 ADMITTING 5.04 33.41 0 33.41 Α -862, 586 OTHER A&G 33.42 NON-ALLOWABLE EXPENSES Α 5.06 33.42 NON-ALLOWABLE EXPENSES -879 HOUSEKEEPI NG 9.00 33.43 33.43 33. 44 NON-ALLOWABLE EXPENSES -8 CENTRAL SERVICES & SUPPLY 14.00 33.44 Α -822 SOCI AL SERVI CE NON-ALLOWABLE EXPENSES 33 45 Δ 17.00 0 33.45 33.46 NON-ALLOWABLE EXPENSES Α -319, 656 I NSERVI CE EDUCATI ON 17.01 33.46 NON-ALLOWABLE EXPENSES -1, 050 &R SERVICES-OTHER PRGM 33.47 Α 22.00 33.47 COSTS APPRV NON-ALLOWABLE EXPENSES -159 PARAMED ED PRGM 33 48 23 00 33 48 Α 0 33.49 NON-ALLOWABLE EXPENSES Α -1, 591 ADULTS & PEDIATRICS 30.00 0 33.49 NON-ALLOWABLE EXPENSES 51 SUBPROVI DER - I PF 33.50 Α 40.00 33.51 NON-ALLOWABLE EXPENSES -281 SUBPROVI DER - I RF 41.00 0 33.51 Α

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0048 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 33.52 NON-ALLOWABLE EXPENSES Α -10 OPERATING ROOM 50.00 33. 52 33. 53 NON-ALLOWABLE EXPENSES -68 DELIVERY ROOM & LABOR ROOM 52.00 33.53 Α 0 -630 RESPIRATORY THERAPY NON-ALLOWABLE EXPENSES 33.54 65.00 33.54 Α -2, 222 PHYSI CAL THERAPY 33. 55 NON-ALLOWABLE EXPENSES Α 66.00 0 33.55 33. 56 NON-ALLOWABLE EXPENSES Α -1, 784 EMERGENCY 91.00 33.56 -2, 117 FAMILY PRACTICE NON-ALLOWABLE EXPENSES 93.00 33.57 33. 57 Α 33.58 NON-ALLOWABLE EXPENSES -94 DURABLE MEDICAL EQUIP-RENTED 96.00 Α 33.58 33. 59 NON-ALLOWABLE EXPENSES -145 HOSPI CE 116.00 33.59 Α 33.60 HAF EXPENSE -18, 179, 574 OTHER A&G 5.06 33.60 Α BOND REFUNDING - 2015 BONDS BOND REFUNDING - 2016 BONDS -401, 531 OTHER A&G 0 33.61 Α 5.06 33.61 33.62 Α -7, 737 OTHER A&G 5.06 33.62 OCC MED - EMPLOYEE COST -48, 378 OTHER A&G 33.63 33.63 Α 5.06 OCC MED - EMPLOYEE COST
OCC MED - EMPLOYEE COST -785, 349 LABORATORY 33.64 60.00 0 33.64 Α -4, 189 RADI OLOGY-DI AGNOSTI C 33.65 Α 54.00 33.65 50.00 TOTAL (sum of lines 1 thru 49) 24, 535, 778 50.00 (Transfer to Worksheet A, column 6, line 200.)

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0048

Worksheet A-8-1

From 01/01/2022

				Го 12/31/2022	Date/Time Pre 5/23/2023 11:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00			REID OUTPATIENT SURGERY	25, 847, 434	31, 036, 564	1. 00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	10, 129, 690	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	29, 750, 402	0	3.00
4.00	5. 02	DATA PROCESSING	INFORMATION SYSTEMS	17, 422, 360	0	4.00
4.01	5. 06	OTHER A&G	A&G	32, 994, 117	0	4.01
5.00	TOTALS (sum of lines 1-4).			116, 144, 003	31, 036, 564	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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.

			Rel ated Organi zation(s) and/	or Home Office	
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 RELAT	TED ORGANIZATION(S) AND/OR HO	OME 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 O/P SURGER	55. 00	0.00	6. 00
7.00	В		O.OO 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.
- 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	REID HOSPITAL & HEALTH	In Lieu of Form CMS-2552-1			
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	M RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0048	From 01/01/2022	Worksheet A-8-1 Date/Time Prepared: 5/23/2023 11:46 am	

								5/23/202	<u> 23 11:</u>	46 am
	Net	Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A	A RESULT OF	TRANSACTI ONS	WITH RELATED	ORGANI ZATI ONS	OR CLAIMED	HOME	
	OFFICE COSTS:									
1.00	-5, 189, 130	0								1.00
2.00	10, 129, 690	9								2.00
3.00	29, 750, 402	0								3.00
4.00	17, 422, 360	0								4.00
4. 01	32, 994, 117	0								4.01
5.00	85, 107, 439									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.

 The second secon	oct amino i ana, cr 2, the amount arrowable choard be interested in contamin i cr three parts	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
0. 00		
B. INTERRELATIONSHIP TO RELATE	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.

i ei ilibui	Selliett under titte Aviii.	
6.00		6.00
	HOME OFFICE	7.00
8.00		8.00
9. 00		9.00
10.00		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 organization.
- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0048

						0 12/31/2022	5/23/2023 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	5. 06	OTHER A&G	40, 251	40, 251	0	179, 000	0	1.00
2.00	17. 01	INSERVICE EDUCATION	327, 863	189, 663	138, 200	179, 000	892	2.00
3.00	22. 00	I&R SERVICES-OTHER PRGM	580, 803	184, 241	396, 562	197, 500	2, 644	3.00
		COSTS APPRV						
4. 00		ADULTS & PEDIATRICS	6, 286, 154			179, 000		1
5. 00		SUBPROVI DER - I RF	148, 200			179, 000		
6. 00		OPERATING ROOM	5, 595, 968			246, 400		
7. 00		RADI OLOGY-DI AGNOSTI C	725, 745			260, 300		
8. 00		LABORATORY	623, 510			260, 300		8. 00
9. 00		ELECTROCARDI OLOGY	43, 642			179, 000		9. 00
10.00	91. 00	EMERGENCY	2, 674, 874			179, 000		10.00
200.00			17, 047, 010		· · · · · · · · · · · · · · · · · · ·		3, 551	
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1.00	2.00	0.00	0.00	Education	12	14.00	
1. 00	1.00	2. <u>00</u> OTHER A&G	8. 00	9.00	12.00	13. 00	14.00	1. 00
2. 00		INSERVICE EDUCATION	76, 763		_	0		2.00
3. 00		I&R SERVICES-OTHER PRGM	251, 053			0		
3.00		COSTS APPRV	251,055	12, 555	U	U	0	3.00
4.00		ADULTS & PEDLATRICS	1, 291	65	0	0	0	4.00
5. 00		SUBPROVI DER - I RF	1,271			0	ĺ	
6. 00		OPERATING ROOM		0	_	0	ĺ	
7. 00		RADI OLOGY-DI AGNOSTI C		0	_	0	0	
8. 00		LABORATORY	0	0	0	0	0	8.00
9. 00		ELECTROCARDI OLOGY	0	0	0	0	Ö	
10. 00		EMERGENCY	0	0	0	0	0	1
200.00			329, 107	16, 456	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	-	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	5. 06	OTHER A&G	0	0	0	40, 251		1.00
2.00	17. 01	INSERVICE EDUCATION	0	76, 763	61, 437	251, 100		2.00
3.00	22. 00	I&R SERVICES-OTHER PRGM	0	251, 053	145, 509	329, 750		3.00
		COSTS APPRV						
4. 00		ADULTS & PEDIATRICS	0		997	6, 284, 863		4.00
5. 00		SUBPROVIDER - IRF	0		0	148, 200		5.00
6. 00	50.00 OPERATING ROOM		0	ľ	0	5, 595, 968		6.00
7.00	54. 00 RADI OLOGY-DI AGNOSTI C		0	ľ	0	725, 745		7. 00
8. 00		LABORATORY	0		0	623, 510		8. 00
9. 00		ELECTROCARDI OLOGY	0		0	43, 642		9. 00
10. 00	91. 00	EMERGENCY	0	_		2, 674, 874		10.00
200.00			0	329, 107	207, 943	16, 717, 903	l	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

				72/31/2022	5/23/2023 11:	
		CAP	ITAL RELATED CO	STS		
Cost Center Description	Net Expenses	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	EMPLOYEE	
Cost Conten Description	for Cost	DEDO & TIXI	& FIXT -	WVDLL LQ011	BENEFITS	
	Allocation		OFFSI TE		DEPARTMENT	
	(from Wkst A					
	col. 7)	1.00	1.01		4 00	
GENERAL SERVICE COST CENTERS	0	1.00	1.01	2. 00	4. 00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT	23, 848, 011	23, 848, 011				1.00
1.01 OO101 NEW CAP BLDG & FLXT - OFFSLTE	7, 994, 001	0	7, 994, 001			1.01
2.00 OO200 CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	21, 714, 847	0	11, 608	0	21, 726, 455	4.00
5. 01 00540 NONPATI ENT TELEPHONES	0	0 475	0	0	0	5. 01
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES	19, 604, 394 89, 873	90, 475 242, 258		0	45, 202 14, 757	5. 02 5. 03
5. 04 00570 ADMITTING	8, 452, 265	12, 617	1	0	1, 164, 110	5.03
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0, 102, 200	0	·	0	0	5. 05
5. 06 00590 OTHER A&G	39, 955, 228	104, 648		0	827, 294	5.06
7.00 OO700 OPERATION OF PLANT	0	300, 508		0	0	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	927, 926	336, 856	1	0	101, 970	8. 00
9. 00 00900 HOUSEKEEPI NG	3, 955, 763	222, 787		0	564, 471	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2, 368, 429 1, 763, 825	500, 028 262, 549		0	231, 243 473, 149	•
13. 00 01300 NURSI NG ADMI NI STRATI ON	323, 913	53, 389		0	63, 582	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	6, 376, 000	229, 696		0	119, 739	
15. 00 01500 PHARMACY	45, 099, 562	269, 567		0	947, 058	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	137, 008	0	0	16.00
17. 00 01700 SOCIAL SERVICE	4, 286, 197	33, 890		0	717, 866	17.00
17. 01 01701 I NSERVI CE EDUCATI ON	2, 584, 245	284, 259	0	0	280, 622	•
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	2, 089, 254	0	0	0	393, 438	•
23. 00 02300 PARAMED ED PRGM	310, 336 282, 847	28, 975	77, 776	0	19, 270 55, 965	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	202, 047	20, 773	11,110		33, 703	25.00
30. 00 03000 ADULTS & PEDIATRICS	31, 959, 351	2, 986, 238	0	0	4, 885, 850	30.00
31. 00 03100 INTENSIVE CARE UNIT	6, 874, 646	670, 490		0	859, 549	31.00
40. 00 04000 SUBPROVI DER - I PF	2, 632, 489	610, 083		0	442, 890	1
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	1, 883, 335 732, 878	488, 776 73, 215	1	0	322, 297 117, 766	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	732,070	75, 215		0	117,700	43.00
50. 00 05000 OPERATING ROOM	31, 602, 078	1, 246, 983	379, 912	0	363, 184	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	924, 377	227, 102		0	,	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 971, 495	1, 910, 045		0	1, 690, 695	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	8, 745, 292 15, 741, 874	370, 829 794, 555		0	435, 978 1, 046, 242	59. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	3, 413, 415	44, 978		0	350, 693	•
66. 00 06600 PHYSI CAL THERAPY	10, 851, 506	220, 766	1	0	1, 669, 390	
69. 00 06900 ELECTROCARDI OLOGY	3, 040, 288	213, 256	0	0	282, 717	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	612, 568	0	112, 949	0	90, 154	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	19, 381, 532	0	0	0	0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	933, 384	40, 690		0	104	
76. 00 03950 ANCI LLARY - OTHER	0	0,070	Ö	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	611, 059	223, 524	0	0	100, 545	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
91. 00 O9100 EMERGENCY	11 000 040	045 541	0	0	1 400 522	01 00
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART	11, 080, 848	845, 541		U	1, 699, 533	91. 00 92. 00
93. 00 04040 FAMILY PRACTICE	2, 308, 402	0	24, 581	0	365, 806	93.00
OTHER REIMBURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	315, 427	48, 446		0	· ·	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	3, 506, 277	12, 152	o	0	411, 534	1
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	369, 149, 437	14, 000, 171	1	0		
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 089, 343	0	3, 139, 274	0		192.00
194. 00 07950 RENTAL SPACE 194. 01 07951 FOUNDATI ON	5, 928, 712 339, 138	5, 626	566, 778	0	0 30, 453	194.00 194.01
194. 01 07951 FOUNDATION 194. 02 07952 RETAIL SERVICES	193, 818	63, 903		0		194.01
194. 03 07953 REID CONTRACTED SERVICES	178, 743	0	l ől	0	18, 753	
194.04 07954 REID PHYSICIAN ASSOC.	0	0	9, 055	0	0	194. 04
194. 05 07955 CONNERSVILLE LOCATION	1, 457, 299	0	0	0		194. 05
194. 06 07956 VACANT SPACE	240, 559	1, 932, 193	498, 230	0	0	194. 06

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048	From 01/01/2022	Worksheet B Part I Date/Time Prepared:

				0 12/31/2022	5/23/2023 11:	
		CAPI	TAL RELATED CO	OSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	NEW CAP BLDG & FLXT - OFFSLTE	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	-
	0	1.00	1. 01	2. 00	4. 00	
194. 07 07957 HOME OFFICE	0	7, 640, 918	1, 300, 541	0		194. 07
194. 08 07958 CAMBRI DGE RHC	0	0	0	0	0	194. 08
194.09 07959 REID HEALTH PAVILION - RES	1, 863, 806	205, 200	0	0	307, 746	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	384, 440, 855	23, 848, 011	7, 994, 001	0	21, 726, 455	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	5/23/2023 11: CASHI ERI NG/AC COUNTS RECEI VABLE	46 am
		5. 01	5. 02	5. 03	5. 04	5. 05	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00 4. 00 5. 01 5. 02 5. 03	00100 OAN REE COSTS-BLDG & FIXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0 0	19, 771, 849 26, 919	1			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	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	0 0 0 0 0 0	1, 534, 371 0 1, 090, 211 0 26, 919 121, 135 713, 348	2, 105 0 1, 851 0 402 9, 903 4, 417	11, 220, 143 0 0 0 0 0 0 0	226, 943 0 0 0 0 0	5. 06 7. 00 8. 00 9. 00 10. 00
13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00	01300 NURSI NG ADMINISTRATION 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 INSERVI CE EDUCATION 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM	0 0 0 0 0 0 0	0 188, 432 888, 320 0 471, 079 821, 023 0 349, 944 188, 432	41, 725 0 454 353 0 39	0 0 0 0 0 0 0	0 0 0 0 0 0 0	14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00
30. 00 31. 00 40. 00 41. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - I PF 04100 SUBPROVIDER - I RF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0 0 0	1, 843, 937 309, 566 228, 810 201, 891	14, 374 2, 678 2, 216	741, 701 103, 065 49, 074 40, 369 12, 773	15, 030 2, 089 994 818 259	31. 00 40. 00 41. 00
91. 00 92. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 00TPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 FAMILY PRACTICE	0 0 0 0 0 0 0 0 0 0 0 0	1, 830, 478 174, 972 2, 005, 447 349, 944 1, 130, 589 188, 432 1, 897, 774 511, 457 269, 188 0 40, 378 0 107, 675 0 1, 103, 670	4, 820 49, 212 32, 310 6, 753 17, 154 2, 614 1, 252 1, 996 0 0 0 205 0 549 0	1, 857, 820 78, 386 1, 949, 809 1, 141, 239 1, 210, 056 266, 086 249, 856 297, 204 68, 527 0 408, 842 1, 474, 693 12, 536 0 18, 698 0	37, 648 1, 588 39, 084 23, 127 24, 521 5, 392 5, 063 6, 023 1, 389 0 8, 285 29, 884 254 0 379 0 22, 259	52. 00 54. 00 59. 00 60. 00 65. 00 66. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97 77. 00 91. 00 92. 00
102. 00 113. 00	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDI CAL EQUI P-RENTED) 10200 OPI 0I D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS) 11300 INTEREST EXPENSE) 11600 HOSPI CE	0 0	148, 053 0 403, 782	0	4, 545 0 61, 737		96. 00 102. 00 113. 00 116. 00
118. 00 190. 00 192. 00 194. 00 194. 02 194. 02 194. 03 194. 04 194. 05 194. 06	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 07951 FOUNDATI ON 207952 RETAIL SERVI CES 307953 REID CONTRACTED SERVI CES 107954 REID PHYSI CI AN ASSOC. 107955 CONNERSVI LLE LOCATI ON 107956 VACANT SPACE 107957 HOME OFFI CE 107958 CAMBRI DGE RHC 107959 REID HEALTH PAVILION - RES	0 0 0 0 0 0 0 0	19, 394, 986 0 0 53, 838 13, 459 0 0 0 0 309, 566	369, 908 0 78 1, 429 612 87 0 0 767 0 0	11, 220, 143 0 0 0 0 0 0 0 0 0 0 0	226, 943 0 0 0 0 0 0 0 0 0	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Peri od: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/23/2023 11: 46 am Provider CCN: 15-0048

						3/23/2023 11.	40 alli
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	19, 771, 849	373, 807	11, 220, 143	226, 943	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Peri od: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/23/2023 11: 46 am

					5/23/2023 11:	46 am_
Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			PLANT	LINEN SERVICE		
	5A. 05	5. 06	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE	1					1.01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	1					
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	1					5.03
5. 04 00570 ADMITTING	1					5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1					5. 05
	41 000 000	44 000 000				
5. 06 00590 OTHER A&G	41, 999, 082	41, 999, 082				5. 06
7.00 00700 OPERATION OF PLANT	345, 723	42, 402	388, 125			7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 394, 073	170, 977	5, 016	1, 570, 066		8.00
9. 00 00900 HOUSEKEEPI NG	4, 874, 059	597, 784	3, 201	0	5, 475, 044	9.00
10. 00 01000 DI ETARY	3, 817, 465	468, 197	7, 446	0	175, 846	10.00
11. 00 01100 CAFETERI A	2, 499, 523	306, 556		0	0	11.00
				U		
13.00 O1300 NURSING ADMINISTRATION	440, 884	54, 073		0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 942, 089	851, 419	3, 420	0	63, 071	14.00
15. 00 01500 PHARMACY	47, 246, 232	5, 794, 529	3, 920	0	69, 754	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	137, 008	16, 803	0	0	0	16.00
17. 00 01700 SOCIAL SERVICE	5, 509, 486	675, 716		0	22, 555	17. 00
				0		
17. 01 01701 I NSERVI CE EDUCATI ON	3, 970, 502	486, 966	3, 791	U	68, 083	17. 01
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	2, 482, 692	304, 492		0	0	21.00
22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	679, 589	83, 349	0	0	0	22.00
23. 00 02300 PARAMED ED PRGM	634, 225	77, 785	1, 141	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	42, 479, 713	5, 209, 967	44, 017	536, 424	2, 552, 487	30.00
31. 00 03100 INTENSIVE CARE UNIT	8, 833, 779	1, 083, 428			390, 538	31.00
40. 00 04000 SUBPROVI DER - I PF	3, 967, 018	486, 539	9, 085		203, 414	40.00
41. 00 04100 SUBPROVI DER - I RF	2, 939, 702	360, 543	7, 278	49, 983	176, 264	41.00
43. 00 04300 NURSERY	939, 233	115, 193	1, 090	o	17, 543	43.00
ANCILLARY SERVICE COST CENTERS	· · · · · ·				·	
50. 00 05000 OPERATI NG ROOM	37, 364, 476	4, 582, 604	16, 520	125, 028	454, 444	50.00
				·	•	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 536, 003	188, 385		74, 629	73, 931	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 662, 220	3, 392, 661	21, 910	153, 958	187, 124	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	11, 098, 719	1, 361, 213	1, 868	73, 234	58, 476	59.00
60. 00 06000 LABORATORY	19, 954, 590	2, 447, 351	8, 212	968	138, 254	60.00
65. 00 06500 RESPIRATORY THERAPY	4, 286, 150	525, 679			25, 897	65.00
66. 00 06600 PHYSI CAL THERAPY	16, 125, 016	1, 977, 669			39, 680	66.00
				13, 320		
69. 00 06900 ELECTROCARDI OLOGY	4, 352, 197	533, 780			58, 476	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 156, 771	141, 873	2, 196	6, 366	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 798, 659	2, 428, 226	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 504, 577	184, 530	0	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	1, 027, 551	126, 025	606	0	67, 665	74.00
	1,027,331	120, 023	000	0	07,003	
		-	-	U		76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	1, 062, 429	130, 303	· ·	0	16, 707	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	15, 882, 576	1, 947, 934	12, 591	212, 071	372, 995	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		,	' '	, -	,	92.00
· ·	2 007 010	240 007	0	44 402	89, 803	
	3, 007, 819	368, 897	U	46, 682	89, 803	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	660, 959	81, 064	1, 526		4, 177	96.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	4, 404, 143	540, 151	0	0	79, 778	
	353, 016, 932		104 021	1 521 222		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	353, 016, 932	38, 145, 063	194, 831	1, 521, 223	5, 406, 962	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 228, 695	1, 009, 217	43, 989	42, 420	58, 476	192. 00
194.00 07950 RENTAL SPACE	6, 496, 919	796, 821	9, 320	0	0	194.00
194. 01 07951 FOUNDATI ON	429, 667	52, 697	84	0		194. 01
194. 02 07952 RETAIL SERVICES	i i					194.01
	304, 340	37, 326		U		
194. 03 07953 REID CONTRACTED SERVICES	197, 496	24, 222		0		194. 03
194.04 07954 REID PHYSICIAN ASSOC.	9, 055	1, 111	0	0		194. 04
194. 05 07955 CONNERSVILLE LOCATION	1, 458, 066	178, 826	0	ol	0	194. 05
194. 06 07956 VACANT SPACE	2, 670, 982	327, 585		n		194.06
194. 07 07957 HOME OFFICE	8, 941, 459	1, 096, 634		٥		194. 07
	1	1, 070, 034		U S		
194. 08 07958 CAMBRI DGE_RHC	0	0	0	0		194. 08
194.09 07959 REID HEALTH PAVILION - RES	2, 687, 244	329, 580	3, 056	6, 423		194. 09
200.00 Cross Foot Adjustments	0					200. 00
201.00 Negative Cost Centers	O	0	0	0		201.00
	-1					

alth Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu o					u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		eri od:	Worksheet B	
				rom 01/01/2022		
			T	o 12/31/2022	Date/Time Pre	pared:
					5/23/2023 11:	
Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			PLANT	LINEN SERVICE		
	5A. 05	5. 06	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	384, 440, 855	41, 999, 082	388, 125	1, 570, 066	5, 475, 044	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

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

5/23/2023 11:46 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY ADMI NI STRATI O SERVICES & **SUPPLY** Ν 10. 00 11.00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER A&G 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 4, 468, 954 10 00 11.00 01100 CAFETERI A 2, 809, 926 11.00 01300 NURSING ADMINISTRATION 497, 960 13 00 0 2, 208 13.00 34, 181 01400 CENTRAL SERVICES & SUPPLY 0 7.894.180 14.00 14.00 0 01500 PHARMACY 0 53, 257, 129 15 00 134, 802 0 7,892 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 103, 789 0 0 0 17.00 01701 INSERVICE EDUCATION 45, 045 0 17.01 0 833 17.01 21.00 |02100|| &R SERVICES-SALARY & FRINGES APPRV 41, 899 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 4,849 0 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 7.144 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 251, 908 737, 035 219, 802 23, 731 1, 159 30.00 03100 INTENSIVE CARE UNIT 31.00 453, 522 113, 183 33, 754 23, 895 1, 206 31.00 04000 SUBPROVI DER - I PF 416, 967 69. 494 20.725 40.00 40.00 168 0 04100 SUBPROVI DER - I RF 47,040 41.00 346, 557 14,028 830 11 41.00 43.00 04300 NURSERY 14, 253 4, 250 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 62 470 18 630 3 817 122 204, 068 50 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 16,868 5,030 13, 875 4, 198 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 252, 369 75, 262 59, 422 951, 397 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 56, 465 16,839 3, 375, 755 453 59.00 06000 LABORATORY 210, 212 60 00 0 393 621 60 00 0 06500 RESPIRATORY THERAPY 49, 224 65.00 14,680 6,069 94 65.00 06600 PHYSI CAL THERAPY 253, 909 66.00 160 76 66.00 69 00 06900 ELECTROCARDI OLOGY 0 0 45. 236 O 72, 130 312, 725 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 17, 424 0 14 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 ol 72.00 0 07300 DRUGS CHARGED TO PATIENTS 51, 458, 281 73 00 0 0 73 00 C 74.00 07400 RENAL DIALYSIS 10 3 0 0 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 19.137 5.707 147 0 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 232, 210 69.250 19,801 144.441 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93 00 0 75, 955 0 0 25, 537 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 16, 202 79, 477 856 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 132, 778 116. 00 116. 00 11600 HOSPI CE 61,099 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 7, 894, 180 118.00 4, 468, 954 2, 723, 712 497, 960 53, 238, 113 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 0 194.00 07950 RENTAL SPACE 0 0 0 194, 00 0 194. 01 07951 FOUNDATI ON 6,829 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 0 8, 561 0 0 0 194.02 194. 03 07953 REID CONTRACTED SERVICES 0 0 194, 03 5, 249 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. C 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 194.05 0 0 C 194.06 07956 VACANT SPACE 0 0 194.06 C 194. 07 07957 HOME OFFICE 0 0 194.07 0 C 194. 08 07958 CAMBRI DGE RHC 0 0 0 0 194.08 194.09 07959 REID HEALTH PAVILION - RES 19, 016 194. 09 65, 575 0 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COS	TS Provi der CCN: 15-0048	Period: Worksheet B From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

						5/23/2023 11:	46 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10. 00	11. 00	13. 00	14. 00	15.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	4, 468, 954	2, 809, 926	497, 960	7, 894, 180	53, 257, 129	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

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

5/23/2023 11:46 am INTERNS & RESIDENTS MEDI CAL SOCI AL I NSERVI CE SERVI CES-SALA SERVI CES-OTHE Cost Center Description RY & FRINGES R PRGM COSTS RECORDS & SERVI CE **FDUCATION** LI BRARY **APPRV APPRV** 16. 00 17.00 17.01 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 00570 ADMITTING 5.04 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 153, 811 16.00 16.00 01700 SOCIAL SERVICE 17.00 6, 311, 724 17.00 17.01 01701 INSERVICE EDUCATION 0 4, 575, 220 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 2, 829, 083 21.00 C 22 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 767, 787 22 00 C 02300 PARAMED ED PRGM 23.00 0 13, 288 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 199 4, 174, 442 1, 337, 699 2, 082, 303 565, 117 30.00 03100 INTENSIVE CARE UNIT 31 00 1, 417 492, 557 196, 479 81, 625 22, 152 31 00 04000 SUBPROVI DER - I PF 40.00 675 121, 705 0 40.00 04100 SUBPROVI DER - I RF 82, 051 0 41.00 555 0 0 41.00 43.00 04300 NURSERY 176 0 24, 784 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 25, 547 0 302, 259 142, 409 38, 649 50.00 05200 DELIVERY ROOM & LABOR ROOM 1,078 52.00 29,635 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 26, 333 0 466, 254 43.417 11, 783 54.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59.00 15, 693 0 97, 765 0 0 60.00 06000 LABORATORY 16, 640 378, 614 0 60.00 0 65 00 06500 RESPIRATORY THERAPY 3,659 94, 917 0 0 65.00 06600 PHYSI CAL THERAPY 457, 817 66.00 3.436 66,00 0 06900 ELECTROCARDI OLOGY 19, 796 69.00 4.087 86, 797 72.941 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 942 29, 952 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 0 Ω 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 5.622 C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 20, 279 0 0 0 0 73.00 74 00 07400 RENAL DIALYSIS 172 0 0 74.00 03950 ANCI LLARY - OTHER 0 76.00 0 0 0 76.00 0 07697 CARDIAC REHABILITATION 76.97 257 r 33, 010 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 175, 407 15. 105 1.644.725 446, 322 47.604 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 93.00 04040 FAMILY PRACTICE 1,027 0 131, 935 0 0 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 27, 948 0 Λ 96,00 63 102.00 10200 OPI OID TREATMENT PROGRAM C 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 849 74. 985 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 153, 811 6, 311, 724 4, 434, 216 2, 598, 102 705, 101 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 62, 686 192. 00 0 0 0 230, 981 194.00 07950 RENTAL SPACE 0 0 0 0 194.00 0 194. 01 07951 FOUNDATION 0 11, 706 ol 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 194. 02 Ω 14, 765 194. 03 07953 REID CONTRACTED SERVICES 0 C 0 0 0 194. 03 194. 04 07954 REID PHYSICIAN ASSOC. 0 194.04 0 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 0 194. 05 194.06 07956 VACANT SPACE 0 C 0 0 194.06 194. 07 07957 HOME OFFICE 0 194.07 194. 08 07958 CAMBRI DGE RHC 0 0 194.08

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048

Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am

						5/23/2023 11:	46 am
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
		RECORDS &	SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM COSTS	
		LI BRARY			APPRV	APPRV	
		16. 00	17. 00	17. 01	21. 00	22. 00	
194. 09 07959	PREID HEALTH PAVILION - RES	0	0	114, 533	0	0	194. 09
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	153, 811	6, 311, 724	4, 575, 220	2, 829, 083	767, 787	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Cost Center Description PARAMED ED Intern & Total Subtotal PRGM Resi dents Cost & Post Stepdown Adj ustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 |00550|DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 17.01 01701 INSERVICE EDUCATION 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 22 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22 00 02300 PARAMED ED PRGM 23.00 733, 583 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 63, 226, 003 -2, 647, 420 60, 578, 583 30.00 0 03100 INTENSIVE CARE UNIT 0 11, 850, 624 11, 746, 847 31 00 -103, 777 31 00 04000 SUBPROVI DER - I PF 40.00 0 5, 411, 239 0 5, 411, 239 40.00 04100 SUBPROVI DER - I RF 0 4, 024, 842 0 4, 024, 842 41.00 41.00 43.00 04300 NURSERY 0 1, 116, 522 0 1, 116, 522 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 47, 154, 226 -181, 058 46, 973, 168 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 947, 014 1, 947, 014 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 733, 583 34, 037, 693 -55, 200 33, 982, 493 54.00 05900 CARDI AC CATHETERI ZATI ON 59 00 16, 156, 480 59 00 0 0 16, 156, 480 60.00 06000 LABORATORY 23, 548, 462 23, 548, 462 60.00 65.00 06500 RESPIRATORY THERAPY 0 5, 006, 855 0 5,006,855 65.00 0 06600 PHYSI CAL THERAPY 18, 890, 698 18, 890, 698 66.00 0 66.00 06900 ELECTROCARDI OLOGY 5, 558, 392 -92, 737 5, 465, 655 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0000 1, 355, 538 0 1, 355, 538 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 22, 232, 507 22, 232, 507 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 53, 167, 667 0 53, 167, 667 73.00 74 00 07400 RENAL DIALYSIS 1, 222, 032 0 1, 222, 032 74.00 0 03950 ANCI LLARY - OTHER 0 76.00 76.00 07697 CARDIAC REHABILITATION 0 0 76.97 1, 269, 186 1, 269, 186 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 21, 223, 032 91.00 0 -223, 011 21, 000, 021 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04040 FAMILY PRACTICE 0 3, 747, 655 0 3, 747, 655 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 872, 272 0 872, 272 96.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 293, 854 0 5, 293, 854 116.00 733, 583 SUBTOTALS (SUM OF LINES 1 through 117) 348, 312, 793 -3, 303, 203 345, 009, 590 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 9, 382, 797 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 9, 676, 464 -293, 667 194.00 07950 RENTAL SPACE 0 7, 303, 060 7, 303, 060 194.00 0 194. 01 07951 FOUNDATION 0000000 504, 324 0 504, 324 194.01 194. 02 07952 RETAIL SERVICES 0 371, 535 194 02 371, 535 194. 03 07953 REID CONTRACTED SERVICES 226, 967 0 226, 967 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 10, 166 10, 166 194.04 194. 05 07955 CONNERSVILLE LOCATION 1, 636, 892 0 1, 636, 892 194. 05 194.06 07956 VACANT SPACE 0 3, 036, 400 3, 036, 400 194.06 194. 07 07957 HOME OFFICE 10, 136, 827 10, 136, 827 194.07 194. 08 07958 CAMBRI DGE RHC 194.08

Health Financial Systems	REID HOSPITAL & HEAL	u of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B
				From 01/01/2022 To 12/31/2022	Part Date/Time Prepared:
				10 12/01/2022	5/23/2023 11: 46 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25.00	26. 00	
194.09 07959 REID HEALTH PAVILION - RES	0	3, 225, 427		0 3, 225, 427	194. 09
200.00 Cross Foot Adjustments	0	0		0 0	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118 through 201	733, 583	384, 440, 855	-3, 596, 87	0 380, 843, 985	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II |
| To | 12/31/2022 | Date/Time | Prepared: | 5/23/2023 | 11:46 am

				0 12/31/2022	5/23/2023 11:	
		CAP	TAL RELATED CO	STS		
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW CAP BLDG & FLXT - OFFSLTE	MVBLE EQUIP	Subtotal	
	0	1. 00	1. 01	2. 00	2A	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 NEW CAP BLDG & FIXT - OFFSITE 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	381	0	11, 608	0	11, 989	2. 00 4. 00
5. 01 00540 NONPATIENT TELEPHONES	0	0	11,000	0	0	1
5. 02 00550 DATA PROCESSING	18, 900	90, 475	31, 778	0		1
5.03 00560 PURCHASING RECEIVING AND STORES	0	242, 258		0	242, 258	
5. 04 00570 ADMI TTI NG	99, 298	12, 617		0	166, 590	1
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 OTHER A&G	4, 610 81, 792	0 104, 648	,	0	231, 553 206, 290	1
7. 00 00700 OPERATION OF PLANT	01, 792	300, 508		0	345, 723	1
8.00 00800 LAUNDRY & LINEN SERVICE	59, 503	336, 856		0	396, 359	1
9. 00 00900 HOUSEKEEPI NG	87, 090	222, 787	1	0		1
10. 00 01000 DI ETARY	125, 674	500, 028		0	625, 702	1
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	262, 549 53, 389	1	0	262, 549 53, 389	
14. 00 01400 CENTRAL SERVICES & SUPPLY	189, 729	229, 696		0	419, 425	
15. 00 01500 PHARMACY	973, 897	269, 567	1	0	1, 243, 464	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	107,000	0	137, 008	1
17. 00 01700 SOCIAL SERVICE	2, 255	33, 890	1	0	36, 145	
17. 01 01701 INSERVICE EDUCATION 21. 00 02100 &R SERVICES-SALARY & FRINGES APPRV	18, 038	284, 259 0		0	302, 297 0	1
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	13, 784	0	0	0		1
23. 00 02300 PARAMED ED PRGM	3, 432	28, 975	77, 776	-	1	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	604, 818	2, 986, 238		0		1
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	436, 069 31, 755	670, 490 610, 083		0	1, 106, 559 641, 838	1
41. 00 04100 SUBPROVI DER - 1 RF	24, 465	488, 776		0	l	1
43. 00 04300 NURSERY	12, 797	73, 215		0		1
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 795, 324	1, 246, 983		0	-,,	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	31, 839 3, 272, 696	227, 102 1, 910, 045		0	258, 941 5, 229, 174	
59. 00 05900 CARDI AC CATHETERI ZATI ON	927, 946	370, 829		0	1, 298, 775	1
60. 00 06000 LABORATORY	806, 358	794, 555	1	0	1, 600, 913	60.00
65. 00 06500 RESPIRATORY THERAPY	105, 845	44, 978		0	150, 823	
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	94, 224 235, 642	220, 766 213, 256		0	1, 543, 037 448, 898	1
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	33, 176	213, 230	112, 949	0	146, 125	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	_	0	· -	
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - OTHER	10, 366	40, 690	0	0	51,056	74. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	5, 457	223, 524		0	l	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0		1
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	364, 887	845, 541	0	0	1, 210, 428 0	1
93.00 04040 FAMILY PRACTICE	37, 563	0	24, 581	0		1
OTHER REIMBURSABLE COST CENTERS	07,000	0	21,001	<u> </u>	02,111	70.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2, 481	48, 446	83, 348	0	134, 275	96.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 NTEREST EXPENSE	1					113.00
116. 00 11600 HOSPI CE	6, 353	12, 152	0	0	18 505	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		14, 000, 171				
NONRE MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	l	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE	116, 699 356, 164	0	3, 139, 274 566, 778		3, 255, 973 922, 942	
194. 01 07951 FOUNDATI ON	3, 320	5, 626		0		194.00
194. 02 07952 RETAIL SERVICES	143	63, 903		0		194. 02
194. 03 07953 REID CONTRACTED SERVICES	0	0	0	0	0	194. 03
194. 04 07954 REID PHYSICIAN ASSOC.	0	0	9, 055	0	9, 055	194.04
194. 05 07955 CONNERSVILLE LOCATION 194. 06 07956 VACANT SPACE	77, 252 10, 874	0 1, 932, 193	0 498, 230	0	77, 252 2, 441, 297	194. 05 194. 06
194.00 07930 VACANT SPACE 194.07 07957 HOME OFFICE	10, 874				1	
	٠	, , , , , , , , ,				

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0048		Worksheet B
		From 01/01/2022	
		To 12/31/2022	Date/Time Prepared:

				T	o 12/31/2022	Date/Time Pre 5/23/2023 11:	
			CAPI	TAL RELATED CO	OSTS		
	Cost Center Description	Directly Assigned New	BLDG & FIXT	NEW CAP BLDG & FIXT -	MVBLE EQUIP	Subtotal	
		Capi tal		OFFSI TE			
		Related Costs					
		0	1.00	1. 01	2. 00	2A	
194. 08 07958	CAMBRI DGE RHC	0	0	0	0	0	194. 08
194. 09 07959	REID HEALTH PAVILION - RES	48, 127	205, 200	0	0	253, 327	194. 09
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	11, 131, 023	23, 848, 011	7, 994, 001	0	42, 973, 035	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0048

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

5/23/2023 11:46 am Cost Center Description **EMPLOYEE** NONPATI ENT DATA PURCHASI NG ADMI TTI NG **BENEFITS** RECEIVING AND **TELEPHONES** PROCESSI NG DEPARTMENT **STORES** 5. 01 5. 02 5. 04 4 00 5.03 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 11, 989 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 25 0 141, 178 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 8 C 192 242, 458 5.03 1, 365 5.04 00570 ADMITTING 640 10, 956 179, 551 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 C O 5.05 00590 OTHER A&G 1, 201 5.06 455 0 7,784 5.06 0 00700 OPERATION OF PLANT 7 00 Ω 0 \cap 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 56 192 261 0 8.00 9.00 00900 HOUSEKEEPI NG 311 6, 423 0 9.00 865 01000 DI ETARY 10.00 10.00 0 0 127 5.094 2.865 11.00 01100 CAFETERI A 260 0 0 11.00 01300 NURSING ADMINISTRATION 13 00 35 0 13.00 01400 CENTRAL SERVICES & SUPPLY 18, 306 14.00 0 14.00 66 1.345 0 01500 PHARMACY 15 00 521 C 6,343 27,063 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 395 0 3, 364 295 0 17.00 01701 INSERVICE EDUCATION 17.01 154 0 5,862 229 0 17.01 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 216 0 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 11 0 2, 499 26 0 22.00 02300 PARAMED ED PRGM 0 23.00 23.00 31 1, 345 149 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,725 0 13, 166 30, 878 11,886 30.00 03100 INTENSIVE CARE UNIT 31.00 473 0 2, 210 9, 323 1,652 31.00 04000 SUBPROVI DER - I PF 0 1.634 1.737 786 40.00 40.00 244 04100 SUBPROVI DER - I RF 41.00 177 0 1, 442 1.437 647 41.00 43.00 04300 NURSERY 0 1, 519 205 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 200 n 13 070 30, 078 29. 773 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 69 C 1, 249 3, 126 1, 256 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 930 0 14, 322 31, 918 30, 988 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 240 0 2, 499 20, 957 18, 289 59.00 06000 LABORATORY 0 8,073 4, 380 19, 392 60 00 576 60 00 06500 RESPIRATORY THERAPY 65.00 193 0 1, 345 11, 127 4, 264 65.00 13, 551 06600 PHYSI CAL THERAPY 4,004 66.00 918 1, 695 66.00 69 00 06900 ELECTROCARDI OLOGY 156 0 3, 652 812 4 763 69 00 07000 ELECTROENCEPHALOGRAPHY 1, 295 70.00 50 0 1,922 1,098 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 ol 6,552 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 Ω 0 23, 633 73 00 0 74.00 07400 RENAL DIALYSIS 0 0 288 133 201 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 55 0 769 356 300 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 935 7,881 20, 946 17,603 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93 00 201 0 1,634 2,602 1, 197 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 31 1, 057 2, 620 73 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 989 116.00 116. 00 11600 HOSPI CE 226 0 2,883 4, 806 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 0 118.00 11, 775 138, 488 239, 928 179, 551 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 51 0 192.00 194.00 07950 RENTAL SPACE 0 927 0 194, 00 0 0 194. 01 07951 FOUNDATI ON 17 0 384 397 0 194. 01 194. 02 07952 RETAIL SERVICES 0 194.02 18 0 96 57 194. 03 07953 REID CONTRACTED SERVICES 10 0 0 194, 03 0 0 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 194.05 0 0 497 0 194.06 07956 VACANT SPACE 0 0 0 0 194.06 194. 07 07957 HOME OFFICE 0 0 194. 07 C 0 0 194. 08 07958 CAMBRI DGE RHC 0 C 0 0 194.08 194.09 07959 REID HEALTH PAVILION - RES 0 194.09 169 2, 210 601 200.00 200.00 Cross Foot Adjustments

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

						5/23/2023 11:	46 am
	Cost Center Description	EMPLOYEE	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	
		BENEFITS	TELEPHONES	PROCESSI NG	RECEIVING AND		
		DEPARTMENT			STORES		
		4. 00	5. 01	5. 02	5. 03	5. 04	
201.00	Negative Cost Centers	0	0	C	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	11, 989	0	141, 178	242, 458	179, 551	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: 5/23/2023 11: 46 am

					5/23/2023 11:	46 am
Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5. 05	5. 06	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 1. 01 00101 NEW CAP BLDG & FIXT OFFSITE 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATIENT TELEPHONES 5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING 5. 05 00580 CASHIERING/ACCOUNTS RECEIVABLE 5. 06 00590 OTHER A&G 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE 17. 01 017701 INSERVICE EDUCATION 21. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 22. 00 02300 PARAMED ED PRGM	231, 553 0 0 0 0 0 0 0 0 0 0 0	215, 730 218 878 3, 071 2, 405 1, 575 278 4, 374 29, 756 86 3, 471 2, 501 1, 564 428 400	345, 941 4, 471 2, 853 6, 636 3, 429 709 3, 049 3, 494 0 159 3, 379 0 0	0 0 0 0 0 0	323, 400 10, 387 0 3, 725 4, 120 0 1, 332 4, 022 0 0	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 17. 00 17. 00 22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	15, 337 2, 131 1, 015 835 264	26, 762 5, 565 2, 499 1, 852 592	39, 233 8, 899 8, 097 6, 487 972	28, 975 29, 575 12, 805	150, 772 23, 068 12, 015 10, 412 1, 036	30. 00 31. 00 40. 00 41. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	20 41/	22 540	14, 724	32, 029	27 042	F0 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 76. 97 07697 CARDIAC REHABILITATION 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 00TPATIENT SERVICE COST CENTERS	38, 416 1, 621 39, 857 23, 599 25, 022 5, 502 5, 167 6, 146 1, 417 0 8, 454 30, 494 259 0 387	23, 540 968 17, 427 6, 992 12, 571 2, 700 10, 159 2, 742 729 0 12, 473 948 647 0 669 0	3, 014 19, 529 1, 665 7, 319 433 17, 477 202 1, 957 0 0 0 540 0	19, 118 39, 441 18, 761 248 0 3, 414 0 1, 631 0 0 0	26, 843 4, 367 11, 053 3, 454 8, 166 1, 530 2, 344 3, 454 0 0 0 0 3, 997 0 987	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 77. 00
91. 00 O9100 EMERGENCY	22, 714	10, 006	11, 222	54, 328	22, 032	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	1, 545	1, 895	0	·	5, 304	92. 00 93. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 102. 00 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	94 0	416 0	1, 360 0			96. 00 102. 00
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 277 231, 553	2, 775 195, 932	0 173, 653	0 389, 705	4, 712 319, 379	113. 00 116. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 194. 00 07950 RENTAL SPACE 194. 01 07951 FOUNDATION 194. 02 07952 RETAIL SERVICES 194. 03 07953 REID CONTRACTED SERVICES 194. 04 07954 REID PHYSICIAN ASSOC. 194. 05 07955 CONNERSVILLE LOCATION 194. 06 07956 VACANT SPACE 194. 07 07957 HOME OFFICE 194. 08 07958 CAMBRIDGE RHC	0 0 0 0 0 0 0	0 5, 184 4, 093 271 192 124 6 919 1, 683 5, 633	0 39, 208 8, 307 75 248 0 0 33, 721 88, 006	10, 867 0 0 0 0 0 0 0	3, 454 0 197 370 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
194.0907959 REID HEALTH PAVILION - RES 200.00 Cross Foot Adjustments	0	1, 693	2, 723	1, 645		194. 09 200. 00

Health Financial Systems	REID HOSPITAL & HEALTI	H CARE SERVICES	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	Peri od: From 01/01/2022	Worksheet B
				Date/Time Prepared: 5/23/2023 11:46 am
Cost Center Description	CASHI ERI NG/AC	OTHER A&G OPERATION C	F LAUNDRY &	HOUSEKEEPI NG

						5/23/2023 11:	46 am
	Cost Center Description	CASHI ERI NG/AC	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		COUNTS		PLANT	LINEN SERVICE		
		RECEI VABLE					
		5. 05	5. 06	7. 00	8. 00	9. 00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	231, 553	215, 730	345, 941	402, 217	323, 400	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

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

5/23/2023 11:46 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY ADMI NI STRATI O SERVICES & **SUPPLY** Ν 10. 00 11.00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER A&G 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 653, 216 10.00 10.00 11.00 01100 CAFETERI A 267, 813 11.00 01300 NURSING ADMINISTRATION 13 00 0 210 54, 621 13.00 01400 CENTRAL SERVICES & SUPPLY 0 3, 258 453, 548 14.00 14.00 0 01500 PHARMACY 0 1, 328, 062 15 00 12,848 0 453 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 9, 892 0 0 0 17.00 01701 INSERVICE EDUCATION 4, 293 0 0 17.01 21 17.01 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 3, 993 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 462 0 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 681 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 475, 324 70, 249 24, 111 1, 363 29 30.00 03100 INTENSIVE CARE UNIT 31.00 66, 290 10, 787 3,702 1, 373 30 31.00 04000 SUBPROVI DER - I PF 60.947 2.273 0 40.00 40.00 6.623 10 04100 SUBPROVI DER - I RF 41.00 50, 655 4, 483 1,539 48 0 41.00 43.00 04300 NURSERY 1, 358 466 0 43.00 ANCILLARY SERVICE COST CENTERS 5, 954 5, 089 50 00 05000 OPERATING ROOM 2, 044 219, 312 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1,608 552 797 105 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 24, 053 8, 255 3, 414 23, 725 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 5, 382 1,847 193, 945 11 59.00 06000 LABORATORY 20, 035 60 00 22, 614 0 60 00 0 06500 RESPIRATORY THERAPY 65.00 4, 692 1,610 349 2 65.00 06600 PHYSI CAL THERAPY 24, 200 66.00 66.00 69 00 06900 ELECTROCARDI OLOGY 00000 4.311 O 7, 798 69 00 4.144 70.00 07000 ELECTROENCEPHALOGRAPHY 1,661 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 ol 72.00 C 0 07300 DRUGS CHARGED TO PATIENTS 1, 283, 205 73 00 0 0 C 73 00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 1, 824 8 76.97 0 76.97 626 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 0 91.00 91.00 09100 EMERGENCY 22, 132 7,596 1.138 3,602 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93 00 0 7, 239 0 0 637 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 1, 544 4, 566 21 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 3, 311 116.00 116. 00 11600 HOSPI CE 5,823 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 653, 216 259, 596 54, 621 453, 548 1, 327, 588 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 C 0 0 194.00 07950 RENTAL SPACE 0 0 194, 00 C 194. 01 07951 FOUNDATI ON 651 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 0 816 0 0 0 194.02 194. 03 07953 REID CONTRACTED SERVICES 0 0 194, 03 500 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. C 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 194.05 0 0 C 194.06 07956 VACANT SPACE C 0 0 194.06 194.07 07957 HOME OFFICE 0 0 194.07 0 C 194. 08 07958 CAMBRI DGE RHC 0 0 0 0 194.08 194.09 07959 REID HEALTH PAVILION - RES 6, 250 0 474 194. 09 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0048	Period: Worksheet B From 01/01/2022 Part II
		To 12/31/2022 Date/Time Prepared:

						5/23/2023 11:	46 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10.00	11. 00	13.00	14. 00	15. 00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	653, 216	267, 813	54, 621	453, 548	1, 328, 062	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: 5/23/2023 11: 46 am

				LAITEDNIC	5/23/2023 11:	46 am
				INTERNS &	RESI DENTS	
Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
2000 20000 20000 40000	RECORDS &	SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM COSTS	
	LI BRARY			APPRV	APPRV	
OFNEDAL CEDIMOR COCT OFNEDO	16. 00	17. 00	17. 01	21. 00	22. 00	
1. 00 GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT		1			Γ	1.00
1.01 OO100 CAP REL COSTS-BLDG & FIXT 1.01 OO101 NEW CAP BLDG & FIXT - OFFSITE						1.00
2. 00 00200 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 PROCESSING						5. 02
5.03 00560 PURCHASING RECEIVING AND STORES						5. 03
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						5.06
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	137, 094					16.00
17.00 01700 SOCIAL SERVICE	0	55, 053				17.00
17. 01 01701 I NSERVI CE EDUCATI ON	0	0	322, 758			17. 01
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	5, 773		21.00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		17, 210	
23. 00 02300 PARAMED ED PRGM	0	0	937			23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	9, 049	36, 411	94, 365			30.00
31. 00 03100 NTENSI VE CARE UNI T	1, 257	4, 296	13, 861			31.00
40. 00 04000 SUBPROVI DER - PF	599	4, 270	8, 586			40.00
41. 00 04100 SUBPROVI DER - I RF	493	o	5, 788			41.00
43. 00 04300 NURSERY	156	o	1, 748			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	22, 666	0	21, 323			50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	956	0	2, 091			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	23, 996	0	32, 892			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	13, 923	0	6, 897			59.00
60. 00 06000 LABORATORY	14, 763	0	26, 709			60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	3, 246 3, 048	0	6, 696 32, 297			65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 626	0	6, 123			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	836	ő	2, 113			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ő	0			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	4, 988	Ö	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 991	О	0			73.00
74.00 07400 RENAL DIALYSIS	153	0	0			74.00
76. 00 03950 ANCI LLARY - OTHER	0	0	0			76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	228	0	2, 329			76. 97
77. 00 O7700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0			77. 00
OUTPATIENT SERVICE COST CENTERS	12 401	14 244	21 404		T	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 401	14, 346	31, 486			91. 00 92. 00
93. 00 04040 FAMILY PRACTICE	911	o	9, 307			93.00
OTHER REIMBURSABLE COST CENTERS	711	<u> </u>	7, 307			73.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	55	0	1, 972			96. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	Ö	0			102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	753	0	5, 290			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	137, 094	55, 053	312, 810	0	0	118. 00
NONREI MBURSABLE COST CENTERS	1	al				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0			192.00
194. 00 07950 RENTAL SPACE 194. 01 07951 FOUNDATI ON	0	0	0 826			194. 00 194. 01
194. 02 07952 RETAIL SERVICES		0	1, 042			194. 01
194. 03 07953 REI D CONTRACTED SERVI CES		٥	1, 042			194. 02
194. 04 07954 REID PHYSICIAN ASSOC.		ol Ol	0			194. 03
194. 05 07955 CONNERSVILLE LOCATION		ől	0			194. 05
194. 06 07956 VACANT SPACE		o	0			194. 06
194. 07 07957 HOME OFFICE	O	О	0			194. 07
194. 08 07958 CAMBRI DGE RHC	0	o	0	<u> </u>	<u> </u>	194. 08

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS REID HOSPITAL & HEALTH CARE SERVICES
Provider CCN: 15-0048

					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	
		16. 00	17. 00	17. 01	21. 00	22. 00	
194. 09 07959	REID HEALTH PAVILION - RES	0	0	8, 080			194. 09
200. 00	Cross Foot Adjustments				5, 773	17, 210	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	137, 094	55, 053	322, 758	5, 773	17, 210	202.00

| Period: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS REID HOSPITAL & HEALTH CARE SERVICES

Provider CCN: 15-0048

					To 12/31/2022	
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	372372023 11.40 dill
		PRGM		Residents Cost & Post		
				Stepdown		
		23. 00	24. 00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	23.00	24.00	25.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
1. 01 2. 00	00101 NEW CAP BLDG & FLXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP					1.01
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 ADMITTING					5.04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G					5.05
7. 00	00700 OPERATION OF PLANT					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9.00
11. 00	l l					11.00
13.00						13.00
14. 00 15. 00						14. 00 15. 00
16. 00						16.00
17.00	• • • • • • • • • • • • • • • • • • •					17.00
17. 01 21. 00	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRV					17. 01 21. 00
22. 00						22. 00
23. 00		114, 743				23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		4, 730, 137		0 4, 730, 137	30.00
31.00	03100 INTENSIVE CARE UNIT		1, 290, 451	1	0 1, 290, 451	31.00
40. 00 41. 00	i i		778, 478 612, 341	1	0 778, 478 0 612, 341	40.00
43. 00	1 1		94, 393	1	0 94, 393	43.00
F0 00	ANCILLARY SERVICE COST CENTERS		2 202 200	I	2 227 222	F0.00
50. 00 52. 00	1 I		3, 907, 280 299, 838	1	0 3, 907, 280 0 299, 838	
54. 00	l l		5, 550, 974	•	0 5, 550, 974	54.00
59.00	l l		1, 617, 236		0 1, 617, 236	59.00
60. 00 65. 00	l l		1, 770, 781 194, 512		0 1, 770, 781 0 194, 512	60.00
66.00	I I		1, 661, 322		0 1, 661, 322	66.00
69. 00 70. 00	l l		496, 827		0 496, 827 0 160, 835	69.00
71.00	1		160, 835 0	1	0 160, 835	70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		32, 467		0 32, 467	72.00
			1, 356, 271 57, 275		0 1, 356, 271 0 57, 275	73. 00 74. 00
76. 00	1 I		0		0 37,273	76.00
76. 97	• • • • • • • • • • • • • • • • • • •		238, 846	•	0 238, 846	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS		0		0 0	77. 00
91. 00	09100 EMERGENCY		1, 471, 796		0 1, 471, 796	
			104 575		0 106, 575	92.00
93.00	OTHER REIMBURSABLE COST CENTERS		106, 575		0 106, 575	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		148, 331		0 148, 331	96.00
102.00	0 10200 0PI0ID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		0		0 0	102.00
113.00	0 11300 I NTEREST EXPENSE					113. 00
	0 11600 H0SPI CE		51, 354	l .	0 51, 354	
118.00	O SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	26, 628, 320		0 26, 628, 320	118. 00
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0 0	190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES		3, 314, 737	1	0 3, 314, 737	
	0 07950 RENTAL SPACE 1 07951 FOUNDATI ON		936, 269 11, 764	l .	0 936, 269 0 11, 764	194. 00 194. 01
194. 02	2 07952 RETAIL SERVICES		66, 885		0 66, 885	194. 02
	3 07953 REID CONTRACTED SERVICES 4 07954 REID PHYSICIAN ASSOC.		634 9, 061		0 634 0 9, 061	194. 03 194. 04
	5 07955 CONNERSVILLE LOCATION		78, 668		0 78, 668	
194.06	6 07956 VACANT SPACE		2, 476, 701		0 2, 476, 701	194. 06
	7 07957 HOME OFFICE 8 07958 CAMBRIDGE RHC		9, 035, 098 0	1	0 9, 035, 098 0 0	
174. 00	OLO 1 YOU OUMDIN DOF KILC	1 1	0	<u> </u>	<u>υ</u> υ	1194.08

Health Financial Systems	REID HOSPITAL & HEAD	TH CARE SERVI	CES	In Lie	u of Form CMS-2552-	-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022	Part II Date/Time Prepare	۶q٠
				10 12/01/2022	5/23/2023 11: 46 a	ım_
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total		
	PRGM		Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
	23. 00	24. 00	25.00	26. 00		
194.09 07959 REID HEALTH PAVILION - RES		277, 172		0 277, 172	194.	. 09
200.00 Cross Foot Adjustments	114, 743	137, 726		0 137, 726	200.	.00
201.00 Negative Cost Centers	o	0		0 0	201.	.00
202.00 TOTAL (sum lines 118 through 201)	114, 743	42, 973, 035		0 42, 973, 035	202.	.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

Period: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am

				'') 12/31/2022	5/23/2023 11:	
		CAP	TAL RELATED CO	OSTS			
	Cost Center Description	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
	oost conto. Good i pti cii	(SQUARE FEET)	& FIXT -	(SQUARE FEET)	BENEFITS	TELEPHONES	
			OFFSITE		DEPARTMENT	(PHONES)	
			(SQUARE FEET)		(GROSS SALARI ES)		
		1. 00	1. 01	2.00	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	873, 266					1.00
1. 01 2. 00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP	0	275, 457	0			1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	400	_	110, 683, 096		4.00
5. 01	00540 NONPATI ENT TELEPHONES	0		Ö	0	0	1
5.02	00550 DATA PROCESSING	3, 313			230, 277	0	
5. 03	00560 PURCHASING RECEIVING AND STORES	8, 871	1 004	0	75, 178	0	
5. 04 5. 05	OO570 ADMI TTI NG OO580 CASHI ERI NG/ACCOUNTS RECEI VABLE	462		0	5, 930, 442 0	0	
5. 06	00590 OTHER A&G	3, 832			4, 214, 566	0	1
7.00	00700 OPERATION OF PLANT	11, 004	1, 558	0	0	0	
8.00	00800 LAUNDRY & LINEN SERVICE	12, 335			519, 475	0	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	8, 158 18, 310			2, 875, 641 1, 178, 046	0	
11. 00	01100 CAFETERI A	9, 614	0	_	2, 410, 409	0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 955	Ö	0	323, 913	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 411	0	0	609, 997	0	14.00
15.00	01500 PHARMACY	9, 871	0	0	4, 824, 693	0	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 1, 241	4, 721 0	0	0 3, 657, 098	0	
17. 00	01701 I NSERVI CE EDUCATI ON	10, 409	1	0	1, 429, 603	0	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		0	2, 004, 328	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	98, 170	0	
23. 00	02300 PARAMED ED PRGM	1, 061	2, 680	0	285, 110	0	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	109, 350	0	0	24, 890, 328	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	24, 552			4, 378, 887	Ö	
40.00	04000 SUBPROVI DER - I PF	22, 340			2, 256, 259	0	
41. 00	04100 SUBPROVI DER – I RF	17, 898			1, 641, 909	0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 681	0	0	599, 946	0	43.00
50.00	05000 OPERATI NG ROOM	45, 662	13, 091	0	1, 850, 204	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 316		0	635, 566	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	69, 942			8, 613, 073	0	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 579 29, 095		0	2, 221, 045 5, 329, 975	0	
65. 00	06500 RESPI RATORY THERAPY	1, 647	Ö	0	1, 786, 568	0	1
66.00	06600 PHYSI CAL THERAPY	8, 084		0	8, 504, 540	0	
69. 00	06900 ELECTROCARDI OLOGY	7, 809		0	1, 440, 272	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 892 0	0	459, 280 0	0	70.00 71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	1
74.00	07400 RENAL DIALYSIS	1, 490		_	532	0	
76.00	03950 ANCILLARY - OTHER	0 105	0	_	0 512 214	0	
	07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON	8, 185 0			512, 214 0	0	1
77.00	OUTPATIENT SERVICE COST CENTERS						77.00
91.00	09100 EMERGENCY	30, 962	0	0	8, 658, 101	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 FAMILY PRACTICE		0.47		1 0/2 5/1	0	92.00
93.00	OTHER REIMBURSABLE COST CENTERS	0	847	0	1, 863, 561	0	93.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	1, 774	2, 872	0	290, 425	0	96.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
110.00	SPECIAL PURPOSE COST CENTERS	T	T	T			140.00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	445	0	0	2, 096, 519	0	113. 00 116. 00
118. 00		512, 658	l e		108, 696, 150		118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		_	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE	0	108, 173 19, 530		0		192. 00 194. 00
	07951 FOUNDATION	206		0	155, 142		194. 00
	07952 RETAIL SERVICES	2, 340		0	168, 485	0	194. 02
	07953 REID CONTRACTED SERVICES	0	0	0	95, 536		194. 03
	107954 REID PHYSICIAN ASSOC.	0	312		0		194. 04 194. 05
	07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	70, 753	17, 168	0	0		194. 05
	· · · · · · · · · · · · · · · · · · ·				-		

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

207.00

Provi der CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2022 Date/Time Prepared: 5/23/2023 11:46 am 12/31/2022 CAPITAL RELATED COSTS BLDG & FIXT NEW CAP BLDG MVBLE EQUIP **EMPLOYEE** NONPATI ENT Cost Center Description & FIXT -**TELEPHONES** (SQUARE FEET) (SQUARE FEET) **BENEFITS** (PHONES) OFFSI TE **DEPARTMENT** (SQUARE FEET) (GROSS SALARI ES) 1. 00 1.01 2.00 5. 01 4. 00 194. 07 07957 HOME OFFICE 0 194. 07 279, 795 0 44, 814 194. 08 07958 CAMBRI DGE RHC 0 194. 08 194.09 07959 REID HEALTH PAVILION - RES 7, 514 0 1, 567, 783 0 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 23, 848, 011 7, 994, 001 0 21, 726, 455 0 202.00 Part I) 0.000000 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 27. 308988 29.020867 0.000000 0.196294 0 204. 00 Cost to be allocated (per Wkst. B, 204.00 11, 989 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000108 0. 000000 205. 00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Cost Center Description DATA **PURCHASI NG** ADMITTI NG CASHI ERI NG/AC Reconciliatio PROCESSI NG (TOTAL REVE COUNTS RECEIVING AND n (TERMI NALS) **STORES** NUE) RECEI VABLE (SUPPLY EXP (TOTAL REVE ENSE) NUE) 5.02 5.03 5.04 5.05 5A. 06 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 |00550|DATA PROCESSING 5.02 1, 469 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 9, 998, 360 5.03 5.04 00570 ADMITTING 114 56, 305 1, 160, 060, 725 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 1, 160, 060, 725 5.05 0 5.06 00590 OTHER A&G 81 49, 518 0 -41, 999, 082 5.06 7.00 00700 OPERATION OF PLANT 7.00 2 00800 LAUNDRY & LINEN SERVICE 10, 751 0 8.00 8.00 0 0 9 0 00900 HOUSEKEEPING 9.00 264, 870 0 9.00 10.00 01000 DI ETARY 53 118, 153 0 10.00 11.00 01100 CAFETERI A 0 0 0 0 0 11.00 01300 NURSING ADMINISTRATION 0 0 13 00 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 754, 871 0 14.00 01500 PHARMACY 15.00 66 1, 116, 020 0 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 35 12, 150 0 0 17.00 0 17.01 01701 INSERVICE EDUCATION 61 9, 451 0 0 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 0 21.00 1, 055 22 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 26 0 Ω 22 00 02300 PARAMED ED PRGM 23.00 14 6, 150 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 137 1, 273, 321 76, 685, 350 76, 685, 350 0 30.00 03100 INTENSIVE CARE UNIT 10, 656, 052 31 00 23 384, 454 10, 656, 052 0 31 00 04000 SUBPROVI DER - I PF 40.00 17 71,634 5, 073, 786 5, 073, 786 0 40.00 04100 SUBPROVI DER - I RF 15 4, 173, 816 4, 173, 816 0 41.00 41.00 59, 271 43.00 04300 NURSERY 0 62, 648 1, 320, 590 1, 320, 590 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 136 1, 240, 339 192, 082, 267 192, 082, 267 0 50.00 128, 926 05200 DELIVERY ROOM & LABOR ROOM 8, 104, 428 8, 104, 428 52.00 13 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 149 1, 316, 288 201, 589, 585 201, 589, 585 0 54.00 05900 CARDI AC CATHETERI ZATI ON 59 00 117, 994, 072 117, 994, 072 59.00 26 864, 206 0 60.00 06000 LABORATORY 84 180, 614 125, 109, 226 125, 109, 226 0 60.00 65 00 06500 RESPIRATORY THERAPY 14 458, 826 27, 510, 977 27, 510, 977 0 65.00 06600 PHYSI CAL THERAPY 141 69, 915 25, 832, 875 25, 832, 875 66.00 66,00 0 06900 ELECTROCARDI OLOGY 69.00 38 33, 481 30, 728, 297 30, 728, 297 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 20 53, 386 7, 085, 048 7, 085, 048 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 C 0 07200 I MPL. DEV. CHARGED TO PATIENTS 42, 270, 688 42, 270, 688 72.00 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 152, 470, 298 152, 470, 298 0 73.00 74 00 07400 RENAL DIALYSIS 3 5, 494 1, 296, 107 1, 296, 107 0 74.00 03950 ANCI LLARY - OTHER 0 76.00 0 76.00 07697 CARDIAC REHABILITATION 76.97 8 14,688 1, 933, 167 1, 933, 167 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 91.00 82 863, 762 113, 568, 281 113, 568, 281 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 17 107, 289 7, 722, 846 7, 722, 846 0 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 11 108, 031 469, 944 469, 944 Ω 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 198, 194 6, 383, 025 6, 383, 025 0 116.00 30 -41, 999, 082 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 441 9, 894, 061 1, 160, 060, 725 1, 160, 060, 725 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 0 2,089 194.00 07950 RENTAL SPACE 0 38, 230 0 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194. 01 16, 367 0 0 194. 02 07952 RETAIL SERVICES 0 0 194, 02 2, 330 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 0 194. 03 194. 04 07954 REID PHYSICIAN ASSOC. o 0 194.04 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 20, 514 0 0 194. 05 194.06 07956 VACANT SPACE 0 0 194.06 C 194. 07 07957 HOME OFFICE 0 194.07 194. 08 07958 CAMBRI DGE RHC 0 0 0 194.08

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

207.00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Cost Center Description DATA **PURCHASI NG** ADMITTI NG CASHIERING/AC Reconciliatio PROCESSI NG RECEIVING AND (TOTAL REVE COUNTS n (TERMI NALS) **STORES** NUE) RECEI VABLE (SUPPLY EXP (TOTAL REVE ENSE) NUE) 5. 02 5.03 5.04 5.05 5A. 06 194.09 07959 REID HEALTH PAVILION - RES 23 24, 769 0 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 19, 771, 849 373, 807 11, 220, 143 226, 943 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 13, 459. 393465 0. 037387 0.009672 0.000196 203.00 204.00 Cost to be allocated (per Wkst. B, 179, 551 141, 178 242, 458 231, 553 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 96. 104833 0.024250 0.000155 0.000200 205.00 II) NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

				11	5 12/31/2022	Date/lime Pre 5/23/2023 11:	
	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		5. 06	7.00	8.00	9. 00	10.00	
4 00	GENERAL SERVICE COST CENTERS		T				
1. 00 1. 01 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO101 NEW CAP BLDG & FIXT - OFFSITE OO200 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 2.00
4. 00 5. 01 5. 02	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING						4. 00 5. 01 5. 02
5. 02 5. 03 5. 04	00550 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 02 5. 03 5. 04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G	342, 441, 773					5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	345, 723	l .				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 394, 073	1		10 100		8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	4, 874, 059 3, 817, 465	1	0	13, 108 421	49, 634	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 499, 523		0	421	49, 034	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	440, 884	1	0	ō	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 942, 089	1	0	151	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	47, 246, 232		0	167 0	0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	137, 008 5, 509, 486	l .	0	54	0	17.00
17. 01	01701 I NSERVI CE EDUCATI ON	3, 970, 502	l .	0	163	0	17. 01
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	2, 482, 692	l .	0	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	679, 589	l .	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS	634, 225	2, 807	0	0	0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	42, 479, 713	108, 244	757, 843	6, 111	36, 117	30.00
31.00	03100 INTENSIVE CARE UNIT	8, 833, 779	24, 552	159, 791	935	5, 037	31.00
40.00	04000 SUBPROVI DER - I PF	3, 967, 018			487	4, 631	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 939, 702 939, 233	1	70, 614 0	422 42	3, 849 0	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	737, 233	2,001		42		43.00
50.00	O5OOO OPERATING ROOM	37, 364, 476	1	176, 635		0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 536, 003	1	105, 433	177	0	52.00
54. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	27, 662, 220 11, 098, 719	1	217, 506 103, 462	448 140	0	54. 00 59. 00
60.00	06000 LABORATORY	19, 954, 590	1	1, 367	331	0	60.00
65. 00	06500 RESPI RATORY THERAPY	4, 286, 150	1	0	62	0	65. 00
66.00	06600 PHYSI CAL THERAPY	16, 125, 016	1		95	0	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	4, 352, 197 1, 156, 771	557 5, 400	0 8, 993	140	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0, 400	0, 773	ő	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 798, 659	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 504, 577		0	0	0	73.00
	07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER	1, 027, 551 0	1, 490 0		162 0	0	74. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON	1, 062, 429	_	_	40	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	15, 882, 576	30, 962	299, 606	893	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 662, 576	30, 702	299,000	073	O	92.00
	04040 FAMILY PRACTICE	3, 007, 819	0	65, 950	215	0	93.00
96. 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	660, 959	3, 752	0	10	0	96.00
	10200 OPI OI D TREATMENT PROGRAM	0					102.00
	SPECIAL PURPOSE COST CENTERS		1				
	11300 I NTEREST EXPENSE 11600 HOSPI CE	4 404 142		0	101	0	113. 00 116. 00
118.00		4, 404, 143 311, 017, 850		2, 149, 128	191 12, 945	49, 634	118 00
110.00	NONREI MBURSABLE COST CENTERS	011,017,000	177,110	2,117,120	12, 710	17,001	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	8, 228, 695					192.00
	07950 RENTAL SPACE 07951 FOUNDATION	6, 496, 919 429, 667	1		0		194. 00 194. 01
	07952 RETAIL SERVICES	304, 340	l .	o o	15		194. 02
194. 03	07953 REID CONTRACTED SERVICES	197, 496	0	0	o	0	194. 03
	07954 REID PHYSICIAN ASSOC.	9, 055	l .	0	0		194.04
	07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	1, 458, 066 2, 670, 982	l .	0	0		194. 05 194. 06
	07957 HOME OFFICE	8, 941, 459			ol		194.00
194. 08	07958 CAMBRI DGE RHC	0	0	0	o	0	194. 08
194. 09	07959 REID HEALTH PAVILION - RES	2, 687, 244	7, 514	9, 074	0	0	194. 09

Health Financial Systems REID HOSPITAL & HEALT		ARE SERVICES	In Lieu of Form CMS-2552-10	
COST ALLOCATION - STATISTICAL BASIS	Pr	rovider CCN: 15-0048	Peri od:	Worksheet B-1

					rom 01/01/2022 o 12/31/2022		nared:
					0 12/31/2022	5/23/2023 11:	
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
			(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)	
				LAUNDRY)			
		5. 06	7. 00	8. 00	9. 00	10.00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202. 00	· · · · · · · · · · · · · · · · · · ·	41, 999, 082	388, 125	1, 570, 066	5, 475, 044	4, 468, 954	202. 00
	Part I)						
203.00		0. 122646					
204.00	· · · · · · · · · · · · · · · · · · ·	215, 730	345, 941	402, 217	323, 400	653, 216	204. 00
	Part II)						
205.00		0. 000630	0. 362452	0. 181331	24. 671956	13. 160656	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			[

Peri od:

Worksheet B-1

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0048

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & (DRUGS) RECORDS & (MANHOURS) Ν **SUPPLY** LI BRARY (DIRECT NUR (MED SUPPLI (TOTAL REVE SING HRS) ES) NUE) 11. 00 13. 00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 |00550|DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 2, 646, 557 11.00 01300 NURSING ADMINISTRATION 2,080 1, 572, 677 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 32, 194 24, 398, 282 14.00 01500 PHARMACY 126, 965 15.00 24, 391 38, 556, 839 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 160, 060, 725 16.00 0 16.00 0 0 01700 SOCIAL SERVICE 97, 755 17.00 0 0 17.00 17.01 01701 INSERVICE EDUCATION 42, 426 C 0 603 0 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 39, 463 0 0 21.00 0 22 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 4 567 C 0 0 Ω 22 00 02300 PARAMED ED PRGM 23.00 6,729 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 694, 184 694, 184 73, 346 839 76, 685, 350 30.00 03100 INTENSIVE CARE UNIT 10, 656, 052 31 00 106, 603 106, 603 73, 850 873 31 00 04000 SUBPROVI DER - I PF 40.00 65, 454 65, 454 520 0 5, 073, 786 40.00 04100 SUBPROVI DER - I RF 44, 305 44, 305 8 4, 173, 816 41.00 2,565 41.00 43.00 04300 NURSERY 13, 424 13, 424 0 1, 320, 590 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 58, 838 58, 838 11, 797, 464 147, 740 192, 082, 267 50.00 05200 DELIVERY ROOM & LABOR ROOM 15, 887 42, 884 8, 104, 428 52.00 15,887 3, 039 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 237, 696 237, 696 183, 652 688. 788 201, 589, 585 54.00 05900 CARDI AC CATHETERI ZATI ON 10, 433, 327 59 00 53, 182 117, 994, 072 53.182 328 59 00 60.00 06000 LABORATORY 197, 990 1, 216, 549 125, 109, 226 60.00 65 00 06500 RESPIRATORY THERAPY 46, 362 46, 362 18, 756 68 27, 510, 977 65.00 06600 PHYSI CAL THERAPY 25, 832, 875 239, 147 66.00 496 55 66,00 C 06900 ELECTROCARDI OLOGY 69.00 42,606 r 222, 931 226, 405 30, 728, 297 69 00 16, 411 70.00 07000 ELECTROENCEPHALOGRAPHY 44 0 7, 085, 048 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 C 0 0 0 07200 I MPL. DEV. CHARGED TO PATIENTS 42, 270, 688 0 72.00 0 C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 37, 254, 518 152, 470, 298 73.00 74 00 07400 RENAL DIALYSIS 0 1, 296, 107 74.00 03950 ANCI LLARY - OTHER 0 76.00 0 76.00 0 07697 CARDIAC REHABILITATION 76.97 18.024 18,024 454 0 1, 933, 167 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 61, 197 104, 572 113, 568, 281 218, 709 218, 709 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04040 FAMILY PRACTICE 71, 539 0 0 18, 488 7, 722, 846 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 15, 260 245, 637 620 469.944 102.00 10200 OPI OID TREATMENT PROGRAM C 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 57, 547 219 6, 383, 025 116. 00 96, 128 1, 572, 677 SUBTOTALS (SUM OF LINES 1 through 117) 2, 565, 356 24, 398, 282 38, 543, 072 1, 160, 060, 725 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 194.00 07950 RENTAL SPACE 0 0 0 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194. 01 6, 432 0 0 0 194. 02 07952 RETAIL SERVICES 0 0 194, 02 8 063 Ω 194. 03 07953 REID CONTRACTED SERVICES 4,944 0 0 0 0 194. 03 194. 04 07954 REID PHYSICIAN ASSOC. o 0 194.04 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 0 194. 05 194.06 07956 VACANT SPACE 0 0 0 0 194.06 194. 07 07957 HOME OFFICE 0 0 0 194.07 194. 08 07958 CAMBRI DGE RHC 0 0 194.08 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10

near th Fina	nciai systems keid	HUSPITAL & HEA	ILIH CARE SERV	TH LIEU OF FORM CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der (Peri od:	Worksheet B-1	
					From 01/01/2022		
					To 12/31/2022		
						5/23/2023 11:	46 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MANHOURS)	ADMI NI STRATI C	SERVICES &	(DRUGS)	RECORDS &	
			N	SUPPLY		LI BRARY	
			(DI RECT NUR	(MED SUPPLI		(TOTAL REVE	
			SING HRS)	ES)		NUE)	
		11. 00	13. 00	14. 00	15. 00	16.00	
194. 09 0795	9 REID HEALTH PAVILION - RES	61, 762	(0	0 13, 767	0	194. 09
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 809, 926	497, 960	7, 894, 18	53, 257, 129	153, 811	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 061729	0. 316632	0. 32355	1. 381263	0. 000133	203.00
204.00	Cost to be allocated (per Wkst. B,	267, 813	54, 62°	1 453, 54	1, 328, 062	137, 094	204.00
	Part II)						
005 00		0 404400	0 00470				laar aa

0. 101193

0. 034731

0. 018589

0. 034444

0.000118 205.00

206. 00

207. 00

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D, Parts III and IV)

NAHE adjustment amount to be allocated (per Wkst. B-2)

205.00

206.00

207.00

II)

Health Financial Systems

COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

Peri od:
From 01/01/2022
To 12/31/2022 Date/Ti me Prepared:

5/23/2023 11:46 am INTERNS & RESIDENTS PARAMED ED SOCI AL I NSERVI CE SERVI CES-SALA | SERVI CES-OTHE Cost Center Description SERVI CE **FDUCATION** RY & FRINGES R PRGM COSTS PRGM (TIME SPENT) (TIME SPENT) **APPRV APPRV** (IN HOUSE E (ASSI GNED (ASSI GNED D) TIME) TIME) 17. 00 17. 01 21.00 22. 00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00540 NONPATIENT TELEPHONES 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5 03 5 03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER A&G 5.06 00700 OPERATION OF PLANT 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 55, 729 17.00 17.01 01701 INSERVICE EDUCATION 43, 382 17.01 02100 L&R SERVICES-SALARY & FRINGES APPRV 1,629 21 00 21 00 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 1, 629 22.00 02300 PARAMED ED PRGM 100 23.00 23.00 126 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 36, 858 12.684 1, 199 1.199 0 31.00 03100 INTENSIVE CARE UNIT 4, 349 1,863 47 47 0 31.00 04000 SUBPROVI DER - I PF 40 00 0 1, 154 0 0 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 778 0 0 0 41.00 04300 NURSERY 43.00 0 235 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 2, 866 82 82 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 281 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 4, 421 25 25 100 54.00 59.00 05900 CARDIAC CATHETERIZATION 0 927 0 0 0 59.00 06000 LABORATORY 0 0 60.00 60.00 3.590 0 06500 RESPIRATORY THERAPY 0 0 65.00 900 0 65.00 66.00 0 06600 PHYSI CAL THERAPY 4, 341 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 823 42 42 0 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 284 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 0 0 07400 RENAL DIALYSIS 74 00 C 0 74 00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 0 0 o 76.97 313 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 14, 522 4, 232 101 101 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93 00 1, 251 O O 93.00 0 0 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 265 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 ol 0 102.00 C SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 711 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 55, 729 42,045 1, 496 1, 496 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 133 133 0 194.00 07950 RENTAL SPACE C 0 0 194.00 0 194. 01 07951 FOUNDATION 111 0 0 0 194, 01 0 194. 02 07952 RETAIL SERVICES 0 0 0 194. 02 140 0 194. 03 07953 REID CONTRACTED SERVICES C 0 0 0 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 0 0 0 0 194.04 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 0 194.05 194.06 07956 VACANT SPACE 0 0 194.06

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/23/2023 11: 46 am Provider CCN: 15-0048

						5/23/2023 11:	46 am_
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PRGM	
		(TIME SPENT)	(IN HOUSE E	APPRV	APPRV	(TIME SPENT)	
		, ,	D)	(ASSI GNED	(ASSI GNED	,	
			,	TIME)	TIME)		
		17. 00	17. 01	21. 00	22. 00	23. 00	
194. 07 07957	HOME OFFICE	0	0	0	0	0	194. 07
	CAMBRI DGE RHC	0	0	0	0		194. 08
194. 09 07959	REID HEALTH PAVILION - RES	0	1, 086	0	0	0	194. 09
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	6, 311, 724	4, 575, 220	2, 829, 083	767, 787	733, 583	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	113. 257442	105. 463556	1, 736. 699202	471. 324125	7, 335. 830000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	55, 053	322, 758	5, 773	17, 210	114, 743	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 987870	7. 439906	3. 543892	10. 564764	1, 147. 430000	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 CCN: 15-0048 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Title XVIII Hospi tal PPS Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 60, 578, 583 60, 578, 583 997 60, 579, 580 30.00 03100 INTENSIVE CARE UNIT 11, 746, 847 11, 746, 847 0 11, 746, 847 31.00 31.00 40.00 04000 SUBPROVI DER - I PF 5, 411, 239 5, 411, 239 0 5, 411, 239 40.00 04100 SUBPROVI DER - I RF 0 4,024,842 41.00 4.024.842 4, 024, 842 41 00 43.00 04300 NURSERY 1, 116, 522 1, 116, 522 1, 116, 522 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 46, 973, 168 46, 973, 168 50.00 46, 973, 168 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1, 947, 014 1, 947, 014 1, 947, 014 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 982, 493 33, 982, 493 0 33, 982, 493 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 16, 156, 480 16, 156, 480 0 16, 156, 480 59.00 06000 LABORATORY 0 23, 548, 462 23, 548, 462 23, 548, 462 60.00 60.00 06500 RESPIRATORY THERAPY 65.00 5, 006, 855 0 5, 006, 855 5, 006, 855 65.00 06600 PHYSI CAL THERAPY 18, 890, 698 18, 890, 698 18, 890, 698 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 5, 465, 655 5, 465, 655 0 0 5, 465, 655 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 355, 538 70 00 70 00 1, 355, 538 1, 355, 538 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 232, 507 22, 232, 507 22, 232, 507 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 53, 167, 667 53, 167, 667 53, 167, 667 73.00 73.00 07400 RENAL DIALYSIS 74.00 1, 222, 032 1, 222, 032 1, 222, 032 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 1, 269, 186 1, 269, 186 1, 269, 186 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 21, 000, 021 21, 000, 021 0 21, 000, 021 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 016, 785 10.016.785 10, 016, 785 92.00 04040 FAMILY PRACTICE 93.00 3, 747, 655 3, 747, 655 3, 747, 655 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 872, 272 872, 272 0 872, 272 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102 00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 293, 854 5, 293, 854 5, 293, 854 116. 00 355, 027, 372 200. 00 200 00 Subtotal (see instructions) 355, 026, 375 0 355, 026, 375 997 10, 016, 785 201. 00 201.00 Less Observation Beds 10, 016, 785 10, 016, 785 202.00 Total (see instructions) 345, 009, 590 345, 009, 590 997 345, 010, 587 202. 00

201.00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0048 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 59, 857, 044 59, 857, 044 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 656, 052 10, 656, 052 31.00 04000 SUBPROVI DER - I PF 5, 073, 786 5, 073, 786 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4, 173, 816 4, 173, 816 41.00 04300 NURSERY 1, 320, 590 43.00 1, 320, 590 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 45, 431, 781 146, 650, 486 192, 082, 267 0.244547 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0. 240241 52.00 7. 088. 476 1,015,952 8, 104, 428 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 45, 773, 798 155, 815, 787 201, 589, 585 0. 168573 0.000000 54.00 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 43, 444, 518 74, 549, 554 117, 994, 072 0. 136926 0.000000 59.00 60.00 06000 LABORATORY 44, 148, 962 80, 960, 264 125, 109, 226 0.188223 0.000000 60.00 22, 587, 917 27, 510, 977 65.00 06500 RESPIRATORY THERAPY 4, 923, 060 0. 181995 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 8, 673, 566 17, 159, 309 25, 832, 875 0.731266 0.000000 66.00 06900 ELECTROCARDI OLOGY 24, 294, 667 0.177870 69 00 6, 433, 630 30, 728, 297 0.000000 69.00 7, 080, 514 7, 085, 048 07000 ELECTROENCEPHALOGRAPHY 4, 534 0.000000 70.00 0.191324 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 198, 997 26, 071, 691 42, 270, 688 0.525956 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 57, 291, 203 95, 179, 095 152, 470, 298 73.00 0.348708 0.000000 73.00 07400 RENAL DIALYSIS 1, 296, 107 0.942848 74.00 1, 132, 276 163, 831 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 700 1, 932, 467 1, 933, 167 0.656532 0.000000 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 33, 486, 656 80, 081, 625 113, 568, 281 0.184911 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.595234 92.00 4, 316, 464 12, 511, 842 16, 828, 306 0.000000 92.00 21, 972 93.00 04040 FAMILY PRACTICE 0.000000 93.00 7, 700, 874 7, 722, 846 0.485269 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 469, 944 469, 944 1.856119 0.000000 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 924, 127 4, 458, 898 6, 383, 025 116.00 200.00 Subtotal (see instructions) 419, 040, 865 741, 019, 860 1, 160, 060, 725 200.00

419, 040, 865

741, 019, 860 1, 160, 060, 725

201.00

202.00

Less Observation Beds

Total (see instructions)

			10 12/31/2022	Date/II me Prepared: 5/23/2023 11:46 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTER	S			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 244547			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 240241			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168573			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 136926			59. 00
60. 00 06000 LABORATORY	0. 188223			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 181995			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 731266			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 177870			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 191324			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 525956			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 348708			73. 00
74.00 07400 RENAL DIALYSIS	0. 942848			74.00
76.00 03950 ANCILLARY - OTHER	0. 000000			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 656532			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 184911			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT F				92.00
93. 00 04040 FAMILY PRACTICE	0. 485269			93. 00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	1. 856119			96.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				112.00
113. 00 11300 I NTEREST 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

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 60, 578, 583 60, 578, 583 997 60, 579, 580 30.00 03100 INTENSIVE CARE UNIT 11, 746, 847 11, 746, 847 0 11, 746, 847 31.00 31.00 40.00 04000 SUBPROVI DER - I PF 5, 411, 239 5, 411, 239 0 5, 411, 239 40.00 04100 SUBPROVI DER - I RF 0 4,024,842 41.00 4.024.842 4, 024, 842 41 00 43.00 04300 NURSERY 1, 116, 522 1, 116, 522 1, 116, 522 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 46, 973, 168 46, 973, 168 50.00 46, 973, 168 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1, 947, 014 1, 947, 014 1, 947, 014 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 33, 982, 493 33, 982, 493 0 33, 982, 493 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 16, 156, 480 16, 156, 480 0 16, 156, 480 59.00 06000 LABORATORY 0 23, 548, 462 23, 548, 462 23, 548, 462 60.00 60.00 06500 RESPIRATORY THERAPY 65.00 5, 006, 855 0 5, 006, 855 5, 006, 855 65.00 06600 PHYSI CAL THERAPY 18, 890, 698 18, 890, 698 18, 890, 698 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 5, 465, 655 5, 465, 655 0 0 5, 465, 655 69.00 07000 ELECTROENCEPHALOGRAPHY 1, 355, 538 70 00 70 00 1, 355, 538 1, 355, 538 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 232, 507 22, 232, 507 22, 232, 507 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 53, 167, 667 53, 167, 667 53, 167, 667 73.00 73.00 07400 RENAL DIALYSIS 74.00 1, 222, 032 1, 222, 032 1, 222, 032 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 0 76. 97 1, 269, 186 1, 269, 186 1, 269, 186 76.97 77 00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 21, 000, 021 21, 000, 021 0 21, 000, 021 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 016, 785 10.016.785 10, 016, 785 92.00 04040 FAMILY PRACTICE 93.00 3, 747, 655 3, 747, 655 3, 747, 655 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 872, 272 872, 272 0 872, 272 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102 00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 293, 854 5, 293, 854 5, 293, 854 116. 00 355, 027, 372 200. 00 200 00 Subtotal (see instructions) 355, 026, 375 0 355, 026, 375 997 10, 016, 785 201. 00 201.00 Less Observation Beds 10, 016, 785 10, 016, 785 202.00 Total (see instructions) 345, 009, 590 345, 009, 590 997 345, 010, 587 202. 00

202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0048 Peri od: Worksheet C From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/23/2023 11:46 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 59, 857, 044 59, 857, 044 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 656, 052 10, 656, 052 31.00 04000 SUBPROVI DER - I PF 5, 073, 786 5, 073, 786 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4, 173, 816 4, 173, 816 41.00 04300 NURSERY 1, 320, 590 43.00 1, 320, 590 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 45, 431, 781 146, 650, 486 192, 082, 267 0.244547 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0. 240241 52.00 7. 088. 476 1,015,952 8, 104, 428 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 45, 773, 798 155, 815, 787 201, 589, 585 0. 168573 0.000000 54.00 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 43, 444, 518 74, 549, 554 117, 994, 072 0. 136926 0.000000 59.00 60.00 06000 LABORATORY 44, 148, 962 80, 960, 264 125, 109, 226 0.188223 0.000000 60.00 22, 587, 917 27, 510, 977 65.00 06500 RESPIRATORY THERAPY 4, 923, 060 0. 181995 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 8, 673, 566 17, 159, 309 25, 832, 875 0.731266 0.000000 66.00 06900 ELECTROCARDI OLOGY 24, 294, 667 0.177870 69 00 6, 433, 630 30, 728, 297 0.000000 69.00 7, 080, 514 7, 085, 048 07000 ELECTROENCEPHALOGRAPHY 4, 534 0.000000 70.00 0.191324 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 16, 198, 997 26, 071, 691 42, 270, 688 0.525956 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 57, 291, 203 95, 179, 095 152, 470, 298 73.00 0.348708 0.000000 73.00 07400 RENAL DIALYSIS 1, 296, 107 0.942848 74.00 1, 132, 276 163, 831 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0.000000 76.00 76. 97 07697 CARDIAC REHABILITATION 700 1, 932, 467 1, 933, 167 0.656532 0.000000 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 33, 486, 656 80, 081, 625 113, 568, 281 0.184911 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.595234 92.00 4, 316, 464 12, 511, 842 16, 828, 306 0.000000 92.00 21, 972 93.00 04040 FAMILY PRACTICE 0.000000 93.00 7, 700, 874 7, 722, 846 0.485269 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 469, 944 469, 944 1.856119 0.000000 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 924, 127 4, 458, 898 6, 383, 025 116.00 200.00 Subtotal (see instructions) 419, 040, 865 741, 019, 860 1, 160, 060, 725 200.00

419, 040, 865

741, 019, 860 1, 160, 060, 725

201.00

202.00

Less Observation Beds

Total (see instructions)

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				10 12/31/2022	5/23/2023 11:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·		
	·	Ratio				
		11. 00				
	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00	D3000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF					40.00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
59.00	D5900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 000000				60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
76. 00	03950 ANCILLARY - OTHER	0. 000000				76.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000				76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
Ī	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
93.00	04040 FAMILY PRACTICE	0. 000000				93.00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
102.00	10200 OPIOID TREATMENT PROGRAM					102.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
	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

Health Financial Systems R	EID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	<u>2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2022	Worksheet D	
				From 01/01/2022		epared:
					5/23/2023 11:	46 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,				
30.00 ADULTS & PEDIATRICS	4, 730, 137		4, 730, 13	·	109. 31	
31.00 INTENSIVE CARE UNIT	1, 290, 451		1, 290, 45	·	256. 19	
40. 00 SUBPROVI DER - I PF	778, 478	0	778, 478	4, 631	168. 10	40.00
41. 00 SUBPROVI DER - I RF	612, 341	0	612, 34°	3, 810	160. 72	41.00
43.00 NURSERY	94, 393		94, 393	1, 417	66. 61	43.00
200.00 Total (lines 30 through 199)	7, 505, 800		7, 505, 800	58, 167	1	200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	14, 946	1, 633, 747				30.00
31.00 INTENSIVE CARE UNIT	1, 904	487, 786				31.00
40. 00 SUBPROVI DER - I PF	1, 864	313, 338				40.00
41. 00 SUBPROVI DER - I RF	1, 643	264, 063				41.00
43. 00 NURSERY	0	0)			43.00
200 00 Total (Lines 20 through 199)	20 257	2 600 024	1			200 00

1, 643 0 20, 357

2, 698, 934

200.00

40.00 | SUBPROVI DER - I PF 41.00 | SUBPROVI DER - I RF 43.00 | NURSERY 200.00 | Total (lines 30 through 199)

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 Co		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATING ROOM	3, 907, 280		0. 02034		450, 467	ł
52.00 05200 DELIVERY ROOM & LABOR ROOM	299, 838					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 550, 974					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 617, 236					59.00
60. 00 06000 LABORATORY	1, 770, 781	125, 109, 226	0. 01415	4 18, 102, 040	256, 216	60.00
65. 00 06500 RESPI RATORY THERAPY	194, 512	27, 510, 977			71, 623	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 661, 322	25, 832, 875	0. 06431	2, 433, 679	156, 510	66.00
69. 00 06900 ELECTROCARDI OLOGY	496, 827	30, 728, 297	0. 01616		48, 406	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	160, 835	7, 085, 048			89	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.00000	0	0	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	32, 467	42, 270, 688	0. 00076		7, 427	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 356, 271	152, 470, 298	0. 00889	5 22, 984, 014	204, 443	73.00
74. 00 07400 RENAL DI ALYSI S	57, 275	1, 296, 107	0. 04419	579, 986	25, 630	74.00
76. 00 03950 ANCI LLARY - OTHER	0	0	0.00000	0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	238, 846	1, 933, 167	0. 12355	2 330	41	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	1, 471, 796	113, 568, 281	0. 01296	14, 703, 522	190, 558	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	782, 121	16, 828, 306	0. 04647	7 1, 759, 989	81, 799	92.00
93.00 04040 FAMILY PRACTICE	106, 575	7, 722, 846	0. 01380	21, 972	303	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	148, 331	469, 944	0. 31563	5 0	0	96.00
200.00 Total (lines 50 through 199)	19, 853, 287	1, 072, 596, 412		146, 419, 667	2, 330, 001	200. 00

Health Financial Systems	REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHER F	PASS THROUGH COST	S Provider CO	CN: 15-0048	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/23/2023 11:	
			Title	XVIII	Hospi tal	PPS	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	O	0		0 0	0	41.00
43. 00 04300 NURSERY	O	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	O	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
'	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)	,	
		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	43, 27	2 0.00	14, 946	30.00
31.00 03100 INTENSIVE CARE UNIT		0	5, 03	7 0.00	1, 904	31.00
40. 00 04000 SUBPROVI DER - 1 PF	O	0	4, 63	1 0.00	1, 864	40.00
41. 00 04100 SUBPROVI DER - RF	l ol	0	3, 81	0.00	1, 643	41.00
43. 00 04300 NURSERY		0	1, 41	7 0.00	0	43.00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpatient				.,	
, , , , , , , , , , , , , , , , , , ,	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	O					31.00
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF						41.00
43. 00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
200.00 10tal (111103 30 till bugil 177)	١					1200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0048 THROUGH COSTS

					To 12/31/2022	Date/Time Pre 5/23/2023 11:	pared:
			Title	XVIII	Hospi tal	PPS	40 alli_
	Cost Center Description	Non Physician		Nursi ng		Allied Health	
	oost content beschiperen	Anesthetist	Program	Program	Post-Stepdown	/ rica ricar tir	
		Cost	Post-Stepdown	9	Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	733, 583	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	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
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	07400 RENAL DIALYSIS	0	0		0	0	74.00
	03950 ANCI LLARY - OTHER	0	0		0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93. 00	04040 FAMILY PRACTICE	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
200.00	Total (lines 50 through 199)	0	0		0	733, 583	200. 00

Health Fin	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10							
APPORTI ON	MENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider Co		Peri od:	Worksheet D		
THROUGH CO	OSTS				rom 01/01/2022			
					Γο 12/31/2022			
			Ti +Lo	XVIII	Hospi tal	5/23/2023 11: PPS	40 alli_	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost		
	cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges		
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷		
		Cost	1, 2, 3, and 4)	col s. 2, 3,	col. 8)	col. 7)		
		0031	7)	and 4)	COI. 0)	(see		
				ana i)		instructions)		
		4. 00	5. 00	6. 00	7. 00	8. 00		
ANC	ILLARY SERVICE COST CENTERS		0.00		1			
50.00 050	000 OPERATING ROOM	0	0	(192, 082, 267	0.000000	50.00	
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0	0	(8, 104, 428	0.000000	52.00	
54.00 054	00 RADI OLOGY-DI AGNOSTI C	0	733, 583	733, 583	201, 589, 585	0. 003639	54.00	
59.00 059	OOO CARDI AC CATHETERI ZATI ON	0	0	. (0.000000	59.00	
60.00 060	000 LABORATORY	0	0	(125, 109, 226	0.000000	60.00	
65. 00 065	000 RESPI RATORY THERAPY	0	0	(27, 510, 977	0.000000	65.00	
66. 00 066	000 PHYSI CAL THERAPY	0	0	(25, 832, 875	0.000000	66.00	
69. 00 069	POO ELECTROCARDI OLOGY	0	0	(30, 728, 297	0.000000	69.00	
70.00 070	000 ELECTROENCEPHALOGRAPHY	0	0	(7, 085, 048	0.000000	70.00	
71. 00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0.000000	71.00	
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(42, 270, 688	0.000000	72.00	
73.00 073	BOO DRUGS CHARGED TO PATIENTS	0	0	(152, 470, 298	0.000000	73.00	
	100 RENAL DI ALYSI S	0	0	(1, 296, 107	0.000000	74.00	
	250 ANCI LLARY - OTHER	0	0	(0	0.000000	76.00	
	97 CARDI AC REHABI LI TATI ON	0	0	(1, 933, 167	0. 000000		
	OO ALLOGENEIC HSCT ACQUISITION	0	0	(0	0.000000	77.00	
	PATIENT SERVICE COST CENTERS							
	00 EMERGENCY	0	0		113, 568, 281	0. 000000		
	200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		16, 828, 306	0. 000000		
	040 FAMILY PRACTICE	0	0	(7, 722, 846	0. 000000	93. 00	
	IER REI MBURSABLE COST CENTERS							
	DOO DURABLE MEDICAL EQUIP-RENTED	0	0	,	469, 944			
200. 00	Total (lines 50 through 199)	0	733, 583	733, 583	1, 072, 596, 412		200. 00	

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	eu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATI	ENT ANCILLADY SEDVICE OTHER DASS	Providor CCN: 15 0049	Pari ad:	Workshoot D

Period: From 01/01/2022 To 12/31/2022 Part IV THROUGH COSTS Date/Time Prepared: 5/23/2023 11:46 am Title XVIII Hospi tal PPS Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Charges Pass-Through Charges Pass-Through (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 10) x col. 12) 13.00 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50 00 05000 OPERATING ROOM 22, 144, 659 45, 157, 937 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 1, 086 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.003639 19, 959, 936 45, 797, 547 54.00 72, 634 166, 657 54.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 20, 930, 405 30, 345, 463 59.00 59.00 0 0 06000 LABORATORY 0 60.00 0.000000 18, 102, 040 10, 219, 319 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 10, 130, 559 0 1, 363, 685 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 2, 433, 679 106, 251 66.00 8, 637, 927 06900 ELECTROCARDI OLOGY 69.00 0.000000 2, 993, 954 69.00 Ω 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 3, 942 2, 021, 054 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 9, 670, 680 0 9, 169, 156 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.000000 22, 984, 014 35, 626, 412 73.00 0 74. 00 07400 RENAL DIALYSIS 0.000000 579, 986 56, 627 0 74.00 03950 ANCI LLARY - OTHER 76.00 0.000000 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 0 76. 97 76.97 0.000000 922, 030 330 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.000000 14, 703, 522 0 16, 126, 515 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 759, 989 1, 991, 577 92.00 0.000000 0 0 92.00 93.00 04040 FAMILY PRACTICE 0.000000 21, 972 0 3, 014, 167 0 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 n 96.00 146, 419, 667 210, 556, 753 166, 657 200. 00 200.00 Total (lines 50 through 199) 72,634

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 244547 45, 157, 937 11, 043, 238 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0. 240241 52.00 1,086 0 52.00 261 45, 797, 547 05400 RADI OLOGY-DI AGNOSTI C 0 7, 720, 230 54.00 0. 168573 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.136926 30, 345, 463 0 0 4, 155, 083 59.00 60.00 06000 LABORATORY 0. 188223 10, 219, 319 0 0 1, 923, 511 60.00 06500 RESPIRATORY THERAPY 0. 181995 0 65.00 1, 363, 685 248, 184 65.00 850 0 66.00 06600 PHYSI CAL THERAPY 0. 731266 106, 251 0 77, 698 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 177870 8, 637, 927 0 0 1, 536, 428 69.00 2, 021, 054 0 o 07000 ELECTROENCEPHALOGRAPHY 0. 191324 386, 676 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.525956 9, 169, 156 0 4, 822, 573 72.00 07300 DRUGS CHARGED TO PATIENTS 0 12, 423, 215 73.00 0.348708 35, 626, 412 70, 114 73.00 07400 RENAL DIALYSIS 0.942848 0 74 00 56, 627 0 53, 391 74 00 0 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.656532 922, 030 0 0 605, 342 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 184911 16, 126, 515 0 0 2, 981, 970 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.595234 1, 991, 577 0 0 1, 185, 454 92.00 1, 462, 682 93.00 04040 FAMILY PRACTICE 0.485269 3, 014, 167 0 ol 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 1. 856119 0 0 96.00 Subtotal (see instructions) 210, 556, 753 0 70, 964 50, 625, 936 200. 00 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 0 70, 964 50, 625, 936 202. 00 Net Charges (line 200 - line 201) 210, 556, 753

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0048 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/23/2023 11:46 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000 52.00 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 06500 RESPIRATORY THERAPY 65.00 155 65.00 06600 PHYSI CAL THERAPY 66.00 0 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 C 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 24, 449 74. 00 07400 RENAL DIALYSIS Ω 74 00 76.00 03950 ANCI LLARY - OTHER 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 04040 FAMILY PRACTICE 93.00 ol 0 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 Subtotal (see instructions) 0 24, 604 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00

0

24,604

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

		HOSPITAL & HEA				u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
			Component		From 01/01/2022 To 12/31/2022		nared:
			Component	CCN. 13-3040	12/31/2022	5/23/2023 11:	
			Title	: XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 907, 280	192, 082, 267	0. 020342	41, 181	838	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	299, 838	8, 104, 428	0. 036997	7 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 550, 974	201, 589, 585	0. 027536	189, 305	5, 213	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 617, 236	117, 994, 072	0. 013706	1, 839	25	59.00
60.00	06000 LABORATORY	1, 770, 781	125, 109, 226	0. 014154	373, 716	5, 290	60.00
65.00	06500 RESPIRATORY THERAPY	194, 512	27, 510, 977	0. 007070	96, 976	686	65.00
66.00	06600 PHYSI CAL THERAPY	1, 661, 322	25, 832, 875	0. 064310	141, 045	9, 071	66.00
69.00	06900 ELECTROCARDI OLOGY	496, 827	30, 728, 297	0. 016168	18, 172	294	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	160, 835	7, 085, 048	0. 022701	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0. 000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	32, 467	42, 270, 688	0. 000768	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 356, 271	152, 470, 298	0.008895	552, 179	4, 912	73.00
74.00	07400 RENAL DIALYSIS	57, 275	1, 296, 107	0. 044190	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0. 000000	o	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	238, 846	1, 933, 167	0. 123552	2 0	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000	o	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	•		•	<u>'</u>		
91.00	09100 EMERGENCY	1, 471, 796	113, 568, 281	0. 012960	335, 583	4, 349	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16, 828, 306	0. 000000	0	0	92.00
93.00	04040 FAMILY PRACTICE	106, 575				0	93.00
	OTHER RELIMBURGARIE COCT CENTERS				•		1

148, 331 469, 944 19, 071, 166 1, 072, 596, 412

0. 315635

1, 749, 996

0 96.00 30,678 200.00

OTHER REI MBURSABLE COST CENTERS

96.00 O9600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

Health Financial Systems REID	HOSPITAL & HEA	IITU CADE SEDVI	CES	In Li	eu of Form CMS-	2552 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2552-10
THROUGH COSTS		Component	CCN: 15-S048	From 01/01/2022 To 12/31/2022		epared: 46 am
		Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown	1	
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	2.00	3A	2.00	
ANCILLARY SERVICE COST CENTERS	1. 00	2A	2.00	3A	3. 00	
50. 00 05000 OPERATING ROOM	0			0	0 (50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM						52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				733, 583	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	0 0	1
60. 00 06000 LABORATORY	0			0		60.00
65. 00 06500 RESPIRATORY THERAPY	0	l o		o o		65.00
66. 00 06600 PHYSI CAL THERAPY	0	O)	0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	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	1	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	0	0		0	0	77. 00
OUTPATIENT SERVICE COST CENTERS			ı			01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	1	0	0 0	1
93. 00 04040 FAMILY PRACTICE	0	0		-		1
OTHER REIMBURSABLE COST CENTERS	0		1	O .	0	73.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0 (96.00
200.00 Total (lines 50 through 199)	0				733, 583	

Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	SS Provider C	CN: 15-0048 P	eri od:	Worksheet D	
THROUGH COSTS		Component		rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
		Title	XVIII	Subprovi der -	5/23/2023 11: PPS	46 am_
				I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	192, 082, 267	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	8, 104, 428	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	733, 583	733, 583	201, 589, 585	0. 003639	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	117, 994, 072	0.000000	59.00
60. 00 06000 LABORATORY	0	0	0	125, 109, 226	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	27, 510, 977	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	25, 832, 875	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	30, 728, 297		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	l o	7, 085, 048	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	l o	0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l o	42, 270, 688	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	152, 470, 298	l e	
74.00 07400 RENAL DIALYSIS	0	0	0	1, 296, 107	l e	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	0	1, 933, 167	l e	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		0. 000000	
OUTPATIENT SERVICE COST CENTERS	-	-	-	_		
91. 00 09100 EMERGENCY	0	0	0	113, 568, 281	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1		
93. 00 04040 FAMILY PRACTICE	0	0	0	1		
OTHER REIMBURSABLE COST CENTERS				.,,010		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	469, 944	0.000000	96.00
200.00 Total (lines 50 through 199)	Ö			1, 072, 596, 412		200.00
	1	, , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	1 ., , 0 , 0 , 1	I	

Heal th	Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co		eri od:	Worksheet D	
THROUG	GH COSTS		Component (rom 01/01/2022 o 12/31/2022		pared: 46 am
			Title	XVIII	Subprovi der -	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	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)	10.00	x col. 10)	10.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
50. 00	05000 OPERATING ROOM	0. 000000	41, 181	C	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	41, 101	0	_	l ~	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 003639	189, 305	689	1		54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	1, 839	007		0	59.00
60.00	06000 LABORATORY	0. 000000	373, 716	0	· ·		60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	96, 976	0	2, 730		65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	141, 045	0	0		66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	18, 172	0	967	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	10, 172	0	707	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	552, 179	0	o o	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 000000	002, 177	0	o o	0	74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000	0	0	o o	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	Ö	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	Ö	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0. 000000	335, 583	C	0	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	0	O	236	0	93.00
	OTHER REIMBURSABLE COST CENTERS		-				1
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	O	0	0	96.00
200.00	Total (lines 50 through 199)		1, 749, 996	689	4, 962	3	200.00

Health Financial Systems	REI	LTH CARE SERVI	CES	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL,	T OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			CN: 15-0048 CCN: 15-S048	Period: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared 5/23/2023 11:46 at		
			Title	e XVIII	Subprovi der - I PF	PPS	40 alli
Cost Center De	escription	Cost to	PPS	Charges Cost	Cost	Costs PPS Services	

					07 207 2020 11.	10 uiii
		Title	× XVIII	Subprovi der -	PPS	
			01	I PF	0	
0	0	DDC	Charges	0 !	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 O5000 OPERATING ROOM	0. 244547				0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 244347				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168573	799			135	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 136926		l .		0	1
60. 00 06000 LABORATORY	0. 188223	2, 730	1		514	
65. 00 06500 RESPI RATORY THERAPY	0. 188223				42	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 731266		1		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 731200		,		172	69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 177870	707			172	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 525956				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 323730			129		73.00
74. 00 07400 RENAL DI ALYSI S	0. 942848) 127	0	74.00
76. 00 03950 ANCI LLARY - OTHER	0. 000000				0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 656532				0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				0	77.00
OUTPATIENT SERVICE COST CENTERS	0. 000000			,		77.00
91. 00 09100 EMERGENCY	0. 184911	0	(0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 595234			o o	0	92.00
93. 00 04040 FAMILY PRACTICE	0. 485269	l e		0	115	
OTHER REIMBURSABLE COST CENTERS				-		1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 856119	0		0	0	96.00
200.00 Subtotal (see instructions)		4, 962		129	978	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		4, 962	(129	978	202.00
	•	•	•	*	•	

	<i></i>	HOSPITAL & HEA				of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0048	Peri od: From 01/01/2022	Worksheet D Part V	
			Component	CCN: 15-S048	To 12/31/2022	Date/Time Pre 5/23/2023 11:	epared: 46 am
			Title	XVIII	Subprovi der - I PF	PPS	
		Cos	its		<u> </u>		
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	0	0				60.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	45				73.00
	07400 RENAL DI ALYSI S	0	0				74.00
	03950 ANCI LLARY - OTHER	0	0				76.00
	07697 CARDIAC REHABILITATION	0	0				76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	OUTPATIENT SERVICE COST CENTERS	1					
	09100 EMERGENCY	0	0	i			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
93.00	04040 FAMILY PRACTICE	0	0				93.00
	OTHER REIMBURSABLE COST CENTERS		0	1			
							1 06 00

0 0 0 0 45

45

96. 00 200. 00 201. 00

202.00

O9600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

96. 00 200. 00 201. 00

202.00

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
			Component	From 01/01/2022 Part			narodi
			Component	CCN. 13-1046	10 12/31/2022	Date/Time Pre 5/23/2023 11:	
			Title	: XVIII	Subprovi der -	PPS	
					IRF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 907, 280		•			1
52.00	05200 DELIVERY ROOM & LABOR ROOM	299, 838					52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 550, 974					
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 617, 236					59.00
60.00	06000 LABORATORY	1, 770, 781					
65.00	06500 RESPI RATORY THERAPY	194, 512					
66.00	06600 PHYSI CAL THERAPY	1, 661, 322					1
69. 00	06900 ELECTROCARDI OLOGY	496, 827		0. 01616		47	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	160, 835	7, 085, 048			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	_	0. 00000		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 467	42, 270, 688	0.00076	0 8	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 356, 271	152, 470, 298	0. 00889	95 492, 093	4, 377	73.00
74.00	07400 RENAL DIALYSIS	57, 275	1, 296, 107	0. 04419	19, 405	858	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0.00000	00	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	238, 846	1, 933, 167	0. 12355	52 0	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 471, 796	113, 568, 281	0. 01296	1, 445	19	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16, 828, 306	0.00000	0 0	0	92.00
93.00	04040 FAMILY PRACTICE	106, 575	7, 722, 846	0. 01380	0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	148, 331	469, 944	0. 31563	5 0	0	96.00
200.00	Total (lines 50 through 199)	19, 071, 166	1, 072, 596, 412		2, 821, 451	113, 415	200.00

Heal th Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10
Component CCN: 15-T048
Non Physician Nursing Program Program Program Program Program Program Adjustments Nursing Program Prog
Anesthetist Program Program Program Adj ustments
Cost Post-Stepdown Adjustments Adjustments Adjustmen
Adjustments 1.00 2A 2.00 3A 3.00
1.00 2A 2.00 3A 3.00
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 0 0 0 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 733, 583 54. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 60. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 733, 583 54. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 60. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 60. 00
60. 00 06000 LABORATORY 0 0 0 0 60. 00
65. 00 06500 RESPI RATORY THERAPY
69. 00 06900 PHTSTCAL THERAPY
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73. 00 0 73. 00
74. 00 07400 RENAL DI ALYSI S
76. 00 03950 ANCI LLARY - OTHER
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 77.00
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY 0 0 0 0 91. 00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00
93.00 04040 FAMILY PRACTICE 0 0 0 93.00
OTHER REIMBURSABLE COST CENTERS
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 96. 00
200.00 Total (lines 50 through 199) 0 0 0 733, 583 200.00

Heal th	Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF			CN: 15-0048 F	eri od:	Worksheet D	
THROUG	GH COSTS				rom 01/01/2022	Part IV	
			Component	CCN: 15-T048 T	o 12/31/2022	Date/Time Pre 5/23/2023 11:	pared: 46 am
-			Title	XVIII	Subprovi der -	PPS	40 aiii
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	., ., .,		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	-, ,		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	733, 583	733, 583			
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	,		
60.00	06000 LABORATORY	0	0	C	125, 109, 226	0. 000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	27, 510, 977	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	25, 832, 875	0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	30, 728, 297	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	7, 085, 048	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	42, 270, 688	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	152, 470, 298	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	C	1, 296, 107	0.000000	74.00
76.00	03950 ANCILLARY - OTHER	0	0	l c	0	0.000000	76.00
76. 97	07697 CARDIAC REHABILITATION	0	0	l c	1, 933, 167	0.000000	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	l c		0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	C	113, 568, 281	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	16, 828, 306	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	C	7, 722, 846	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00		0	0	C			96.00
200.00	Total (lines 50 through 199)	0	733, 583	733, 583	1, 072, 596, 412		200.00

Health Financial Systems REID) HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co		eri od:	Worksheet D	
THROUGH COSTS		Component (rom 01/01/2022 o 12/31/2022		narodi
		Component	JCN. 13-1046 1	0 12/31/2022	5/23/2023 11:	46 am
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
ANOLILIARY OFFICE COOT OFFITERS	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS		25 222				
50. 00 05000 OPERATING ROOM	0. 000000	85, 993	0	_		00.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	0	0	_		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 003639	108, 412	395		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 060	0	_	0	
60. 00 06000 LABORATORY	0. 000000	316, 518	0	1	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	284, 051	0	0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 505, 573	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 901	0	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	,
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	492, 093	0	0	0	,
74.00 07400 RENAL DIALYSIS	0. 000000	19, 405	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	_	· -	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	1, 445	0		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0		_	92.00
93. 00 04040 FAMILY PRACTICE	0. 000000	0	0	468	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0			
200.00 Total (lines 50 through 199)		2, 821, 451	395	468	0	200.00

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D	
		Component CCN: 15-T048			
		Title XVIII	Subprovi der -	PPS	
			I RF		
		Charges		Costs	

					5/23/2023 11:	46 am_
		Title	XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 244547	0	(0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 240241	0	(0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 168573	0	(0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 136926	0	(0	0	59.00
60. 00 06000 LABORATORY	0. 188223	0	(0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 181995	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 731266	0	(0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 177870	0	(0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 191324	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 525956	0		o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 348708	0		o	0	73.00
74.00 07400 RENAL DIALYSIS	0. 942848	0		o	0	74.00
76. 00 03950 ANCI LLARY - OTHER	0. 000000	0		o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 656532	0		o	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		o	0	77.00
OUTPATIENT SERVICE COST CENTERS			•	*		
91. 00 09100 EMERGENCY	0. 184911	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 595234	0		0	0	92.00
93.00 04040 FAMILY PRACTICE	0. 485269	468		0	227	93.00
OTHER REIMBURSABLE COST CENTERS			,	<u>'</u>		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	1. 856119	0		0	0	96.00
200.00 Subtotal (see instructions)		468		0	227	200.00
201.00 Less PBP Clinic Lab. Services-Program				ol o		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		468		0	227	202.00
3	•	•	•	1	'	

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lieu	ı of Form CMS-:	2552-10
APPORT	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		CCN: 15-T048	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/23/2023 11:	pared: 46 am
			Titl€	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS	6.00	7.00				
69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 76. 97	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 0 0 0 0 0 0 0 0 0 0					50. 00 52. 00 54. 00 59. 00 60. 00 65. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00 77. 00
92.00	O9100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0 0 0	C C				91. 00 92. 00 93. 00
96 00	09600 DUBARI E MEDI CAL FOLLI P-PENTED	0		1			96 00

0 0 0

0

96. 00 200. 00 201. 00

202.00

96. 00 200. 00 201. 00

202.00

O9600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/23/2023 11:46 am Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 016, 545 0. 244547 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0. 240241 31, 349 52.00 0 52.00 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 3, 082, 628 0. 168573 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.136926 825, 445 0 0 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0. 188223 1, 572, 393 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.181995 107, 520 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.731266 601,080 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 177870 274, 942 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 191324 59, 399 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.525956 284, 405 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 605, 549 0 0 0 73.00 73.00 0.348708 07400 RENAL DIALYSIS 0.942848 0 5, 759 74 00 0 74 00 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.656532 0 20, 977 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 0. 184911 0 2, 638, 175 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 595234 405, 880 0 0 92.00 04040 FAMILY PRACTICE 93.00 0.485269 0 134, 818 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 1. 856119 0 0 0 96.00 200.00 Subtotal (see instructions) 0 13, 666, 864 0 0 200.00 0 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00 13, 666, 864

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0048 Peri od: Worksheet D From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/23/2023 11:46 am Titl<u>e XIX</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 493, 140 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 531 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 519, 648 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 113, 025 0 59.00 60.00 06000 LABORATORY 295, 961 0 60.00 06500 RESPIRATORY THERAPY 19, 568 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 439, 549 66.00 69.00 06900 ELECTROCARDI OLOGY 48, 904 69.00 11, 364 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 149, 585 0 72.00 07300 DRUGS CHARGED TO PATIENTS 559, 868 0 73.00 73.00 74. 00 07400 RENAL DIALYSIS 0 5, 430 74 00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 13, 772 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 487, 828 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 241, 594 0 92.00 04040 FAMILY PRACTICE 93.00 65, 423 0 93.00 OTHER REIMBURSABLE COST CENTERS

3, 472, 190

3, 472, 190

0

0

0

96.00

200.00

201.00

202.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

202.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERV	ICES	In Lieu	of Form CMS-25	52-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der	CCN: 15-0048 Period:	1/01/2022	Worksheet D-1	
		To 12		Date/Time Prepa 5/23/2023 11:46	
	Ti tI	e XVIII Hos	pi tal	PPS	

				5/23/2023 11:	46 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day			43, 272	
2. 00	Inpatient days (including private room days, excluding swing-			43, 272	
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	rivate room days,	0	3.00
	do not complete this line.				
4. 00	Semi-private room days (excluding swing-bed and observation b			36, 117	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.00
	reporting period		04 6 11	ا	
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)		21 -6 -1		7 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	ill days) through becember	31 OF the Cost	0	7.00
8. 00	Teporiting period Total swing-bed NF type inpatient days (including private roo	m days) after December 1	11 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	ill days) after beceiliber s	of the cost	١	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing_had and	14, 946	9.00
7.00	newborn days) (see instructions)	o the rrogram (excruding	g swifig-bed and	14, 740	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private m	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc		com dayo,	ا	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	ol	11.00
	December 31 of the cost reporting period (if calendar year, e			1	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	o	12.00
	through December 31 of the cost reporting period	3 .	,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)		
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost	0. 00	17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
00.00	reporting period		1	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	ne cost	0.00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instruction	(6)		60, 579, 580	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing ported (line		21.00
22.00	5 x line 17)	el 31 di the cost report	ing period (inte	i	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line A	0	23.00
23.00	x line 18)	31 of the cost reportin	ig period (Title C	Ĭ	23.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24.00
21.00	7 x line 19)	. Or or the cost reporti	ng perrou (rine	ĭ	21.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	ol	25.00
	x line 20)		, , , , , , , , , , , , , , , , , , , ,	·	
26. 00	Total swing-bed cost (see instructions)			ol	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		60, 579, 580	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mi		ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	60, 579, 580	37.00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
					I
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	instructions)		1, 399. 97	
38. 00 39. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJAIN Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	instructions) 38)		20, 923, 952	39.00
38. 00 39. 00 40. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	e instructions) e 38) am (line 14 x line 35)			39. 00 40. 00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAI	Provi der C	CN: 15-0048	Period: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/23/2023 11:	pared
	Cost Center Description	Total Inpatient Cost	Title Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.0
2.00	Intensive Care Type Inpatient Hospital Units	ΟĮ		ıj 0. c	0	0	42.0
3. 00 4. 00 5. 00 6. 00 7. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	11, 746, 847	5, 037	2, 332. 1	1 1, 904	4, 440, 337	43. 0 44. 0 45. 0 46. 0 47. 0
	Cost Center Description					1. 00	
8. 00 8. 01	Program inpatient ancillary service cost (Wk. Program inpatient cellular therapy acquisiti			III line 10	column 1)	36, 635, 148 0	
9. 00					, cordillir 1)	61, 999, 437	1
0.00	Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	2, 121, 533	50.0
1. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	2, 402, 635	51.0
2. 00 3. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated, non-ph	ysician anest	hetist, and	4, 524, 168 57, 475, 269	
4. 00 5. 00 5. 01 5. 02 6. 00 7. 00 8. 00 9. 00	Program discharges Target amount per discharge Permanent adjustment amount per discharge Adjustment amount per discharge (contractor of Target amount (line 54 x sum of lines 55, 55). Difference between adjusted inpatient operations payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, 65).	01, and 55.02) ng cost and ta	arget amount (ŕ	0 0.00 0.00 0.00 0 0 0	55. 0 55. 0 55. 0 56. 0 57. 0 58. 0
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report,	updated by the	0. 00	60.0
1. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	the amount by	which operati	ng costs (line	0	61.0
2. 00 3. 00		ent (see instru	ucti ons)			0	
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.0
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65.0
6. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient roution CAH, see instructions</pre>	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66.0
7. 00	Title V or XIX swing-bed NF inpatient routing ((ine 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [December 31 of	the cost rep	orting period	0	68.0
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY		0	69.0
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Skilled nursing facility/other nursing facili	ost per diem (I 71) able to Program ce costs (line	ine 70 ÷ line n (line 14 x l e 72 + line 73	2) ine 35))			70. 0 71. 0 72. 0 73. 0 74. 0 75. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compatination routine service cost per diem limit Inpatient routine service cost limitation (line Reasonable inpatient routine service costs (see inservices (see inservices (see inservices))	76) s line 77) s costs (from parison to the cation ne 9 x line 81 see instruction structions) (see instructic of lines 83 th	cost limitatio) ns) ons)		nus line 79)		76. C 77. C 78. C 79. C 80. C 81. C 82. C 83. C 84. C 85. C 86. C

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 46 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			10, 016, 785	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 730, 137	60, 579, 580	0. 07808	1 10, 016, 785	782, 121	90.00
91.00 Nursing Program cost	0	60, 579, 580	0.00000	0 10, 016, 785	0	91.00
92.00 Allied health cost	0	60, 579, 580	0.00000	0 10, 016, 785	0	92.00
93.00 All other Medical Education	o	60, 579, 580	0. 00000	0 10, 016, 785	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-S048		
	Title XVIII	Subprovi der -	PPS
		IDE	

		IPF		
	Cost Center Description		1 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4, 631	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 631	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		4, 631	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Dece	mber 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Decemb	or 21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	er 31 or the cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through Decem	per 31 of the cost	0	7.00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after Decembe	r 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (exclud	ing swing-bed and	1, 864	9. 00
10. 00	<pre>lnewborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including privat</pre>	a room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	e room days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including privat	e room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including pri	vate room days)	0	12.00
	through December 31 of the cost reporting period		_	
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this Medically necessary private room days applicable to the Program (excluding swing-b		0	14.00
15. 00		eu uays)	0	15.00
	Nursery days (title V or XIX only)		0	
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 3	1 of the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31	of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing had NE sorvices applicable to sorvices through December 31	of the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 reporting period	of the cost	0.00	19.00
20. 00	1 31	f the cost	0. 00	20.00
	reporting period			
21.00			5, 411, 239	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost rep	orting period (line	0	22. 00
22.00	5 x line 17)		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reportx line 18)	ting period (line o	0	23. 00
24. 00		rting period (line	0	24.00
21.00	7 x line 19)	tring portion (trine	ŭ	200
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost report	ing period (line 8	0	25. 00
	x line 20)			
26. 00			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 2 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5)	5, 411, 239	27.00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed	charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	charges)	0	1
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	1
34.00	Average per diem private room charge differential (line 32 minus line 33)(see inst	ructions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	1
36.00	· · · · · · · · · · · · · · · · · · ·	differential (lim	0 5 411 220	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost 27 minus line 36)	urrierentiai (IINe	5, 411, 239	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 168. 48	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		2, 178, 047	1
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		2, 178, 047	41.00

····· ·	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0048	Peri od:	Worksheet D-1	2552-
			Component	CCN: 15-S048	From 01/01/2022 To 12/31/2022		
			Ti tle	e XVIII	Subprovi der -	PPS	70 U
	Cost Center Description	Total Inpati ent	Total I npati ent	Average Per Diem (col.		Program Cost (col. 3 x	
		1.00	Days 2.00	÷ col. 2)	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only)	0					42.
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	0	(0.	00 0	0	
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 45.
5. 00	SURGICAL INTENSIVE CARE UNIT						46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (W	kst. D-3, col.	3, line 200)			491, 201	48.
3. 01	Program inpatient cellular therapy acquisiti	ion cost (Works	heet D-6, Part), column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.	01)(see instru	ctions)		2, 669, 248	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routino	sorvi cos (fro	m Wkst D si	um of Darts L and	313, 338	50.
). 00	rass through costs appricable to Frogram Fin	patrent routine	services (iic	III WKSt. D, St	un or raits i and	313, 336	30.
1.00	Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	31, 367	51.
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				344, 705	52.
3. 00	Total Program inpatient operating cost exclu		elated, non-ph	vsician anes	thetist, and	2, 324, 543	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	١
i. 00	Program discharges Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor	use only)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 5					0	
. 00	Difference between adjusted inpatient opera	ting cost and t	arget amount (line 56 minus	s line 53)	0	
. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	m the cost ren	ortina nerio	dending 1996	0.00	
. 00	updated and compounded by the market basket		iii the cost rep	or tring period	a charing 1770,	0.00	"
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	, or line 55 fr	om prior year	cost report,	updated by the	0.00	60
1.00	Continuous improvement bonus payment (iflimus 55.01, or line 59, or line 60, enter the less) are less than expected costs (lines 54.25)	sser of 50% of	the amount by	which operati	ng costs (line	0	61
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
	Allowable Inpatient cost plus incentive payr	ment (see instr	uctions)			0	1
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ete through Doc	ombor 21 of th	o cost ropor	ting pariod (Sac	1 0	64
. 00	instructions)(title XVIII only)	313 till odgil bec	ember 31 01 tr	e cost repor	ing period (see		04
. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decem	ber 31 of the	cost reporti	ng period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routio	ne costs throug	h December 31	of the cost i	reportina period	0	67
	(line 12 x line 19)	-					
3. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs arter	necellinet, 31 Ot	the cost rep	on tring period	0	68
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil				7)		70
. 00	Adjusted general inpatient routine service				•		71
. 00	Program routine service cost (line 9 x line			653			72
. 00	Medically necessary private room cost applications and program general inpatient routine services.	9	•	,			73
. 00	Capital-related cost allocated to inpatient	•		•	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ine 2)					76
. 00	Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for excess				nue Line 70)		79
.00	Total Program routine service costs for com Inpatient routine service cost per diem limi		cost iimitätic	n (iine /8 Mi	nus iine 79)		80
. 00	Inpatient routine service cost per drem rimi		1)				82
. 00	Reasonable inpatient routine service costs						83
\cap	Program inpatient ancillary services (see i						84
		1900 instructi	one)			1	85
1. 00 5. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur	•					86

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		'	CCN: 15-S048	From 01/01/2022 To 12/31/2022	5/23/2023 11:	
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	778, 478	5, 411, 239	0. 14386	3 0	0	90.00
91.00 Nursing Program cost	0	5, 411, 239	0. 00000	0	0	91.00
92.00 Allied health cost	0	5, 411, 239	0. 00000	0	0	92.00
93.00 All other Medical Education	0	5, 411, 239	0. 00000	0 0	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-T048		
	Title XVIII	Subprovi der -	PPS
		IDE	

		Title Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 810	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivata room days	3, 810 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	i vate i ooiii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 810	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December :	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber t	01 01 110 0031	G	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember o	. Or the cost	G	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	1, 643	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therading private	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter O on this line	e)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (excruding swriig-bed to	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost	0.00	17. 00
17.00	reporting period	es till ough becember 31 o	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	3 thi dagir bedember or or	110 0031	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	ne cost	0. 00	20.00
21. 00	Teportring perrou Total general inpatient routine service cost (see instruction	s)		4, 024, 842	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	a ported (Line A	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrod (Trile 0	U	23.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or or the cost reporting	perrod (Trite o	0	20.00
26.00	Total swing-bed cost (see instructions)	(1) 21 1) 2()		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		4, 024, 842	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11110 20)		0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	4, 024, 842	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 056. 39	38.00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 735, 649	39. 00
40.00	Medically necessary private room cost applicable to the Progr	,		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ iine 40)	I	1, 735, 649	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL	Provider CO		Period: From 01/01/2022	w of Form CMS-2 Worksheet D-1	
			Component (CCN: 15-T048	To 12/31/2022	Date/Time Pre 5/23/2023 11:	
			Title	XVIII	Subprovi der -	PPS	10 4111
	Cost Center Description	Total Inpati ent	Total Inpatient	Average Per Diem (col. 1		Program Cost (col. 3 x	
		1. 00	Days 2.00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only)	0	0	0.0	00 0	0	42.0
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	00 0	0	43. C
4. 00	CORONARY CARE UNIT						44. C
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. C
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					4.00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	. line 200)			1. 00 1, 442, 919	48. C
8. 01	Program inpatient cellular therapy acquisiti	on cost (Worksho	eet D-6, Part		, column 1)	0	48.0
9. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	1)(see instrud	ctions)		3, 178, 568	49.0
0.00	Pass through costs applicable to Program inp	patient routine :	services (fror	 n Wkst. D, su	m of Parts I and	264, 063	50.0
1. 00	Pass through costs applicable to Program inpand IV)	patient ancillar	y services (fi	om Wkst. D,	sum of Parts II	113, 810	51.0
2. 00	Total Program excludable cost (sum of lines					377, 873	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	ysician anest	hetist, and	2, 800, 695	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					0	
5. 00 5. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
5. 02	Adjustment amount per discharge (contractor	use only)				0.00	1
6.00	Target amount (line 54 x sum of lines 55, 55				50)	0	
7. 00 3. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	
	updated and compounded by the market basket)		•		•	0.00	
0. 00 1. 00	Expected costs (lesser of line 53 ÷ line 54, market basket) Continuous improvement bonus payment (if line)			•		0.00	60.0
1. 00	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	which operati	ng costs (line		
2 00	enter zero. (see instructions)						(2)
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			0	
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST	I December 1			1		1
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decei	mber 31 of the	e cost report	ing period (See	0	64.
5. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the d	cost reportin	g period (See	0	65.0
5. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line 6	55)(title XVI	II only); for	0	66. (
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 d	of the cost r	eportina period	0	67.
	(line 12 x line 19)	· ·					
8. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after De	ecemper 31 of	ine cost rep	orting period	0	68.0
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY		0	
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•)		70. 71.
2. 00	Program routine service cost (line 9 x line		,	-/			72.
	Medically necessary private room cost applic						73.
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•	,		Part II, column		74. 75.
5. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
7.00	Program capital -related costs (line 9 x line						77.
3. 00 9. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider record	(ab			78. 79.
0.00	Total Program routine service costs for comp				nus line 79)		80.
	Inpatient routine service cost per diem limi		`				81.
2. 00 3. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 83.
4. 00	Program inpatient ancillary services (see in	•	٠,				84.
5. 00	Utilization review - physician compensation	(see instruction	•				85.
	Total Program inpatient operating costs (sum	n of lines 83 th	rough 85)				86.
5. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	•				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ĺ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	612, 341	4, 024, 842	0. 15214	0 0	0	90.00
91.00 Nursing Program cost	0	4, 024, 842	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 024, 842		0 0	0	92.00
93.00 All other Medical Education	0	4, 024, 842		0 0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH	CARE SERVICES	In Lieu	u of Form CMS-255	52-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Prepare 5/23/2023 11:46	
		Title XIX	Hospi tal	Cost	

			10 12/31/2022	5/23/2023 11:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS		1	10.070	
1.00	npatient days (including private room days and swing-bed days, excluding newborn)			43, 272	1.00
2.00	patient days (including private room days, excluding swing-bed and newborn days) vate room days (excluding swing-bed and observation bed days). If you have only private room days			43, 272	2.00
3. 00	do not complete this line.	iys). Ti you nave only pr	Tvate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	and days)		36, 117	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cos			30, 117	5. 00
3.00	reporting period			Ĭ	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost				6. 00
	reporting period (if calendar year, enter 0 on this line)			0	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost			0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost			0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excludinç	g swing-bed and	759	9. 00
10 00	newborn days) (see instructions)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		coom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, e		oon days) arter	۷	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12. 00
	through December 31 of the cost reporting period	x only (morading priva	lo room dayo,	Ĭ	.2.00
13. 00		X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
15. 00	Total nursery days (title V or XIX only)			1, 417	15.00
16. 00	Nursery days (title V or XIX only)			96	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0. 00	17. 00
10 00	reporting period	ft D	46	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es arter becember 31 or	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	0.00	19. 00
17.00	reporting period	3 through becember 31 of	the cost	0.00	17.00
20. 00		es after December 31 of 1	the cost	0. 00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction	ıs)		60, 578, 583	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ting period (line	0	22.00
	5 x line 17)				
23. 00		31 of the cost reporting	ng period (line 6	0	23. 00
04.00	x line 18)	24 . 6 . 11			04.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $17 \times 11 = 19$	er 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	21 of the cost reporting	a ported (line 9	0	25. 00
23.00	x line 20)	31 of the cost reporting	g perrou (Trile o	ď	23.00
26. 00				0	26. 00
27. 00	,	(line 21 minus line 26)		60, 578, 583	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private seem cost di	fforontial (1:-	0 40 E70 E03	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line			60, 578, 583	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
		LISTMENTS			
38 NN	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		T	1 300 05	38 00
38. 00 39. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJADJusted general inpatient routine service cost per diem (see	e instructions)		1, 399. 95 1, 062, 562	
39. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJAdjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	e instructions) e 38)		1, 399. 95 1, 062, 562 0	39.00
39. 00 40. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJADJusted general inpatient routine service cost per diem (see	e instructions) e 38) ram (line 14 x line 35)		1, 062, 562	39. 00 40. 00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1	
					To 12/31/2022	Date/Time Pre 5/23/2023 11:	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	oust defined besen paren	I npati ent	I npati ent	Diem (col.		(col. 3 x	
		1. 00	2. 00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1, 116, 522	1, 417	787.		75, 643	42.00
42.00	Intensive Care Type Inpatient Hospital Units	11 74/ 047	F 027	2 222	101	225 542	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	11, 746, 847	5, 037	2, 332. 1	101	235, 543	43.00 44.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
17.00	Cost Center Description						17.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 1, 994, 683	48. 00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10	, column 1)	1, 774, 003	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0°	1)(see instru	ctions)		3, 368, 431	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine :	services (from	m Wkst. D. su	m of Parts I and	0	50. 00
E4 00			•				F4 00
51. 00	Pass through costs applicable to Program inp and IV)	allent ancillar	y services (fi	rom wkst. D,	Sum or Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	5 1	lated, non-phy	ysician anest	hetist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	54.00 55.00
55. 01	Permanent adjustment amount per discharge					0. 00	55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0. 00 0	55. 02 56. 00
57. 00	Difference between adjusted inpatient operat		rget amount (I	ine 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)				100/	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 trom	the cost repo	orting period	enaing 1996,	0. 00	59. 00
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year o	cost report,	updated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin					0	61.00
	55.01, or line 59 , or line 60 , enter the les 53) are less than expected costs (lines 54 x						
	enter zero. (see instructions)	,	3		,,		,,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST				1		
64.00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decei	mber 31 of the	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65.00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line (65)(title XVI	II only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)	-					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Do	ecember 31 of	ine cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (li			ĺ		71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73))			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from \	Worksheet B,	Part II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		rovi der record	ds)			79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	n (line 78 mi	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim)				82.00
83.00	Reasonable inpatient routine service costs (s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00	Total observation bed days (see instructions)			I	7, 155	87.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 46 am
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			10, 016, 642	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 730, 137	60, 578, 583	0. 07808	3 10, 016, 642	782, 129	90.00
91.00 Nursing Program cost	0	60, 578, 583	0.00000	0 10, 016, 642	0	91.00
92.00 Allied health cost	0	60, 578, 583	0.00000	0 10, 016, 642	0	92.00
93.00 All other Medical Education	o	60, 578, 583	0. 00000	0 10, 016, 642	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-S048		
	Title XIX	Subprovi der -	Cost
		IDF	

			IPF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			4, 631	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		room days	4, 631 0	2. 00 3. 00
0.00	do not complete this line.	ys). It you have only private	room days,	· ·	0.00
4. 00	Semi-private room days (excluding swing-bed and observation b			4, 631	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through December 31 c	f the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 31 of	the cost	0	6.00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of	the cost	0	7. 00
7.00	reporting period	iii days) tiii dagii beediibei oi oi	the cost	· ·	7.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 31 of t	he cost	0	8.00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding swing	-bed and	215	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		ys)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		ys) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		davs)	0	12. 00
	through December 31 of the cost reporting period	3 .		_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line)	days)	0	13.00
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed days)		0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			·	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			70	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 of the	cost	0. 00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of the co	st	0.00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the c	ost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the cos	t	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instruction	s)		5, 411, 239	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		riod (line	0	
22.00	5 x line 17)	21 -6	(1: (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)			0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting per	iod (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting perio	d (line 8	0	25.00
	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 411, 239	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	3,		0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	-	0. 00 0. 00	
35.00	Average per diem private room cost differential (line 34 x li			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differer	tial (line	5, 411, 239	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	1, 168. 48	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	,		251, 223	
40.00	Medically necessary private room cost applicable to the Progr			0	
41.00	Total Program general inpatient routine service cost (line 39	+ II ne 40)	- 1	251, 223	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HUSPITAL & HEAL	TH CARE SERVICES Provider CCN:	15-0048 F	In Lie Period: From 01/01/2022	u of Form CMS-2 Worksheet D-1	
			Component CCN		o 12/31/2022	Date/Time Pre 5/23/2023 11:	
			Title X	.I X	Subprovi der - I PF	Cost	
	Cost Center Description	Total Inpatient Cost	Inpatient Di Days	verage Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.0
	Intensive Care Type Inpatient Hospital Units						
4. 00 5. 00 6. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	0	0	43. 0 44. 0 45. 0 46. 0 47. 0
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wk					0	48. 0
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				column 1)	0 251, 223	48. 0 49. 0
0. 00	Pass through costs applicable to Program inp	atient routine s	services (from W	kst. D, sum	of Parts I and	0	50.0
1. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	patient ancillary	y services (from	Wkst. D, s	um of Parts II	0	51.0
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ıding capital rel	lated, non-physi	cian anesth	etist, and	0	
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 0
5. 00	Target amount per discharge					0. 00	55.0
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)				0. 00 0. 00	1
	Target amount (line 54 x sum of lines 55, 55	J ,				0.00	1
7. 00	Difference between adjusted inpatient operat		rget amount (lin	e 56 minus	line 53)	0	1
8. 00 9. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost report	ing period	endi ng 1996,	0 0. 00	
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)		m prior year cos	t report, u	pdated by the	0. 00	60.0
1. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of th	he amount by whi	ch operatin	g costs (line	0	61.0
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.0
3. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.0
4. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decer	mber 31 of the c	ost reporti	ng period (See	0	64.0
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after Decembe	er 31 of the cos	t reporting	period (See	0	65. C
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65)	(title XVII	l only); for	0	66.0
7. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of	the cost re	porting period	0	67.0
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of th	e cost repo	rting period	0	68. 0
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.0
	Skilled nursing facility/other nursing facil	,		t (line 37)			70.0
1. 00 2. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /u ÷ line 2)				71. 0 72. 0
	Medically necessary private room cost applic	able to Program		35)			73.0
4. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•	,	ksheet B, P	art II, column		74. 0 75. 0
6. 00	Per diem capital-related costs (line 75 ÷ li	,					76.0
7. 00 3. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.0
	Aggregate charges to beneficiaries for exces		rovi der records)				79. 0
0. 00	Total Program routine service costs for comp	parison to the co		line 78 min	us line 79)		80.0
	Inpatient routine service cost per diem limi		\				81.0
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.0
4. 00	Program inpatient ancillary services (see in		-,				84. (
	Utilization review - physician compensation	(see instruction	,				85.0
5. 00			OF)				86.0
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				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		Provi der Co		Peri od:	Worksheet D-1	
		Component (CCN: 15-S048	From 01/01/2022 To 12/31/2022		pared: 46 am_
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	•				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ĺ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	778, 478	5, 411, 239	0. 14386	3 0	0	90.00
91.00 Nursing Program cost	o	5, 411, 239	0. 00000	0	0	91.00
92.00 Allied health cost	0	5, 411, 239	0. 00000	0	0	92.00
93.00 All other Medical Education	o	5, 411, 239	0. 00000	0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-T048		
	Title XIX	Subprovi der -	Cost

		II tie xix	I RF	COST	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 810	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		to room days	3, 810 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only priva	te room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		3, 810	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December 3	1 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 31	of the cost	0	6. 00
0. 00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember 31	or the cost	J	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31	of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 31 o	f the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter beceiiber 31 o	Title cost	O	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding sw	ing-bed and	0	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room	days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		uays)	U	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room	days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e		nom daya)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including private r	oom days)	U	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private r	oom days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line)			44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed day	s)	0 1 <i>4</i> 17	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)				16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of t	he cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of the	cost	0. 00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	c through Docombor 21 of th	o cost	0.00	19. 00
19.00	reporting period	s through becember 31 of th	e cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of the	cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instruction	s)		4, 024, 842	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reporting	period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting n	oried (line 4	0	23. 00
23.00	x line 18)	31 of the cost reporting p	errod (Trile o	U	23.00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting	period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting pe	riod (line 8	0	25. 00
24 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 024, 842	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,	
	General inpatient routine service charges (excluding swing-be	d and observation bed charg	es)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi		ns)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost diffe	rential (line	4, 024, 842	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 056. 39	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	· ·		0	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	•		0	40. 00 41. 00
71.00	Trotal Trogram general Tripatrent routine service cost (Title 37	11110 40)	I	ΟĮ	+1.00

OMPUT	Financial Systems REID ATION OF INPATIENT OPERATING COST		Provider (CN: 15-0048	Peri od:	worksheet D-1	
			Component	CCN: 15-T048	From 01/01/2022 To 12/31/2022		
			Ti t	e XIX	Subprovi der -	Cost	10 0
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
2 00	NUDGEDY (11 II - W o WI V - I)	1. 00	2. 00	3.00	4.00	5. 00	10
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.	00 0	0	42.
3. 00	INTENSIVE CARE UNIT	0		0.	00 0	0	43.
4. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT						45.
5.00	SURGICAL INTENSIVE CARE UNIT						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
- 00	Dunarian langti art and Illania	D 2	2 11 - 200)			1. 00	10
3. 00 3. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti	(ST. D-3, COL.	3, line 200) hoot D-6 Part	III line 10) column 1)	0	
	Total Program inpatient costs (sum of lines), corumin r)	0	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	oatient routine	services (fro	m Wkst. D, sı	um of Parts I and	0	50.
00			(4	W+ D			
. 00	Pass through costs applicable to Program inpand IV)	patrent ancilla	ry services (†	ı OIII WKST. D,	Sum or Parts II	0	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	thetist, and	0	53
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0.00	
01	Permanent adjustment amount per discharge					0.00	55
02	Adjustment amount per discharge (contractor					0.00	
00	Target amount (line 54 x sum of lines 55, 55				- 1: 50)	0	
00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and t	arget amount (line 56 minus	s line 53)	0	
.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 fro	m the cost rem	ortina period	d endina 1996.	0.00	
	updated and compounded by the market basket)	1		0 .			
. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fr	om prior year	cost report,	updated by the	0.00	60
. 00	market basket) Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 >	sser of 50% of	the amount by	which operati	ing costs (line	0	61
. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62
	Allowable Inpatient cost plus incentive paym	ment (see instr	uctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dec	ember 31 of th	e cost report	ting period (See	0	64
00	Medicare swing-bed SNF inpatient routine cos	sts after Decem	ber 31 of the	cost reportir	ng period (See	0	65
.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina	64 plus lina	65)(+i+l	(II only): for	0	66
. 00	CAH, see instructions	ne costs (Trie	04 prus Triic	00)(11110 XVI	11 om y), 101		
. 00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs throug	h December 31	of the cost r	reporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after	December 31 of	the cost re	porting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 ± lir	A 68)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILIT	Y, AND ICF/IID	ONLY		0	
.00	Skilled nursing facility/other nursing facil				1)		70
00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		line /U ÷ line	2)			71
. 00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73
. 00	Total Program general inpatient routine serv	vice costs (Ĭin	e 72 + line 73)			74
00	Capital-related cost allocated to inpatient 26, line 45)	routine servic	e costs (from	Worksheet B,	Part II, column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu		nrovi don rocci	·de)			78
00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		80
00	Inpatient routine service cost per diem limi			(, , ,		81
. 00	Inpatient routine service cost limitation (I	ine 9 x line 8					82
00	Reasonable inpatient routine service costs (•	ns)				83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84
						i .	1 00
. 00	Total Program inpatient operating costs (sum	•					86

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2022 To 12/31/2022		pared: 46 am_
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	•				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ĺ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	612, 341	4, 024, 842	0. 15214	0 0	0	90.00
91.00 Nursing Program cost	0	4, 024, 842	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 024, 842		0 0	0	92.00
93.00 All other Medical Education	0	4, 024, 842	0. 00000	0 0	0	93.00

	& HEALTH CARE SERVI			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022		
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00		col . 2)	
LAIDATI ENT. DOUTLAGE CEDAU CE, COCT. CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			04.047.005		
30. 00 03000 ADULTS & PEDI ATRI CS			24, 017, 335		30.00
31. 00 03100 INTENSI VE CARE UNI T			4, 100, 297		31.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF			0		40. 00 41. 00
			0		41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50, 00 05000 OPERATING ROOM		0. 24454	7 22, 144, 659	5, 415, 410	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 24024			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16857			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13692			59.00
60. 00 06000 LABORATORY		0. 18822			
65. 00 06500 RESPIRATORY THERAPY		0. 18199			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 73126			
69. 00 06900 ELECTROCARDI OLOGY		0. 17787			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19132	4 3, 942	754	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 52595	6 9, 670, 680	5, 086, 352	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 34870	8 22, 984, 014	8, 014, 710	73.00
74.00 07400 RENAL DIALYSIS		0. 94284	8 579, 986	546, 839	74.00
76. 00 03950 ANCI LLARY - OTHER		0.00000	0 0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION		0. 65653		217	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
91 00 09100 EMERGENCY		l ∩ 18491	1 14 703 522	2 718 843	I 01 00

0. 184911

0.595234

0. 485269

1.856119

14, 703, 522

1, 759, 989

146, 419, 667 0 146, 419, 667

21, 972

2, 718, 843

1, 047, 605

10, 662

0

36, 635, 148 200. 00 201. 00

91.00

92.00

93.00

96.00

202.00

91.00

93.00

200. 00 201. 00 202. 00

09100 EMERGENCY

04040 FAMILY PRACTICE

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

INPATIENT ROUTINE SERVICE COST CENTERS	CCN: 15-S048 e XVIII Ratio of Cos To Charges 1.00		Date/Time Pre 5/23/2023 11: PPS Inpatient Program Costs	
INPATI ENT ROUTI NE SERVI CE COST CENTERS	Ratio of Cos To Charges	I PF t I npati ent Program	PPS Inpati ent	40 diii
INPATIENT ROUTINE SERVICE COST CENTERS	To Charges	t Inpatient Program		
INPATI ENT ROUTI NE SERVI CE COST CENTERS	To Charges	Program		4
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 43. 00 04100 SUBPROVI DER - I RF 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DI AGNOSTIC 059. 00 05900 CARDIAC CATHETERIZATION 06500 RESPIRATORY THERAPY 06500 PHYSICAL THERAPY 06500 PHYSICAL THERAPY 069. 00 06900 ELECTROCARDIOLOGY 06900 ELECTROCARDIOLOGY 07000 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07100 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07400 RENAL DIALYSIS 07400 RENAL DIALYSIS 07500 ALLOGENEIC HSCT ACQUISITION 0000 0000 MEDICAL SUPPLIES CHARGED TO PATIENTS 07500 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 0000 0000 MERGENCY 00000 00000 00000 0000 00000 00000 00000 0000 00000 00000 00000 0000	3		FPCOGRAM COSTS	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 64. 00 05400 RADIOLOGY-DI AGNOSTIC 65. 00 06500 CARDIAC CATHETERIZATION 66. 00 06500 RESPIRATORY THERAPY 66. 00 66500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 67. 00 07000 ELECTROCARDIOLOGY 67. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0000 EMERGENCY 09100 EMERGENCY	1.00		(col. 1 x	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 64. 00 05400 RADIOLOGY-DI AGNOSTIC 65. 00 06500 CARDIAC CATHETERIZATION 66. 00 06500 RESPIRATORY THERAPY 66. 00 66500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 67. 00 07000 ELECTROCARDIOLOGY 67. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0000 EMERGENCY 09100 EMERGENCY	1.00		col . 2)	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 64. 00 05400 RADIOLOGY-DI AGNOSTIC 65. 00 06500 CARDIAC CATHETERIZATION 66. 00 06500 RESPIRATORY THERAPY 66. 00 66500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 67. 00 07000 ELECTROCARDIOLOGY 67. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0000 EMERGENCY 09100 EMERGENCY	_	2. 00	3. 00	
31. 00				
40. 00	1			30.00
41. 00				31.00
43. 00		2, 041, 993		40.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC 59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0UTPATIENT SERVICE COST CENTERS 91. 00 O9100 EMERGENCY				41.00
50. 00				43.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 69. 00 06600 PHYSI CAL THERAPY 69. 00 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 90 07500 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 00UTPATI ENT SERVI CE COST CENTERS 09100 EMERGENCY	0.0445	17 14 101	10.074	
54. 00	0. 24454		10, 071	
59. 00	0. 24024 0. 16857		0 31, 912	
60. 00	0. 13692		252	
65. 00	0. 18822			
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON 77. 00 0000 ALLOGENEI C HSCT ACQUI SI TI ON 0000 DUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	0. 18199		17, 649	
69. 00	0. 73126		103, 141	•
70. 00 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07400 RENAL DIALYSIS 07400 ANCILLARY - OTHER 07697 CARDI AC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 00TPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0. 17787		3, 232	
71. 00	0. 19132		0	
72. 00	0.00000		o o	
74. 00	0. 52595		0	72.00
76. 00 03950 ANCILLARY - OTHER 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	0. 34870	08 552, 179	192, 549	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	0. 94284	18 0	0	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	0.00000	00	0	76.00
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	0. 65653	32 0	0	76. 97
91. 00 09100 EMERGENCY	0. 00000	00	0	77. 00
	0. 18491		62, 053	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 59523		0	
93. 00 04040 FAMILY PRACTICE	0. 48526	59 0	0	93.00
OTHER REIMBURSABLE COST CENTERS	1.05/44	10		1 04 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 85611			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1, 749, 996		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61 202.00 Net charges (line 200 minus line 201)		1, 749, 996		201. 00 202. 00

ΙΝΡΔΤΙ	Financial Systems REID HOSPITAL & ENT ANCILLARY SERVICE COST APPORTIONMENT	HEALTH CARE SERVI		Peri od:	u of Form CMS-2 Worksheet D-3	
1 101 7411	ENT ANOTEENIN SERVICE COST ALLORITORINENT	Trovider 6	CIV. 13 0040	From 01/01/2022	WOLKSHEEL D 3	
		·	CCN: 15-T048	To 12/31/2022	Date/Time Pre 5/23/2023 11:	
		Titl€	· XVIII	Subprovi der – I RF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
					col . 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1			4
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
40.00	04000 SUBPROVI DER - I PF			4 700 000		40.00
41.00	04100 SUBPROVI DER - I RF			1, 799, 890		41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 2445	47 85, 993	21, 029	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 24434		21,029	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1685		18, 275	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1369		693	1
60.00	06000 LABORATORY		0. 1882		59, 576	
65.00	06500 RESPIRATORY THERAPY		0. 1819		51, 696	
66. 00	06600 PHYSI CAL THERAPY		0. 7312		1, 100, 974	
69. 00			0. 1778		516	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1913		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000	00 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5259!	56 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34870	08 492, 093	171, 597	73.00
74.00	07400 RENAL DI ALYSI S		0. 9428	48 19, 405	18, 296	74.00
76.00	03950 ANCI LLARY - OTHER		0.00000		0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 6565		0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	00 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0. 1849		267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 5952		0	
93. 00	04040 FAMILY PRACTICE		0. 4852	69 0	0	93.00
0/ 00	OTHER REIMBURSABLE COST CENTERS		1 05/1	10	0	1 0/ 00
96.00		00)	1. 8561		1 442 010	
200.00				2, 821, 451	1, 442, 919	
201.00		charges (Tine 61)		0		201. 00 202. 00
202.00				2, 821, 451		

Health Financial Systems	REID HOSPITAL & HEALTH CARE	SERVI CES	In Lieu	of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	IT Provi	ider CCN: 15-0048	Peri od:	Worksheet D-3

Title XIX Hospital Cost Cost Center Description Title XIX Hospital Cost Inpatient Program Cost	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2022	Worksheet D-3	
Ratio of Cost Inpatient To Charges Program Costs Cost Cost Program Costs Cost Cost Cost Program Costs Cost Co				To 12/31/2022		
NPATIENT ROUTINE SERVICE COST CENTERS		Ti tl			Cost	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3			To Charges	Program	Program Costs	
INPATI ENT ROUTINE SERVICE COST CENTERS				Charges	(col. 1 x	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 2,113,685 30.00					col . 2)	
30. 00 03000 ADULTS & PEDI ATRIC CS 2, 113, 685 30. 00 31. 00 03100 INTENSI VE CARE UNIT 369, 644 31. 00 40. 00 04000 SUBPROVI DER - I IPF 121, 677 40. 00 40. 00 40. 00 50. 0			1.00	2.00	3. 00	
31. 00 03100 INTENSIVE CARE UNIT 369, 644 0.00 04000 SUBPROVI DER - I PF 40. 00 40. 00 5000 SUBPROVI DER - I RF 40. 00 41. 00 50						
40. 00 04000 SUBPROVI DER - I PF				2, 113, 685		
41. 00 04100 SUBPROVI DER - IRF				369, 644		31.00
43. 00 0.4300 NURSERY ARCILLARY SERVICE COST CENTERS 174, 282 43. 00 174, 282 50. 00	40. 00 04000 SUBPROVI DER - 1 PF			121, 677		40.00
ANCILLARY SERVICE COST CENTERS	41. 00 04100 SUBPROVI DER - I RF			78, 875		41.00
50. 00 05000 OPERATI NG ROOM 0. 244547 1, 020, 7555 249, 623 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 240241 354, 313 85, 121 52. 00 54. 00 05400 RADIO LOGY-DI AGNOSTI C 0. 168573 1, 229, 289 207, 225 54. 00 05900 CARDI AC CATHETERI ZATI ON 0. 136926 238, 351 32, 636 59. 00 06. 00 06. 00 0. 180925 0. 181995 632, 315 32, 636 59. 00 06. 00 0. 180925 0. 181995 632, 315 115, 078 55. 00 06. 00 06. 00 PHYSI CAL THERAPY 0. 181995 632, 315 115, 078 55. 00 06. 00 06. 00 PHYSI CAL THERAPY 0. 177870 169, 366 30, 125 06. 00 070. 00 0. 177870 0. 191324 0. 0 0. 00 0.	43. 00 04300 NURSERY			174, 282		43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.240241 354, 313 85, 121 52.00						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.168573 1, 229, 289 207, 225 54. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.136926 238, 351 32, 636 59. 00 60. 00 06000 LABORATORY 0.188223 1, 515, 661 285, 282 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.181995 632, 315 115, 078 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.731266 183, 065 133, 869 66. 00 69. 00 07000 ELECTROCARDI OLOGY 0.177870 169, 366 30, 125 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.179324 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.52956 95, 864 50, 420 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.52956 95, 864 50, 420 73. 00 74. 00 07400 RENAL DI ALVESI S 0.942848 44, 164 41, 640 74. 00	50. 00 05000 OPERATING ROOM		0. 24454	7 1, 020, 755	249, 623	50.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0. 136926 238, 351 32, 636 59.00 60.00 0. 00000 LABORATORY 0. 188223 1, 515, 661 285, 282 60.00 60.00 60.00 RSEPI RATORY THERAPY 0. 181995 632, 315 115, 078 65.00 60.00	52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 24024	1 354, 313	85, 121	52.00
60. 00	54. OO 05400 RADI OLOGY-DI AGNOSTI C		0. 16857	1, 229, 289	207, 225	54.00
65. 00 06500 RESPIRATORY THERAPY 0. 181995 632, 315 115, 078 65. 00 660 06600 PHYSI CAL THERAPY 0. 731266 183, 065 133, 869 66. 00 06900 ELECTROCARDI OLOGY 0. 177870 169, 366 30, 125 69. 00 07000 ELECTROCARDI OLOGY 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0 0 0. 191324 0. 191324	59. OO 05900 CARDI AC CATHETERI ZATI ON		0. 13692	5 238, 351	32, 636	59.00
66. 00	60. 00 06000 LABORATORY		0. 18822	1, 515, 661	285, 282	60.00
69. 00	65. 00 06500 RESPI RATORY THERAPY		0. 18199	632, 315	115, 078	65.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.191324 0 0.70.00 0.525956	66. 00 06600 PHYSI CAL THERAPY		0. 73126	183, 065	133, 869	66.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 00	69. 00 06900 ELECTROCARDI OLOGY		0. 17787	169, 366	30, 125	69.00
72. 00 07200 1 MPL. DEV. CHARGED TO PATIENTS 0.525956 95,864 50,420 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.348708 1,696,243 591,494 73. 00 74. 00 07400 RENAL DI ALYSIS 0.942848 44,164 41,640 74. 00 76. 00 03950 ANCILLARY - OTHER 0.000000 0 0 0 0 0 0 0	70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 19132	4 0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 525956 95, 864 50, 420 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 348708 1, 696, 243 591, 494 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 942848 44, 164 41, 640 74. 00 76. 00 03950 ANCILLARY - OTHER 0. 000000 0 0 0 76. 00 76. 97 07697 CARDI AC REHABILI TATI ON 0. 656532 0 0 0 76. 97 07700 ALLOGENEI C HSCT ACQUI SITI ON 0. 000000 0 0 0 77. 00 000000 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	ol o	0	71.00
74. 00 07400 RENAL DI ALYSI S 0.942848 44, 164 41, 640 74. 00 76. 00 0.3950 ANCI LLARY - OTHER 0.000000 0 0 76. 00 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.656532 0 0 0 76. 97 0.000000 0 0 0 0 0 0 0	72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 52595	95, 864	50, 420	72.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - OTHER 76. 00 03950 ANCI LLARY - OTHER 77. 00 07697 CARDI AC REHABI LI TATI ON 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 77. 00 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 34870	1, 696, 243	591, 494	73.00
76. 00 03950 ANCILLARY - OTHER	74. 00 07400 RENAL DI ALYSI S				41, 640	74.00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0.000000 0 0 0 0 0 0 0	76. 00 03950 ANCI LLARY - OTHER		0.00000		0	76. 00
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS 91.00	76. 97 07697 CARDI AC REHABI LI TATI ON		0. 65653	2 0	0	76. 97
91. 00 09100 EMERGENCY 0. 184911 931, 097 172, 170 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 595234 0 0. 92. 00 04040 FAMILY PRACTICE 0. 485269 0 0 0 93. 00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 1. 856119 0 0 96. 00 00 00 00 00 00 00 00	77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	o	0	77. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 595234 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0 0. 485269 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS			· ·		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 595234 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0. 485269 0 0 0 0. 485269 0 0 0 0 0 0 0 0 0	91. 00 09100 EMERGENCY		0. 18491	1 931, 097	172, 170	91.00
93. 00 04040 FAMILY PRACTICE 0.485269 0 0 0 0 0 0 0 0 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 59523		0	92.00
OTHER REIMBURSABLE COST CENTERS 96. 00			1		0	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 1.856119 0 0 96. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 8, 110, 483 1, 994, 683 200. 00 201. 00 0 201. 00 201				-,		
200.00 Total (sum of lines 50 through 94 and 96 through 98) 8,110,483 1,994,683 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1, 85611	9 0	0	96. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						
		s (line 61)		0		
		. (31)		8, 110, 483		

Heal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0048	Peri od:	Worksheet D-3	3
		Component	CCN: 15-S048	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	
		Ti tl	e XIX	Subprovi der -	Cost	
				IPF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF			121, 677		40.00
41. 00	04100 SUBPROVI DER – I RF			121,077		41.00
43.00	04300 NURSERY					43.00
43.00	ANCILLARY SERVICE COST CENTERS		l		l .	1 43.00
50.00	05000 OPERATING ROOM		0. 24454	47 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 24024			1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1685		l o	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 13692			1
60.00	06000 LABORATORY		0. 18822		0	1
65.00	06500 RESPI RATORY THERAPY		0. 1819	95 0	0	65.00
66.00	06600 PHYSI CAL THERAPY		0. 73126	66 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 1778	70 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 19132	24 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000	00	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5259	56 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34870	0 80	0	73.00
74.00	07400 RENAL DI ALYSI S		0. 94284	48 0	0	74.00
76.00	03950 ANCI LLARY - OTHER		0.00000	00	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 65653		0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	00	0	77. 00
	OUTPATIENT SERVICE COST CENTERS					
91. 00	09100 EMERGENCY		0. 1849 ⁻			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 59523			
93. 00	04040 FAMILY PRACTICE		0. 4852	59 0	0	93. 00
0/ 00	OTHER REIMBURSABLE COST CENTERS		1 05:11	10	1 -	0, 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		1. 8561			
200.00		(11 /1)		0		200.00
201.00		(IINE 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)		I	0	I	202. 00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0048	Peri od:	Worksheet D-3	
		Component	CCN: 15-T048	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	
		Ti tl	e XIX	Subprovi der -	Cost	10 4111
		,		I RF		
	Cost Center Description		Ratio of Cos	The state of the s	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00						30.0
31. 00	03100 I NTENSI VE CARE UNI T					31.0
10.00	04000 SUBPROVI DER – I PF					40.0
11.00	04100 SUBPROVI DER – I RF			78, 875		41.0
13.00	04300 NURSERY			70,070		43. 0
	ANCI LLARY SERVI CE COST CENTERS		1			1
0.00	05000 OPERATING ROOM		0. 24454	47 0	0	50.0
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 24024		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1685		0	54.0
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 13692	26 0	0	59.0
50.00	06000 LABORATORY		0. 18822	23 0	0	60.0
5.00	06500 RESPI RATORY THERAPY		0. 1819	95 0	0	65.0
66.00	06600 PHYSI CAL THERAPY		0. 73126	66 0	0	66.0
59. 00	06900 ELECTROCARDI OLOGY		0. 1778	70 0	0	69.0
0. 00	07000 ELECTROENCEPHALOGRAPHY		0. 19132	24 0	0	70.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	00	0	71.0
72. 00			0. 5259		0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34870		0	73.0
	07400 RENAL DI ALYSI S		0. 94284		0	
6. 00			0. 00000		0	76.0
6. 97			0. 65653		0	76. 9
7.00	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	00	0	77.0
	OUTPATIENT SERVICE COST CENTERS					
1.00	09100 EMERGENCY		0. 1849		0	
2.00			0. 59523		0	92.0
3. 00			0. 48526	69 0	0	93.0
14 00	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUIP-RENTED		1, 8561	10 0	0	96. C
		h 00)	1.8561			
200. 00 201. 00				0	0	200.0
	ILESS PRE CLINIC LADOCATORY SERVICES-PROGRAM ONL	v charges (Tine 61)	1	1 ()1		201.0

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES In Lieu		u of Form CMS-2552-10	
CALCULATION OF RELMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od:	Worksheet F

From 01/01/2022 Part A 12/31/2022 Date/Time Prepared: 5/23/2023 11: 46 am Title XVIII Hospi tal **PPS** 1.00 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments 1.00 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 35, 678, 568 1.01 1.01 instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 11, 260, 280 1.02 instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1.03 1.03 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 1.04 0 1.04 October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.00 2.01 Outlier reconciliation amount 0 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2 02 0 2 02 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 333, 256 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 55, 204 2.04 3.00 Managed Care Simulated Payments 19, 863, 914 3.00 Bed days available divided by number of days in the cost reporting period (see instructions) 163.40 4 00 4 00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on 0.00 5.00 or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 0.00 5.01 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for 17.91 6.00 new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of 6.26 the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7 00 0 00 7 00 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the 0.00 7.01 cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural 7.02 0.00 7.02 track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00 8.00 affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 8.01 0.00 8.01 report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 8.02 0.00 8.02 under § 5506 of ACA. (see instructions) 8. 21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 0.00 8.21 instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or 9.00 17.91 9.00 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 16.37 10 00 FTE count for residents in dental and podiatric programs. 0.00 11.00 Current year allowable FTE (see instructions) 16.37 12.00 12.00 Total allowable FTE count for the prior year. 13.00 16.44 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 16.92 14.00 otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.58 15.00 Adjustment for residents in initial years of the program (see instructions) 0 00 16 00 16 00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjusted rolling average FTE count 16.58 18.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.101469 19.00 0.099180 20.00 Prior year resident to bed ratio (see instructions) 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.099180 21.00 22.00 IME payment adjustment (see instructions) 2, 473, 912 22.00 IME payment adjustment - Managed Care (see instructions) 1, 046, 928 22.01 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C).24.00 IME FTE Resident Count Over Cap (see instructions) -1.54 24.00 If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see 25.00 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28 00 IME add-on adjustment amount (see instructions) 28.00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 28.01 0 2, 473, 912 29.00 Total IME payment (sum of lines 22 and 28) 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 1,046,928 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 4.22 30.00 Percentage of Medicaid patient days (see instructions) 31.00 25.07 31.00

29 29

32 00

13. 38 33. 00

Sum of lines 30 and 31

33.00 | Allowable disproportionate share percentage (see instructions)

32 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/23/2023 11:	
		Title XVIII	Hospi tal	PPS	
				1 00	
34. 00	Disproportionate share adjustment (see instructions)			1. 00 1, 570, 104	34.0
			Prior to 10/1		
			1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		7 192 008 710	6, 874, 403, 459	35. 0
35. 01	Factor 3 (see instructions)		0.000240562	0. 000172527	
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this lin	e) 1, 730, 124	1, 186, 020	35. 0
35. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental UC	'D (see instructions)	1, 294, 038	298, 942	35. 0
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(See Thistructions)	1, 592, 980	270, 742	36.0
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 thro	ugh 46)		
10.00	Total Medicare discharges (see instructions)		0		40.0
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruct	i ons)	0		41. 0 41. 0
12.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.0
13.00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
14. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by /	0. 000000		44.00
15. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45.00
16.00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46.00
17. 00 18. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	emall rural bosnitals	52, 964, 304 60, 310, 350		47. 00 48. 00
+0.00	only. (see instructions)	silari Turai 1105pitars	00, 310, 330		40.00
				Amount	
19. 00	Total payment for inpatient operating costs (see instructions	.1		1. 00 61, 357, 278	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an)	3, 728, 445	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions)		586, 980	1
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			165, 142 301, 702	
54. 01	Islet isolation add-on payment			0	54.0
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55.0
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intr	cuctions)		0	55. 0 56. 0
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	0	57.0
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)	0 ,	72, 634	
59.00	Total (sum of amounts on lines 49 through 58)			66, 212, 181	1
50. 00 51. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	s line 60)		11, 184 66, 200, 997	
52. 00	Deductibles billed to program beneficiaries	·,		5, 014, 140	
53.00	Coinsurance billed to program beneficiaries			45, 513	
54. 00 55. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 025, 284 666, 435	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		561, 372	
57. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	•		61, 807, 779	67.0
8.00	Credits received from manufacturers for replaced devices for		. 1	0	68.0
59. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(For SCH See Instruction	ns)	0	69. C
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	Ö	70.5
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70.7
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70. 8 70. 8
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70.8
	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	70. 9
70. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 91					
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 9 70. 9
70. 91				-406, 062	70. 9

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

	ATION OF REIMBURSEMENT SETTLEMENT Provider Co		Peri od: From 01/01/2022 To 12/31/2022 Hospi tal		epared:
			Y (yyyy)	Amount	
			0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0	70. 97
70. 98	Low Volume Payment-3			0	70. 98
	HAC adjustment amount (see instructions)			485, 023	1
	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			60, 916, 694	1
	Sequestration adjustment (see instructions)			767, 551	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			60, 192, 358	71. 03
	Interim payments Interim payments-PARHM or CHART			00, 172, 330	72.00
	Tentative settlement (for contractor use only)			0	1
73. 01	Tentative settlement-PARHM or CHART (for contractor use only)			Ĭ	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-43, 215	
74. 01	Balance due provider/program-PARHM or CHART (see instructions)				74. 01
	Protested amounts (nonallowable cost report items) in accordance with			0	
	CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90.00
	plus 2.04 (see instructions)				
	Capital outlier from Wkst. L, Pt. I, line 2			0	
	Operating outlier reconciliation adjustment amount (see instructions)			0	1
	Capital outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the time value of money (see instructions)			0.00	
96. 00	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instructions)			0	
70.00	Trinc varies of money for capital related expenses (see first detrons)		Prior to 10/1		70.00
			1.00	2. 00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0. 000000000	0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment				
	HRR adjustment factor (see instructions)		0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104. 00
200 00	Rural Community Hospital Demonstration Project (§410A Demonstration) Adju				1000 00
200.00	Is this the first year of the current 5-year demonstration period under century Cures Act? Enter "Y" for yes or "N" for no.	the ZISt			200.00
	Cost Reimbursement				-
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201. 00
	Medicare discharges (see instructions)				202.00
	Case-mix adjustment factor (see instructions)				203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year	of the curr	ent 5-year demons	strati on	
	peri od)				
204.00	Medicare target amount				204.00
	Case-mix adjusted target amount (line 203 times line 204)				205.00
206. 00	Medicare inpatient routine cost cap (line 202 times line 205)				206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement				ļ
	Program reimbursement under the §410A Demonstration (see instructions)				207.00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
	Adjustment to Medicare IPPS payments (see instructions) Reserved for future use				209. 00 210. 00
	Total adjustment to Medicare IPPS payments (see instructions)				210.00
211.00	Comparision of PPS versus Cost Reimbursement				<u></u>
212 00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212. 00
	Low-volume adjustment (see instructions)				213. 00
				1	
210.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost rein	mbursement)			218.00
210.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost rein (line 212 minus line 213) (see instructions)	mbursement)			218. 00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/23/2023 11:46 am
		Ti +1 o VV/I I I	Hospi tal	DDC

PART B - NEUTCAL AND UTHEN REACH SERVICES 1.00				5/23/2023 11:	46 am
MRK B - MEDICAL AND OTHER HEALTH SERVICES 2.4,004 1.0		Title XVIII H	ospi tal	PPS	
MRK B - MEDICAL AND OTHER HEALTH SERVICES 2.4,004 1.0				1 00	
Medical and other services relatursed under OPPS (see Instructions) 50,49,797 2,00 600		PART B - MEDICAL AND OTHER HEALTH SERVICES		11.00	
0.000 1.00	1.00			24, 604	1.00
0.00 Control		· · · · · · · · · · · · · · · · · · ·	ļ		•
0.000 0.00			ļ		1
Enter the hospital appocific payment to cost ratio (see instructions)			ļ	l	1
Line 2 Times Line 5 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·	ļ		•
2.00 Sam of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 0.00			ļ		1
Ancillary service other pass through costs from West. D. Pt. IV. col. 13, line 200 166,657 0.00 1.0			ļ	0.00	1
0.00 Organ acquist tions 24,004 11.00 Total cost (sum of Lines 1 and 10) (see Instructions) 24,004 11.00 Total cost (sum of Lines 1 and 10) (see Instructions) 70,044 12.00 12.0		Transitional corridor payment (see instructions)	ļ	0	8. 00
1.00			ļ	l	1
COMPUTATION OF INSPER OF COST OR CHARGES 12.00 Ancillary service 12.00		9 '	ļ	· ·	ı
Reasonable charges 70,964 12,00 Another lary service charges 70,964 13,00 70,964 13,00 70,964 13,00 70,964 14,00 107a1 reasonable charges (sum of lines 12 and 13) 70,964 14,00 107a1 reasonable charges (sum of lines 12 and 13) 70,964 14,00 107a1 reasonable charges (sum of lines 12 and 13) 70,964 14,00 16,00 70,964 14,00 70,	11.00			24, 604	11.00
2.00 Ancil lary service charges 70, 944 12.00 12.00 12.01					
13.00 Organ acquisition charges (From Wist. D.4, Pt. III, col. 4, line 69)	12. 00			70, 964	12.00
Customary charges			ļ		
15.00 Aggregate amount actually collected from patients Liable for payment for services on a charge basis 0 15.00				70, 964	14.00
16. 00 Amounts that would have been reallized from patients liable for payment for services on a chargebasis 0 16. 00 Nation of Line 15 to Line 16 (not to exceed 1.00000) 0.000000 77. 00 0.0000000 77. 00 0.0000000000					
had such payment been made in accordance with 42 CFR \$413.13(e)					
17.00 Ratio of line 1s to line 16 (not to exceed 1.000000) 17.00	16.00		hargebasis	0	16.00
18.00 Total customary charges (see instructions) 70.764 18.00 19.00 10.00	17 00		ļ	0 000000	17 00
19. 00 Excess of customary charges over reasonable cost (complete only if fine 18 exceeds line 11) (see 46,360 19. 00			ļ	1	•
instructions) (see		•
Instructions 24,004 21.00			´ `	· ·	
1.00 Lesser of cost or charges (see instructions) 22,00 21.00 22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 23.00 25.	20.00) (see	0	20. 00
22.00 Interns and residents (see instructions)	04.00		ļ		
23.00 Cost of physicians' services in a teaching hospital (see instructions) 54,150,452 24.00			ļ	l	1
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 54,150,452 24.00			ļ		•
COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 25.00 26				1	•
25.00 Deductible sand coinsurance amounts (For CAH, see instructions) 0, 25.00	21.00			01,100,102	21.00
27.00 Subtotal [(I lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 45.000,837 27.00	25.00			0	25.00
Instructions	26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instruction	ns)	9, 174, 219	26. 00
28. 00	27.00		23] (see	45, 000, 837	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0	00.00		ļ	400 400	00.00
30.00 Subtotal (sum of lines 27 through 29) 45,438,969 30.00 30.00 7 through payments 17,792 31.00 32.00 32.00 32.00 33.00 3			ļ	l	1
31.00 Primary payer payments 17,792 31.00 Subtotal (line 30 minus line 31) 45,421,177 32.00 ALDOMABLE BAD DEBTS [CXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 33.00 34.00 All lowable bad debts (see instructions) 2,390,808 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 1,554,025 35.00 36.00 All lowable bad debts (see instructions) 1,554,025 35.00 37.00 Subtotal (see instructions) 46,975,202 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.75 Pioneer ACO demonstration payment adjustment amount (see instructions) 0 39.97 2		, , , , , , , , , , , , , , , , , , ,	ļ		•
32.00 Subtotal (line 30 minus line 31) A5, 421, 177 32.00			ļ	1	1
33.00 Composite rate ESRD (From Wkst. I-5, line 11)			ļ		1
34.00 All owable bad debts (see instructions) 2, 390, 808 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 1, 768, 492 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 1, 768, 492 36.00 37.00 Subtotal (see instructions) 46, 975, 202 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.75 39.75 NS respirator payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 0 39.99 40.00 Subtotal (see instructions) 46, 975, 202 40.00 40.01 Sequestration adjustment (see instructions) 46, 975, 202 40.00 40.01 40.		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
35. 00 Adjusted reimbursable bad debts (see instructions) 1,554,025 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 1,768,492 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 46,975, 202 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 46,975, 202 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 46,975, 202 37. 00 39. 00 70 70 70 70 70 70 70			ļ		1
36.00 Al owable bad debts for dual eligible beneficiaries (see instructions) 1,768,492 36.00 37.00 30.00 37.00 30.00 39.00 39.00 39.00 39.00 39.00 39.00 39.00 39.50			ļ		
37. 00 Subtotal (see instructions) 46, 975, 202 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 MSP-LCC reconciliation amount from PS&R 0 39. 00 39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 99 39. 90 39.			l		
38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment amount (see instructions) 39. 50 39. 75 N95 respirator payment adjustment amount before sequestration 0 39. 75 39. 97 Partial or full credit sreceived from manufacturers for replaced devices (see instructions) 0 39. 97 39. 98 Partial or full credit sreceived from manufacturers for replaced devices (see instructions) 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 01 Sequestration adjustment (see instructions) 46, 975, 202 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 591, 888 40. 01 40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 45, 578, 301 41. 00 41. 00 Interim payments 45, 578, 301 41. 00 42. 01 Tentative settlement (for contractors use only) 45, 578, 301 42. 01 43. 01 Bal ance due provider/program (see instructions) 805, 013 43. 00 43. 01 Be COMPLETED			ļ		•
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.50 39.		l ` ' '	ļ		1
39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50			l	l	1
39. 97 39. 98 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0	39. 50		ļ		
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 591,888 40.01 40.02 Demonstration payment adjustment amount after sequestration 591,888 40.01 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program (see instructions) 43.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 591.00 Outlier amount (see instructions) 90.00 Outlier amount (see instructions) 91.00 Outlier amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 10 39.98 39.99 39.99 40.00 40.00 40.01 591,888 40.01 40.02 40.02 40.02 40.03 41.01 45,578,301 41.00 41.01 42.00 42.00 42.00 42.00 42.00 42.00 42.01 42.00 42.00 42.00 43.01 44.00 90.00 91.00 91.00 92.00 71 ime Value of Money (see instructions) 90.00 93.00	39. 75	N95 respirator payment adjustment amount (see instructions)	ļ	0	39. 75
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 591, 888 40. 01 A0. 02 40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 41. 00 Interim payments 45, 578, 301 41. 00 41. 01 Interim payments-PARHM or CHART 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM or CHART (for contractor use only) 42. 01 Tentative settlement-PARHM or CHART (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 To BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 93. 00 Time Value of Money (see instructions) 0 94. 00 95. 00 96. 00 97. 00					ł
40.00 Subtotal (see instructions) 46, 975, 202 40.00 40.01 Sequestration adjustment (see instructions) 591, 888 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM or CHART pass-throughs 45, 578, 301 41.00 41.01 Interim payments-PARHM or CHART 45, 578, 301 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 805, 013 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 80.00 Si15.2 0 70 70)	· ·	1
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 591, 888 40.01 40.02			l		ł
40.02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs Interim payments Interim payments-PARHM or CHART Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, To BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 40.00		,	ļ	l	1
40. 03 Sequestration adjustment-PARHM or CHART pass-throughs 45,578,301 41.00 41.01 1nterim payments 45,578,301 41.00 41.01 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 42.00 43.00 Bal ance due provider/program (see instructions) 805,013 43.00 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 45.578 44.00 45.578			ļ		1
41.00			l	Ĭ	1
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 42.00 42.00 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 42.01 43.00 43.01 44.00 95.015 43.01 44.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00		, · · · · · · · · · · · · · · · · · · ·	ļ	45, 578, 301	•
42.01 Tentative settlement-PARHM or CHART (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.01 Tentative settlement-PARHM or CHART (for contractor use only) 42.01 43.00 43.00 43.01 44.00 90.00 91.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Original outlier amount (see instructions) 92.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)	41.01	Interim payments-PARHM or CHART	ļ		41.01
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	ļ	0	1
43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, protested amounts (nonallowable cost report items) 44.00 43.01 43.01 43.01 44.00 43.01 44.00 45.01 47.0		, , , , , , , , , , , , , , , , , , , ,	ļ		•
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f		, , , , , , , , , , , , , , , , , , , ,	ļ	805, 013	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00			1		1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 93.00	44.00		ei I,	"	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00					1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90.00			0	90.00
93.00 Time Value of Money (see instructions) 0 93.00		, ,	ļ	0	
		l y	ļ	l	1
94.00 IOTAI (SUM OF LINES 91 and 93) 0 94.00			l		1
	94.00	Total (Sum of Tines 91 and 93)		l 0	94.00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pro	
				5/23/2023 11:	46 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				C	200.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet E Part B
	Component CCN: 15-S048	To 12/31/2022	Date/Time Prepared: 5/23/2023 11:46 am
	Title XVIII	Subprovi der -	PPS

	litle XVIII Subprovider -	PPS	
		1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1. 00	
1.00	Medical and other services (see instructions)	45	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	975	2.00
3.00	OPPS payments	576	3.00
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	5.00
6.00	Line 2 times line 5	0	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	8. 00 9. 00
10.00	Organ acquisitions	0	10.00
	Total cost (sum of lines 1 and 10) (see instructions)	45	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
10.00	Reasonable charges	120	10.00
12.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	129 0	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	129	14. 00
	Customary charges		
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. 00
18. 00	Total customary charges (see instructions)	129	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	84	19. 00
20.00	instructions)	0	20.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21. 00	Lesser of cost or charges (see instructions)	45	21. 00
22. 00	Interns and residents (see instructions)	0	22. 00
	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	579	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	93	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	531	27. 00
28. 00	instructions)	o	28. 00
29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30. 00		531	30.00
31.00	Primary payer payments	0	31.00
32. 00		531	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33. 00
	Allowable bad debts (see instructions)	0	34.00
35. 00	,	Ö	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36. 00
37. 00		531	37.00
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	U	39.50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 531	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)	6	40.00
40. 02		0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs		40. 03
41.00	Interim payments	523	
41. 01 42. 00	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)	0	41. 01 42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)		42.00
43.00	Balance due provider/program (see instructions)	2	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	93. 00 94. 00
74.00	Tiotal (Sam of Times /1 and /o/	١	74.00

Health Financial Systems	REID HOSPITAL 8	& HEALTH	CARE SERVICES	In Lie	u of Form CMS-	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der CCN: 15-0048	Peri od:	Worksheet E	
				From 01/01/2022		
			Component CCN: 15-S048	To 12/31/2022	Date/Time Pr	epared:
			•		5/23/2023 11	:46 am_
			Title XVIII	Subprovi der -	PPS	
				I PF		
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days						200. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:		Worksheet E
	Component CCN:	From 01/01/2022 15-T048 To 12/31/2022	Part B Date/Time Prepared:
	Compensive con	. 10 10 10 10 12, 01, 2022	5/23/2023 11: 46 am
	Ti tle XV	/III Subprovider -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		227	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			219 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	. col. 13. Line 200		0	9.00
10.00	Organ acqui si ti ons	,		0	10.00
11. 00				0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges Ancillary service charges			0	12. 00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iir	ne 69)		0	13.00
14.00		,		0	14.00
45 00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		on a chargebasis	U	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			0	21. 00
	Interns and residents (see instructions)			0	22. 00
23. 00		ıcti ons)		0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			219	24. 00
25. 00				0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line		ructions)	0	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23] (see	219	27. 00
28. 00	instructions) Direct graduate modical education payments (from Wkst. E. 4. Lir	10 EO)		0	28. 00
29. 00	Direct graduate medical education payments (from Wkst. E-4, lir ESRD direct medical education costs (from Wkst. E-4, line 36)	ie 50)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			219	
31.00	,			0	31.00
32. 00	Subtotal (line 30 minus line 31)	0)		219	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33.00
	Allowable bad debts (see instructions)			0	34.00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		0	36.00
37.00				219	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			O .	39.50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 219	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			3	40.00
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs				40. 03
41.00	Interim payments			215	
41. 01 42. 00	Interim payments-PARHM or CHART Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)			O	42. 01
43. 00	Balance due provider/program (see instructions)			1	43.00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chapter 1	0	43. 01 44. 00
50	TO BE COMPLETED BY CONTRACTOR				55
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money				92.00
93.00	,			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0048	Peri od:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-T048	To 12/31/2022	Date/Time Pr	epared:
				5/23/2023 11	:46 am
		Title XVIII	Subprovi der -	PPS	
			IRF		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 60, 146, 358 45, 578, 301 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate 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 04/13/2022 46,000 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 46,000 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 60, 192, 358 45, 578, 301 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 805, 013 6.01 SETTLEMENT TO PROGRAM 6.02 43, 215 6.02 7.00 Total Medicare program liability (see instructions) 60, 149, 143 46, 383, 314 7.00 Contractor NPR Date Number (Mo/Day/Yr)

Provider CCN: 15-0048

Peri od:

1.00

2.00

8 00

8.00 Name of Contractor

Health Financial Systems REID HOSPI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/23/2023 11: 46 am

Subprovi der - PPS Provider CCN: 15-0048 Component CCN: 15-S048 Title XVIII

		Title	XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3.00	4. 00	
1.00	Total interim payments paid to provider		1, 924, 863		523	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3.04
3. 05	Dravi dan ta Dragnam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM					3. 50
3. 52			ĺ		Ö	3. 52
3. 53			Ö		l ol	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 924, 863		523	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Described to Describe		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM					5. 50
5. 51						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)		_			
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		63, 267		2	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 988, 130		525	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			00	2.00	8. 00
	· · · · · · · · · · · · · · · · · · ·			į.		

Health Financial Systems REID HOSPI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0048 Component CCN: 15-T048

		Title	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 090, 75		215	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		I	ol	1 0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER			0		3. 01
3. 03				Ö	l ő	3. 03
3. 04				0	0	3.04
3.05				0	0	3.05
	Provi der to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51 3. 52				0	0 0	3. 51 3. 52
3. 52				0		3. 52
3. 54				Ö	l ő	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 090, 75	8	215	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER			ol	1 0	5. 01
5. 01	TENTATIVE TO PROVIDER			0		5. 02
5. 03				Ö	o o	5. 03
	Provi der to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5.50
5. 51				0	0	5. 51
5. 52 5. 99				0	0	5. 52 5. 99
5. 99	5. 50-5. 98)			O O		5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		8, 52		1	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 099, 28	Contractor	216 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems REID HOSPITAL & HEALT	TH CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0048	Peri od: From 01/01/2022	Worksheet E-1 Part II	
			To 12/31/2022		epared:
				5/23/2023 11:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	11			5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified нії tecnnology	WKST. S-2, PT. I		7. 00
0.00	line 168				8.00
8. 00 9. 00	Calculation of the HIT incentive payment (see instructions) Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(see Histructions)			10.00
30 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and	lina 31) (saa instructio	ne)		32.00
32.00	parance due provider (Time o (or Time 10) illinus Time 30 and 1	THE 31) (See HISTIACTIO			1 32.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	S In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	: 15-0048 Peri od: From 01/01/2022	Worksheet E-3
	Component CCN	N: 15-S048 To 12/31/2022	
	Title X	(VIII Subprovider -	PPS

	IPF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 123, 361	1. 00
. 00	Net IPF PPS Outlier Payments	5, 938	2.00
. 00	Net IPF PPS ECT Payments	0	3.00
. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
	15, 2004. (see instructions)		
. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4.0
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
. 00	New Teaching program adjustment. (see instructions)	0.00	5.00
. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6.00
	teaching program" (see instuctions)		
. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7.00
	teaching program" (see instuctions)		
. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
. 00	Average Daily Census (see instructions)	12. 687671	9.00
0. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
1. 00	Teaching Adjustment (line 1 multiplied by line 10).	o	11.0
2. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2, 129, 299	12. 0
3. 00	Nursing and Allied Health Managed Care payment (see instruction)	ol	13. 0
4. 00	Organ acquisition (DO NOT USE THIS LINE)		14. 0
5. 00	Cost of physicians' services in a teaching hospital (see instructions)	ol	15. 0
6. 00	Subtotal (see instructions)	2, 129, 299	
	Primary payer payments	-,,	17. 0
8. 00	Subtotal (line 16 less line 17).	2, 129, 299	
	Deducti bl es	192, 296	
	Subtotal (line 18 minus line 19)	1, 937, 003	
	Coinsurance	33, 454	
	Subtotal (line 20 minus line 21)	1, 903, 549	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	168, 095	
	Adjusted reimbursable bad debts (see instructions)	109, 262	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	133, 885	
	Subtotal (sum of lines 22 and 24)	2, 012, 811	
	Direct graduate medical education payments (see instructions)	2,012,011	27. 0
	Other pass through costs (see instructions)	689	28. 0
	Outlier payments reconciliation	007	29. 0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.0
	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 5
0. 98	Recovery of accelerated depreciation.	0	30. 9
	Demonstration payment adjustment amount before sequestration	0	30. 9
	Total amount payable to the provider (see instructions)	2, 013, 500	
	Sequestration adjustment (see instructions)	25, 370	
	Demonstration payment adjustment amount after sequestration	25, 370	31.0
	Interim payments	1, 924, 863	
	Tentative settlement (for contractor use only)	1, 724, 803	33. 0
	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		
5.00		63, 267 0	35.0
3.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	٩	33.0
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
0 00	Original outlier amount from Worksheet E-3, Part II, line 2	5, 938	50. 0
			50.0
2.00	Outlier reconciliation adjustment amount (see instructions) The rate weed to calculate the Time Value of Meney.	0 00	
	The rate used to calculate the Time Value of Money	0.00	
3. 00	Time Value of Money (see instructions)	0	53. 0
9. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		99. 0
	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000 0. 000000	

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet E-3
		Component CCN: 15-T048		
		Title XVIII	Subprovi der -	PPS
			IRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
00	Net Federal PPS Payment (see instructions)	3, 017, 460	1.
00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0091	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)	145, 140	3.
00	Outlier Payments	19, 328	4.
00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5.
01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5.
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 period of a "new teaching program" (see instructions)	0. 00	7.
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8
00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9
00	Average Daily Census (see instructions)	10. 438356	10
00	Teaching Adjustment Factor (see instructions)	0.000000	11
00	Teaching Adjustment (see instructions)	0	12
00	Total PPS Payment (see instructions)	3, 181, 928	13
00	Nursing and Allied Health Managed Care payments (see instruction)	0	14
00	Organ acquisition (DO NOT USE THIS LINE)		15
00	Cost of physicians' services in a teaching hospital (see instructions)	0	16
00	Subtotal (see instructions)	3, 181, 928	17
00	Primary payer payments	0	18
00	Subtotal (line 17 less line 18).	3, 181, 928	
00	Deducti bl es	14, 004	20
00		3, 167, 924	
00		38, 122	
00	Subtotal (line 21 minus line 22)	3, 129, 802	
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	13, 285	24
00	Adjusted reimbursable bad debts (see instructions)	8, 635	
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7, 653	20
00	Subtotal (sum of lines 23 and 25)	3, 138, 437	2
00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28
00	Other pass through costs (see instructions)	395	20
00	Outlier payments reconciliation	0	30
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	3
50 98	Pioneer ACO demonstration payment adjustment (see instructions) Recovery of accelerated depreciation.	0	31
99	Demonstration payment adjustment amount before sequestration	0	31
00	Total amount payable to the provider (see instructions)	3, 138, 832	
01	Sequestration adjustment (see instructions)	39, 549	32
02		0	32
00	Interim payments	3, 090, 758	33
00	Tentative settlement (for contractor use only)	0,070,730	34
00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	8, 525	35
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36
00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4	19, 328	50
00	Outlier reconciliation adjustment amount (see instructions)	0	51
00	The rate used to calculate the Time Value of Money	0.00	
. 00	Time Value of Money (see instructions)	0.00	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	EID HOSPITAL & HEALTH CARE SERVICES	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15	-0048 Period:	Worksheet F-3

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2022 To 12/31/2022		pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		3, 368, 431		1.00
2. 00	Medical and other services			3, 472, 190	2.00
3.00	Organ acquisition (certified transplant programs only)		0 0 0 101	0 470 400	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		3, 368, 431	3, 472, 190	1
5. 00 6. 00	Inpatient primary payer payments		0	0	5. 00 6. 00
7. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		3, 368, 431	3, 472, 190	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		3, 300, 431	3, 472, 170	7.00
	Reasonable Charges				
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		8, 110, 483	13, 666, 864	9.00
10.00	Organ acquisition charges, net of revenue		0	., ,	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		8, 110, 483	13, 666, 864	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000		1
	Total customary charges (see instructions)	: 6 : 1/	8, 110, 483	13, 666, 864	1
17. 00	Excess of customary charges over reasonable cost (complete onl line 4) (see instructions)	y II IIIle 16 exceeds	4, 742, 052	10, 194, 674	17. 00
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 4 exceeds line	7	0	18. 00
10.00	16) (see instructions)	y IT TITLE 4 EXCECUS TITLE		0	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	3, 368, 431	3, 472, 190	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		lers.		
	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	
	Subtotal (sum of lines 22 through 26)		0	0	27.00
	Customary charges (title V or XIX PPS covered services only)		2 240 421	2 472 100	28.00
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 368, 431	3, 472, 190	29. 00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1	3, 368, 431	3, 472, 190	•
32. 00	Deductibles	,	0, 300, 431	0, 472, 170	32.00
33. 00	Coinsurance		0	0	33.00
	Allowable bad debts (see instructions)		O	0	34.00
	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	3, 368, 431	3, 472, 190	36.00
37.00	ZERO OUT MEDICAID		-3, 368, 431	-3, 472, 190	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		l

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVIC	CES In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCI	N: 15-0048 Peri od: From 01/01/2022	Worksheet E-3 Part VII
	Component Co	CN: 15-S048 To 12/31/2022	Date/Time Prepared: 5/23/2023 11:46 am
	Ti tl e		Cost
		l I PF	

		77.	IPF	0001	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TI	TLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpati ent hospi tal /SNF/NF services		251, 223		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		251, 223	0	4.00
5. 00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		251, 223	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		, , ,		
	Reasonabl e Charges				
8. 00	Routi ne servi ce charges		0		8.00
9. 00	Ancillary service charges		o	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		o	0	1
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services or	n a charge	0	0	13.00
	basis	3			
14.00	Amounts that would have been realized from patients liable for payment for	services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.	3(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	` '	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		o	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 10	exceeds	o	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if line 4	exceeds line	251, 223	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for	or PPS provid	ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		251, 223	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS	Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od: From 01/01/2022	Worksheet E-3 Part VII
	Component CCN: 15-T048	To 12/31/2022	Date/Time Prepared: 5/23/2023 11:46 am
	Title XIX	Subprovi der -	Cost
		I RF	

	"	tie xix	I RF	COST	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOI	R TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5.00	Inpatient primary payer payments		0		5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	1
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		0	0	12.00
13. 00	Amount actually collected from patients liable for payment for service:	c on a charge	0	0	13.00
13.00	basis	S on a charge	U	U	13.00
14. 00	Amounts that would have been realized from patients liable for payment	for services or	o	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 CFR §4			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	10. 10(0)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		0	0.000000	1
17. 00	Excess of customary charges over reasonable cost (complete only if line	e 16 exceeds	0	0	
17.00	line 4) (see instructions)	с то слоссиз		Ü	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line	e 4 exceeds line	o	0	18.00
	16) (see instructions)			_	
19.00	Interns and Residents (see instructions)		o	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	d for PPS provid	ers.		1
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00			0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
31.00			0	0	
32.00	Deducti bl es		0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0		35.00
	, , , , , , , , , , , , , , , , , , , ,		0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		0	0	
	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	
	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	0	
43.00		UMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				I

	Financial Systems REID HOSPITAL & HEALTH (GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT P	rovi der CC		Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Title	XVIII	Hospi tal	5/23/2023 11: PPS	46 am
		11116	AVIII	позрі саі	113	
	COMPLITATION OF TOTAL DIDECT CHE ANOUNT				1. 00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic pr	ograms for	cost report	ina periods	0.00	1.0
00	ending on or before December 31, 1996.	og. amo . o.	0001 . opo. 1	g por rodo	0.00	
. 01	FTE cap adjustment under §131 of the CAA 2021 (see instructions		4) (0.00	
. 00 . 26	Unweighted FTE resident cap add-on for new programs per 42 CFR Rural track program FTE cap limitation adjustment after the cap	,	17. 91	2.0		
20	the CAA 2021 (see instructions)	building	willdow crose	a anaci 3127 or		2.2
. 00	Amount of reduction to Direct GME cap under section 422 of MMA				0.00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance w	ith 42 CFR	§413.79 (m)	. (see	0.00	3.0
3. 02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural track	FTF limit	ation(s) for	rural track		3. 0
,. OZ	programs with a rural track Medicare GME affiliation agreement				}	0.0
	49075 (August 10, 2022) (see instructions)					
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and os GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))	teopathi c	programs due	to a Medicare	0.00	4. C
l. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	ctions for	cost report	ina periods	0.00	4.0
	straddling 7/1/2011)		·	0.1		
. 02	ACA Section 5506 number of additional direct GME FTE cap slots	(see inst	ructions for	cost reporting	0.00	4.0
1. 21	periods straddling 7/1/2011) The amount of increase if the hospital was awarded FTE cap slot	s under 81	26 of the CA	A 2021 (see		4.2
	instructions)	S ander 31	20 01 1110 07	W 2021 (300		'. 2
. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines			nus lines 3 and	17. 91	5.0
. 00	3.01, plus or minus line 3.02, plus or minus line 4, plus lines Unweighted resident FTE count for allopathic and osteopathic pr			woor from your	16. 37	6.0
5. 00	records (see instructions)	ograilis ror	the current	year rrolli your	10.37	0.0
7. 00	Enter the lesser of line 5 or line 6				16. 37	7. C
			Primary Care		Total	
3. 00	Weighted FTE count for physicians in an allopathic and osteopat	hi c	1. 00 15. ⁰	2. 00 99 0. 00	3. 00 15. 99	8.0
	program for the current year.					
0. 00	If line 6 is less than 5 enter the amount from line 8, otherwis multiply line 8 times the result of line 5 divided by the amount		15. 9	99 0.00	15. 99	9.0
	6. For cost reporting periods beginning on or after October 1,					
	if Worksheet S-2, Part I, line 68, is "Y", see instructions.					
0.00				0.00	l .	10.0
0. 01	Unweighted dental and podiatric resident FTE count for the curr Total weighted FTE count	ent year	15. 9	0. 00 99	l	10. 0 11. 0
1 00		vear (see	15. 8		l e	12.0
	liotal weighted resident FIE count for the prior cost reporting					
2. 00	Total weighted resident FTE count for the prior cost reporting instructions)	, ,				
 1. 00 2. 00 3. 00 	instructions) Total weighted resident FTE count for the penultimate cost repo	, ,	16. 4			
 2. 00 3. 00 	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions)	orting	16. 4	0.00		13. C
 2. 00 3. 00 4. 00 	instructions) Total weighted resident FTE count for the penultimate cost repo	orting		0. 00 09 0. 00		13. C
 2. 00 3. 00 4. 00 5. 00 	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro	orting by 3). bgrams	16. <i>4</i>	0. 00 09 00 00 0. 00		13. C
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided be Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closu	orting by 3). bgrams are	16. 4 16. 0 0. 0 0. 0	0. 00 09 00 00 00 00 00 00 00 00 00 00 00 0		13. 0 14. 0 15. 0 15. 0 16. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closu	orting by 3). bgrams are	16. 4 16. (0. (0. (0. 00 09 00 00 00 00 00 00 00 00 00 00 00 0		13. 0 14. 0 15. 0 15. 0 16. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure	orting by 3). bgrams are	16. 4 16. 0 0. 0 0. 0	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0		13. 0 14. 0 15. 0 15. 0 16. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hos closure	orting by 3). bgrams are	16. 4 16. 0 0. 0 0. 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		13. 0 14. 0 15. 0 15. 0 16. 0 16. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 8. 00 8. 01	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided be Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new propadjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure. Adjusted rolling average FTE count. Per resident amount.	orting by 3). bgrams are	16. 4 0. 0 0. 0 0. 0 16. 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		13. 0 14. 0 15. 0 15. 0 16. 0 17. 0 18. 0 18. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided by Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	orting by 3). bgrams are	16. (0. (0. (0. (0. (0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		13. 0 14. 0 15. 0 15. 0 16. 0 17. 0 18. 0 18. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided be Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new propadjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure. Adjusted rolling average FTE count. Per resident amount.	orting by 3). bgrams are	16. 4 0. 0 0. 0 0. 0 16. 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		13. 0 14. 0 15. 0 15. 0 16. 0 17. 0 18. 0 18. 0
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01 9. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE	orting oy 3). ograms ore opital	16. 4 0. (0. (0. (16. (104, 184. { 1, 676, 3.	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0	1, 676, 335	13. C 14. C 15. C 15. C 16. C 16. C 17. C 18. C 19. C
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01 9. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)	orting oy 3). ograms ore	16. 4 0. (0. (0. (16. (104, 184. { 1, 676, 3.	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0	1, 676, 335 1. 00 0. 00	13. C 14. C 15. C 15. C 16. C 17. C 18. C 19. C
2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01 9. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided be Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new propadjustment for residents displaced by program or hospital closure. Adjusted rolling average FTE count. Per resident amount. Per resident amount under §131 of the CAA 2021. Approved amount for resident costs. Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct)	orting oy 3). ograms ore opital resident cions)	16. 4 0. (0. (0. (16. (104, 184. { 1, 676, 3.	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0	1, 676, 335 1. 00 0. 00 0. 00	13. 0 14. 0 15. 0 15. 0 16. 0 16. 0 17. 0 18. 0 19. 0
2. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 01 9. 00 20. 00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided b Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pro Adjustment for residents displaced by program or hospital closu Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4)	orting oy 3). ograms ore opital resident cions)	16.4 0.0 0.0 0.0 16.0 104, 184.8 1, 676, 33	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0	1, 676, 335 1. 00 0. 00 0. 00 0. 00	13. 0 14. 0 15. 0 15. 0 16. 0 17. 0 18. 0 19. 0
2.00 4.00 5.00 5.01 6.00 6.01 7.00 8.00 8.01 9.00 20.00 21.00 22.00 23.00 24.00	instructions) Total weighted resident FTE count for the penultimate cost repoyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided be Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new propadjustment for residents displaced by program or hospital closus Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FTE Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct Allowable additional direct GME FTE Resident Count (see instruct	orting oy 3). ograms ore opital resident cions)	16.4 0.0 0.0 0.0 16.0 104, 184.8 1, 676, 33	0.00 09 00 00 00 00 00 00 00 00 00 00 00 0	1, 676, 335 1. 00 0. 00 0. 00 0. 00	13. C 14. C 15. C 15. C 16. C 17. C 18. C 18. C 19. C 21. C 22. C 23. C 24. C

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der C	CN: 15-0048	Peri od: From 01/01/2022	Worksheet E-4	
WEDI OF	E EBBOATTON 30313			To 12/31/2022	Date/Time Pre 5/23/2023 11:	
		Titl∈	XVIII	Hospi tal	PPS	
			Inpatient Part A	Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	20, 3	57 10, 418		26.00
27. 00	Total Inpatient Days (see instructions)		49, 7	70 49, 770		27.00
28. 00	Ratio of inpatient days to total inpatient days		0. 4090			28. 00
29. 00	Program direct GME amount		685, 6	·	1, 036, 551	
29. 01	Percent reduction for MA DGME			3. 26		29. 01
	Reduction for direct GME payments for Medicare Advantage			11, 439		
31.00	Net Program direct GME amount				1, 025, 112	31.00
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	F XVIII ONI	Y (NURSING PR	ROGRAM AND PARAME		
	EDUCATION COSTS)	_ ,,,,,,	. (.51 5/12	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum	of col. 20 ar	nd 23, lines 74	0	32.00
33. 00	, ,				1, 296, 107	33.00
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line	33)	•	0.000000	34.00
35. 00]				0	35.00
36. 00	Medicare outpatient ESRD direct medical education costs (line		35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				1
07.00	Part A Reasonable Cost				(7.047.050	07.00
37. 00 38. 00	Reasonable cost (see instructions) Organ acquisition and HSCT acquisition costs (see instruction	c)			67, 847, 253 0	1
39.00	Cost of physicians' services in a teaching hospital (see inst				0	
	Primary payer payments (see instructions)	r de trons)			11, 184	
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)			67, 836, 069	
	Part B Reasonable Cost	,				1
42. 00	Reasonable cost (see instructions)				50, 651, 790	42.00
43. 00	Primary payer payments (see instructions)				17, 792	
	Total Part B reasonable cost (line 42 minus line 43)				50, 633, 998	
45. 00	Total reasonable cost (sum of lines 41 and 44)		. = >		118, 470, 067	
46. 00					0. 572601	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA		45)		0. 427399	47.00
48 00	Total program GME payment (line 31)	IX I D			1, 025, 112	48 00
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instr	uctions)		586, 980	
	10 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)					

Heal th	Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2	552-10
					Worksheet E-5	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/23/2023 11:4	
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E,	Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2					0	2.00
3.00	Operating outlier reconciliation adjust	tment amount (see instr	uctions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					O	4.00
5.00 The rate used to calculate the time value of money (see instructions)					0.00	5.00
6.00 Time value of money for operating expenses (see instructions)				0	6.00	
7.00 Time value of money for capital related expenses (see instructions)				0	7. 00	

Health Financial Systems REID HOSPITAL & H BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0048

Peri od: From 01/01/2022 To 12/31/2022 Worksheet G Date/Time Prepared: 5/23/2023 11:46 am

					5/23/2023 11:	<u>46 am</u>
		General Fund	Speci fi c	Endowment	Plant Fund	
			Purpose Fund	Fund		
	OUDDENT ACCETS	1. 00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	4/ 450 7/1				1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	46, 452, 761 446, 704, 772	0	0	0	1. 00 2. 00
3. 00	Notes receivable	440, 704, 772	0	0	0	3.00
4. 00	Accounts recei vable	141, 322, 373	-	0	0	4.00
5. 00	Other receivable	614, 594, 524	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	8, 652, 615	1	0	0	7.00
8. 00	Prepaid expenses	13, 480, 721	0	0	0	8.00
9. 00	Other current assets	13,400,721		0	0	9.00
10. 00	Due from other funds	100	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	1, 207, 206, 117	0	0		11.00
11.00	FIXED ASSETS	1, 201, 200, 111	0		0	11.00
12. 00	Land	18, 717, 396	0	0	0	12.00
13. 00	Land improvements	10, 883, 356		0		13.00
14. 00	Accumulated depreciation	10,000,000	0	0	Ö	14.00
15. 00	Bui I di ngs	344, 604, 749	-	0	Ő	15. 00
16. 00	Accumulated depreciation	-204, 653, 442		0	0	16.00
17. 00	Leasehold improvements	13, 645, 110		0	0	17. 00
18. 00	Accumulated depreciation	-9, 239, 627		0	0	18.00
19. 00	Fi xed equipment	2, 237, 098		0	Ö	19.00
20. 00	Accumulated depreciation	-2, 004, 506		0	Ö	20.00
21. 00	Automobiles and trucks	2,001,000	0	0	Ö	21.00
22. 00	Accumulated depreciation		0	0	0	22. 00
23. 00	Major movable equipment	220, 799, 729		0	0	23. 00
24. 00	Accumulated depreciation	-161, 837, 405		0	0	24.00
25. 00	Mi nor equi pment depreci abl e	101,037,409		0	Ö	25. 00
26. 00	Accumulated depreciation			0	Ö	26.00
27. 00	HIT designated Assets	0		0	ő	27.00
28. 00	Accumulated depreciation	0		0	Ö	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	Ö	0	ő	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	233, 152, 458		0		30.00
00.00	OTHER ASSETS	200, 102, 100	<u> </u>			00.00
31. 00	Investments	0	0	0	0	31.00
32. 00	Deposits on leases	0	0	0	Ō	32.00
33. 00	Due from owners/officers	0	0	0	ő	33.00
34. 00	Other assets	100, 168, 516	0	0	Ō	34.00
35. 00	Total other assets (sum of lines 31-34)	100, 168, 516	1	0	Ō	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 540, 527, 091	0	0		36.00
	CURRENT LIABILITIES	, , , , , , , , , , , , , , , , , , , ,			-	
37.00	Accounts payable	30, 058, 146	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	14, 262, 083	I	0	0	38.00
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	12, 967, 152	O	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	4, 192, 382				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	61, 479, 763	0	0	0	45. 00
	LONG TERM LIABILITIES		•			
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	322, 245, 048	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	3, 051, 461		0	Ō	49.00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	325, 296, 509	1	0	Ō	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	386, 776, 272	1	0		51.00
01.00	CAPITAL ACCOUNTS	000///0/2/2	<u> </u>			0 00
52.00	General fund balance	1, 153, 750, 819				52.00
53. 00	Specific purpose fund	1,100,700,017	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			Ü	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				Ő	58.00
	replacement, and expansion				ĺ	
59.00	Total fund balances (sum of lines 52 thru 58)	1, 153, 750, 819	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	1, 540, 527, 091	1	0	0	60.00
	59)			· ·		
		•			-	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

					10 12/31/2022	5/23/2023 11:	
		Genera	I Fund	Special F	Purpose Fund	Endowment	
						Fund	
		1. 00	2. 00	3.00	4.00	5. 00	
1. 00	Fund balances at beginning of period	1.00	1, 167, 554, 328		4.00	5.00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		104, 319, 928				2.00
3.00	Total (sum of line 1 and line 2)		1, 271, 874, 256		0	•	3.00
4.00	Additions (credit adjustments) (specify)	0			0	0	4.00
5.00		0			0	0	5.00
6. 00		0			0	0	
7. 00		0			0	0	7.00
8.00		0			0	0	
9. 00 10. 00	Total additions (sum of line 4.0)	0	_		0	0	9.00
11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		1, 271, 874, 256	1	0		11.00
12. 00	AMOUNTS INCLUDED ON HOME OFFICE	118, 123, 437	1, 271, 674, 230		0	0	
13. 00	AWOONTS TWOEDED ON HOWE OFFICE	0			0	ő	
14. 00		0			o	Ō	
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17. 00		0			0	0	
18. 00	Total deductions (sum of lines 12-17)		118, 123, 437		0		18. 00
19. 00	Fund balance at end of period per balance		1, 153, 750, 819		0		19. 00
	sheet (line 11 minus line 18)	Endowment	DI ont	E Fund			
		Fund	Prant	Fullu			
		Tuna					
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0	1			4.00
5.00			0				5.00
6. 00 7. 00			0				6. 00 7. 00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			o		11.00
12.00	AMOUNTS INCLUDED ON HOME OFFICE		0				12.00
13.00			0)			13.00
14.00			0				14.00
15.00			0				15.00
16. 00			0				16.00
17.00	Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	0				17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00
	I succe (Time II milius IIIIe 10)	I	I	I	I		I

 Heal th Financial
 Systems
 REID HO

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 15-0048

In Lieu of Form CMS-2552-10

		'	0 12/31/2022	5/23/2023 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	77, 910, 974		77, 910, 974	1.00
2.00	SUBPROVI DER - I PF	5, 079, 945	5	5, 079, 945	2.00
3.00	SUBPROVI DER - I RF	4, 230, 371		4, 230, 371	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	87, 221, 290		87, 221, 290	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>			
11.00	INTENSIVE CARE UNIT	12, 702, 527	'	12, 702, 527	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 12, 702, 527	,	12, 702, 527	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	99, 923, 817	,	99, 923, 817	17. 00
18.00	Ancillary services	300, 306, 573	664, 061, 258	964, 367, 831	18. 00
19.00	Outpati ent servi ces	33, 007, 946	89, 451, 554	122, 459, 500	19.00
20.00	RURAL HEALTH CLINIC			0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		6, 391, 594	6, 391, 594	
27. 00	OTHER	5, 205, 344		7, 627, 275	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to			1, 200, 770, 017	28. 00
	G-3, line 1)	122, 113, 221		.,,	
	PART II - OPERATING EXPENSES	<u>.</u>			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		359, 905, 077		29. 00
30.00	ADD (SPECIFY))		30.00
31.00)		31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00					38.00
39.00					39. 00
40.00					40.00
41.00					41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	359, 905, 077		43.00
	to Wkst. G-3, line 4)				
		•			

lealth Financial Systems REID HOSPITAL & HEALTH		I CARE SERVICES	In Lieu	In Lieu of Form CMS-2552-10	
STATEMENT OF DEVENUES AND EVDENCES		Providor CCN: 15 0049	Pori od:	Workshoot C 2	

Heal th	Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0048	Peri od:	Worksheet G-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/23/2023 11:	
					3/23/2023 11.	40 aiii
					1. 00	
1. 00	Total patient revenues (from Wkst.	G-2, Part I, column 3, lir	ne 28)		1, 200, 770, 017	1. 00
2.00	Less contractual allowances and dis	counts on patients' accour	nts		713, 587, 132	2.00
3.00	Net patient revenues (line 1 minus	line 2)			487, 182, 885	3.00
4.00	Less total operating expenses (from	Wkst. G-2, Part II, line	43)		359, 905, 077	4.00
5.00	Net income from service to patients	(line 3 minus line 4)			127, 277, 808	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests,	etc			197, 061	6.00
7.00	Income from investments				-44, 672, 849	7.00
8.00	Revenues from telephone and other m		n services		0	8.00
9.00	Revenue from television and radio s	ervi ce			0	9.00
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking Lot receipts				0	12.00
	Revenue from Laundry and Linen serv				137, 804	
	Revenue from meals sold to employee	9			3, 688, 927	
	Revenue from rental of living quart				0	15.00
	Revenue from sale of medical and su		than patients		0	16.00
	Revenue from sale of drugs to other				0	17.00
	Revenue from sale of medical record				612	
	Tuition (fees, sale of textbooks, u				56, 813	
	Revenue from gifts, flowers, coffee	shops, and canteen			0	20.00
	Rental of vending machines				7, 775	
22. 00	Rental of hospital space				7, 781, 364	
23. 00	Governmental appropriations				0	23.00
24.00	OTHER INCOME				9, 844, 613	
24. 50	COVI D-19 PHE Funding				0	24. 50
25.00	Total other income (sum of lines 6-	24)			-22, 957, 880	25.00
	Total (line 5 plus line 25)				104, 319, 928	26.00
	OTHER EXPENSES (SPECIFY)				0	
	Total other expenses (sum of line 2				0	28.00
29. 00	Net income (or loss) for the period	(line 26 minus line 28)			104, 319, 928	29. 00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS In Lieu of Form CMS-2552-10 Provider CCN: 15-0048 Peri od: Worksheet 0

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/23/2023 11:46 am Hospi ce CCN: 15-1524

SALARIES OTHER SUBTOTAL Celebrate S							5/23/2023 11:	46 am_
Col. 1 pt Us						Hospi ce I		
			SALARI ES	OTHER			SUBTOTAL	
GENERAL SERVICE COST CENTERS 1,660					(col. 1 plus	CATI ONS		
ENERAL SERVICE COST CENTERS 1, 050 1, 650								
1.00 CAP REL COSTS-BLOG & FIXT"			1.00	2. 00	3. 00	4. 00	5. 00	
2.00 CAP REL COSTS-AWBLE EQUIP* 0.00 CAP NOVE SEMPHETS DEPARTMENT* 0.00 CAP NOVE SEMPHETS DEPARTMENT* 1.00 CAP NOVE SEMPHETS DEPARTMENT SEMPH			1	4 (50		4 (50		
5.00 EMPLOYEE BENEFITS DEPARTMENT* 0 94,400 94,400 52,501 146,901 3.00		4			,	-1, 650		
ADMINISTRATIVE & CENERAL* 349, 350 54, 730 404, 080 23, 282 427, 362 4.00						0		
PLANT OPERATION & MAINTERANCE*								
AUNDRY & LINEN SERVICE*			349, 350	54, 730	404, 080	23, 282		
0.00 0.00			0	0	0	0		
B.00 DIETARY* 0			0	0	0	0		
9.00 NURSI NG ADMINISTRATION" 0 0 0 0 0 0 0 0 0			0	0	0	0		
10. 00 ROUTINE MEDICAL SUPPLIES* 0 0 0 0 0 0 0 10. 00			0	1, 377	1, 377	0		
11.00 MEDI CAL RECORDS* 0 0 0 0 11.00 17.00 13.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01 12.00 13.01			0	0	0	0		
12.00 STAFF TRANSPORTATION* 0 103, 171 103, 171 10 103, 171 12.00			0	0	0	0		
13. 00 VOLUNTEER SERVICE COORDINATION* 0 0 0 0 0 12.00			0	0	0	0		
14. 00 PHARMACY* 0 96, 128 96, 128 0 96, 128 14. 00 15. 00 15. 00 17. 00 0 0 0 0 0 0 0 15. 00 15. 00 15. 00 0 0 0 0 0 0 0 15. 00 15. 00 0 0 0 0 0 0 0 15. 00 15. 00 15. 00 0 0 0 0 0 0 0 0 0			0	103, 171	103, 171	0		
15. 00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 0 0 0 0 15. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 0 16. 00 18. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 0 0 0			0	0	0	0		
16. 00 OTHER GENERAL SERVICES O O O O O O O O O O O O O O O O O O			0	96, 128	96, 128	0		
PATIENT/RESIDENTIAL CARE SERVICES			0	0	0	0		
DIRECT PATIENT CARE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
25. 00 INPATIENT CARE-CONTRACTED**	17. 00							17. 00
26. 00 PHYSICIAN SERVICES**			1		_	_1		
27.00 NURSE PRACTITIONER*				0	_	0		
28.00 REGISTERED NURSE** 831, 229 0 831, 229 567, 146 1, 398, 375 28.00			0	79, 775		0		
29.00 PHYLVN**		4	0	0	l ~	0		
30.00 DHYSICAL THERAPY**		4		0				
33.00 OCCUPATI ONAL THERAPY** 0 0 0 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 32.00 33.00 MEDI CAL SCI AL SERVI CES** 0 0 0 0 0 0 32.00 34.00 SPIRI TUAL COUNSELI NG** 0 0 0 0 0 0 34.00 35.00 DIETARY COUNSELI NG** 0 0 0 0 0 0 35.00 36.00 COUNSELI NG - * 0 0 0 0 0 0 0 35.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 139,041 0 139,041 80,822 219,863 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 38.00 41.00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 41.00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 43.00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 44.00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45.00 OTHER PATIENT CARE SERVICES (SPECI FY)** 0 714,663 714,663 0 714,663 60.00 THER PATIENT CARE SERVICES (SPECI FY)** 0 0 0 0 0 0 61.00 OULNITEER PROGRAM * 0 0 0 0 0 0 62.00 HOSPI CEPALLI ATI VE CARE PROGRAM * 0 0 0 0 0 0 64.00 PALLI ATI VE CARE PROGRAM * 0 0 0 0 0 0 65.00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 66.00 RESEAVEMENT PROGRAM * 0 0 0 0 0 0 66.00 OTHER PHYSI CI AN SERVI CES * 0 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURSI ING FACI LI TY ROOM & BOARD* 0 0 0 0 0 67.00 ONURS		4	1	0	90, 605	15, 044	· ·	
32.00 SPECH/LANGUAGE PATHOLOGY** 0 0 0 0 0 0 0 0 32.00		4	0	0	0	0		
33.00 MEDI CAL SOCI AL SERVI CES** 0 0 0 0 0 0 0 33.00 34.00 SPRI TITUAL COUNSELING** 0 0 0 0 0 0 0 34.00 35.00 DI ETARY COUNSELING** 0 0 0 0 0 0 0 35.00 36.00 COUNSELING - OTHER** 0 0 0 0 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 139,041 0 139,041 80,822 219,863 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 0 0 39.00 1 MAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	0		
34. 00 SPIRITUAL COUNSELING** 0 0 0 0 0 0 34. 00 35. 00 DIETARY COUNSELING** 0 0 0 0 0 0 0 35. 00 35. 00 OCUNSELING - OTHER** 0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPICE ALDE & HOMEMAKER SERVICES** 139, 041 0 139, 041 80, 822 219, 863 37. 00 39. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 39. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	0	-	
35. 00 DI ETARY COUNSELING** 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER** 0 0 0 0 0 0 0 0 36. 00 37. 00 HOSPICE AI DE & HOMEMAKER SERVICES** 139, 041 0 139, 041 80, 822 219, 863 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 0 0 39. 00 40. 00 I IMAGI NG SERVICES** 0 0 0 0 0 0 0 0 0 0 41. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 190, 666 190, 666 46, 845 237, 511 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 44. 00 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 714, 663 714, 663 0 714, 663 46. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 714, 663 714, 663 714, 663 714, 663 714, 663 714, 663 70 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	0		
36. 00 COUNSELING - OTHER** 0 0 0 0 0 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 139, 041 0 139, 041 80, 822 219, 863 37. 00 39. 00 PATI ENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 139,041 0 139,041 80,822 219,863 37.00 38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 39.00 40.00 1MAGI NG SERVICES** 0 0 0 0 0 0 0 40.00 40.00 41.00 LABS & DI AGNOSTICS** 0 0 0 0 0 0 0 41.00 42.50 42.50 MBOI CAL SUPPLI ES-NON-ROUTI NE** 0 190,666 190,666 46,845 237,511 42.00 42.50 MBOI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 42.50 43.00 OUTPATI ENT SERVICES** 0 0 0 0 0 0 43.00 44.00 44.00 ALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 45.00 45.00 MONEEI MBURSABLE COST CENTERS 0 714,663 714,663 0 714,663 0 714,663 0 0 0 0 0 0 0 0 0			0	0	0	0	-	
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 39. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 190, 666 190, 666 46, 845 237, 511 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 190, 666 190, 666 46, 845 237, 511 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 43. 00 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 44. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 45. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 714, 663 714, 663 0 714, 663 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 714, 663 714, 663 0 714, 663 46. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 45. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 47. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 47. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 47. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 47. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 48. 00 OUTPATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 OUTPATI ENT CARE SERVI CES* 0 0 0 0 0 49. 00 0 0 0 0 0 49. 00 0 0 0 0 0 49. 00 0 0 0 0 0 49. 00 0 0 0 0 0 49. 00 0 0 0 0 0 49. 00 0 0 0 0 49. 00 0 0 0 0 4			0	0	0	0	-	
39.00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			139, 041	0	139, 041	80, 822		
40. 00 IMAGI NG SERVI CES**			0	0	0	0		
41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 190, 666 190, 666 46, 845 237, 511 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 714, 663 714, 663 0 714, 663 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 0 64. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE* 0 0 0 0 0 0 0 0 0 69. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*			0	0	0	0		
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 190, 666 190, 666 46, 845 237, 511 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 0 0 0 42. 50 43. 00 0UTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 0 45. 00 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 0 42. 50 43. 00 OUTPATIENT SERVI CES** 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 45. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) ** 0 714, 663 714, 663 0 714, 663 0 714, 663 **NONREI MBURSABLE COST CENTERS** 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 63. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 64. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 68. 00 69. 00 THEIR TSTORE* 0 0 0 0 0 0 0 69. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*			0	0	0	0		
43. 00			0	190, 666	190, 666	46, 845		
44. 00 PALLIATI VE RADIATI ON THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLIATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) ** 0 714, 663 714, 663 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 714, 663 714, 663 0 714, 663			0	0	0	0		
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 714, 663 714, 663 0 714, 663 0 60. 00 NONREIMBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 60. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 65. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
NONREIMBURSABLE COST CENTERS O O O O O O O O O O O O O O O O O O			1	0	0	0		
60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 60. 00 61. 00 61. 00 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 0 0 0 0 0 0 0 63. 00 64. 00 64. 00 PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46. 00		0	714, 663	714, 663	0	/14, 663	46.00
61. 00					_	_1		
62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 68. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*		4	0	0	0	0		
63.00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63.00 64.00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64.00 65.00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 65.00 66.00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66.00 67.00 ADVERTI SI NG* 0 0 0 0 0 0 66.00 68.00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 68.00 69.00 THRI FT STORE* 0 0 0 0 0 0 0 69.00 70.00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 71.00 OTHER NONREI MBURSABLE (SPECI FY)*			0	0	0	0		
64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTISING* 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING* 0 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE* 0 0 0 0 0 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 0 0 0 71. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY)*			0	0	0	0	_	
65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 0 0 65. 00 66. 00 67. 00 RESIDENTIAL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 68. 00 0 0 0 0 67. 00 68. 00 0 0 0 0 0 67. 00 68. 00 0 0 0 0 0 68. 00 69. 00 THER PHYSICIAN SERVICES* 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 0 71. 00		4	0	0	0	0		
67. 00 ADVERTI SI NG* 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 71. 00		4	0	0	0	0		
68. 00 TELEHEALTH/TELEMONI TORI NG*			0	0	0	0	-	
69. 00			0	0	0	0		
70.00 NURSING FACILITY ROOM & BOARD* 0 0 0 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 0 71.00		1	0	0	0	0		
71.00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 0 71.00			0	0	0	0		
		1	0	0	0	0		
100. 00 101AL 1, 410, 225 1, 352, 655 2, 762, 880 783, 990 3, 546, 870 100. 00		, , ,	1 440 005	1 252 755	0 7/0 000	700 000		
* T C II I 7 I. WILL OF I 4 II	100.00	IUIAL	1,410,225	1, 352, 655	2, 762, 880	/83, 990	3, 546, 870	100.00

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. ** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 15-0048 Hospi ce CCN: 15-1524 Peri od: From 01/01/2022 To 12/31/2022

Date/Time Prepared: 5/23/2023 11:46 am

					Hospi ce I	3/23/2023 11.	. 40 dili
		ADJUSTMENTS	TOTAL (col. 5				
			± col. 6)				
		6. 00	7. 00				
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0	•			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	16, 095				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	146, 901				3.00
4. 00	ADMINISTRATIVE & GENERAL*	-40, 593	386, 769				4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0				5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0				6.00
7.00	HOUSEKEEPI NG*	0	0				7.00
8.00	DI ETARY*	0	1, 377				8.00
9.00	NURSING ADMINISTRATION*	0	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0				10.00
11. 00	MEDI CAL RECORDS*	0	0				11.00
12.00	STAFF TRANSPORTATION*	0	103, 171				12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0				13.00
14.00	PHARMACY*	0	96, 128				14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0				15.00
16.00	OTHER GENERAL SERVICE*	0	0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17. 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	79, 775				26.00
27.00	NURSE PRACTITIONER**	0	0				27.00
28.00	REGI STERED NURSE**	0	1, 398, 375				28. 00
29.00	LPN/LVN**	0	105, 649				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 AIDE & HOMEMAKER SERVICES**	0	219, 863				37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38. 00
39.00	PATI ENT TRANSPORTATI ON**	0	0				39. 00
40.00	I MAGING SERVICES**	0	0				40.00
41.00	LABS & DI AGNOSTI CS**	0	0				41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	237, 511				42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0				42. 50
43.00	OUTPATIENT SERVICES**	0	0				43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0				44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0				45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	714, 663				46. 00
	NONREI MBURSABLE COST CENTERS						
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		0	0				69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0				70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71.00
100.00	TOTAL	-40, 593	3, 506, 277				100.00
* Tron	nsfer the amounts in column 7 to Wkst. 0-5. co	Jump 1 lino o	c appropriate				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E ROUTINE HOME	Provi der Co		eriod: rom 01/01/2022	Worksheet 0-2		
CARE		Hospi ce CCI		o 12/31/2022	Date/Time Pre 5/23/2023 11:	pared: 46 am	
				Hospi ce I			
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL		
			(col. 1 +	CATI ONS			
			col. 2)				
	1. 00	2. 00	3.00	4. 00	5. 00		
DIRECT PATIENT CARE SERVICE COST CENTERS							
25. 00 I NPATI ENT CARE-CONTRACTED						25.00	
26.00 PHYSICIAN SERVICES	0	79, 775	79, 775	0	79, 775	26.00	
27. 00 NURSE PRACTITIONER	0	0	C	0	0	27. 00	
28. 00 REGI STERED NURSE	831, 229	0	831, 229	0	831, 229	28. 00	
29. 00 LPN/LVN	90, 605	0	90, 605	0	90, 605	29. 00	
30. 00 PHYSI CAL THERAPY	0	0	C	0	0	30.00	
31. 00 OCCUPATI ONAL THERAPY	0	0	C	0	0	31.00	
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	C	0	0	32.00	
33.00 MEDICAL SOCIAL SERVICES	0	0	C	0	0	33.00	
34. 00 SPIRITUAL COUNSELING	0	0	C	0	0	34.00	
35. 00 DI ETARY COUNSELI NG	0	0	C	0	0	35.00	
36. 00 COUNSELING - OTHER	0	0	C	0	0	36.00	
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	139, 041	0	139, 041	0	139, 041	37.00	
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	C	0	0	38.00	
39.00 PATIENT TRANSPORTATION	0	0	C	0	0	39.00	
40.00 I MAGING SERVICES	0	0	C	0	0	40.00	
41.00 LABS & DIAGNOSTICS	0	0	C	0	0	41.00	
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	190, 666	190, 666	0	190, 666	42.00	
42.50 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	42.50	
43. 00 OUTPATIENT SERVICES	0	0	C	0	0	43.00	
44.00 PALLIATIVE RADIATION THERAPY	0	0	C	0	0	44.00	
45.00 PALLIATIVE CHEMOTHERAPY	o	0	c	0	0	45.00	
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	o	714, 663	714, 663	0	714, 663	46.00	
100. 00 TOTAL *	1, 060, 875	985, 104	2, 045, 979	0	2, 045, 979	100.00	
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.							

		ADJUSTMENTS	TOTAL (col. 5	
		715000111151110	± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25. 00
26.00	PHYSICIAN SERVICES	0	79, 775	26.00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	831, 229	28. 00
29.00	LPN/LVN	0	90, 605	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 AIDE & HOMEMAKER SERVICES	0	139, 041	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	190, 666	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	714, 663	46. 00
100.00	TOTAL *	0	2, 045, 979	100.00

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

nour tir i i nanor ur o yo tomo			301 1 171E & 11E/1E11							
ANALYSIS OF HOSPITAL-BASED HOSPI	CE COSTS FOR	HOSPI CE	I NPATI ENT	Provi der	CCN:	15-0048	Perio	od:	Worksheet 0-3	3
RESPITE CARE								01/01/2022		
				Hospi ce	CCN:	15-1524	To	12/31/2022	Date/Time Pro	
									5/23/2023 11:	:46 am
							Н	neni ca I		

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PATIENT CARE SERVICE COST CENTERS						
	ENT CARE-CONTRACTED		0	0	0	0	
	CLAN SERVICES	0	0	0	0	0	26. 00
	PRACTI TI ONER	0	0	0	0	0	27. 00
	TERED NURSE	0	0	0	56, 658	56, 658	
29.00 LPN/LV		0	0	0	1, 503	1, 503	
	CAL THERAPY	0	0	0	0	0	30.00
	ATI ONAL THERAPY	0	0	0	0	0	31.00
	H/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
	AL SOCIAL SERVICES	0	0	0	0	0	33.00
	FUAL COUNSELING	0	0	0	0	0	34.00
	RY COUNSELING	0	0	0	0	0	35.00
36. 00 COUNSE	ELING - OTHER	0	0	0	0	0	36.00
37. 00 HOSPI 0	CE ALDE & HOMEMAKER SERVICES	0	0	0	8, 074	8, 074	37.00
38. 00 DURABL	LE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00 PATI EN	NT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 I MAGI N	NG SERVICES	0	0	0	0	0	40.00
41.00 LABS 8	k DIAGNOSTICS	0	0	0	0	0	41.00
42. 00 MEDI CA	AL SUPPLIES-NON-ROUTINE	0	0	0	4, 680	4, 680	42.00
42. 50 DRUGS	CHARGED TO PATIENTS	0	0	0	0	0	42.50
43. 00 OUTPAT	TIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLI A	ATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45. 00 PALLI A	ATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46. 00 OTHER	PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100. 00 TOTAL	*	0	0	0	70, 915	70, 915	100.00

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
	6. 00	7. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00 I NPATI ENT CARE-CONTRACTED	C	0	25. 0
26. 00 PHYSI CI AN SERVI CES	C	0	26.0
27. 00 NURSE PRACTITIONER	C	0	27.0
28. 00 REGISTERED NURSE	C	56, 658	28.0
29. 00 LPN/LVN	C	1, 503	29.0
30. 00 PHYSI CAL THERAPY	C	0	30.0
31. 00 OCCUPATI ONAL THERAPY	C	0	31.0
32. 00 SPEECH/LANGUAGE PATHOLOGY	C	o	32.0
33. 00 MEDICAL SOCIAL SERVICES	C	o	33.0
34. 00 SPIRITUAL COUNSELING		o	34.0
35. 00 DI ETARY COUNSELING	C	o	35.0
36. 00 COUNSELING - OTHER	C	o	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	8, 074	37.0
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	o	38.0
39. 00 PATIENT TRANSPORTATION	C	o	39.0
40. 00 I MAGI NG SERVI CES	C	o	40.0
41. 00 LABS & DIAGNOSTICS	C	o	41.0
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	C	4, 680	42.0
42. 50 DRUGS CHARGED TO PATIENTS	C	o	42.5
43. 00 OUTPATIENT SERVICES	C	o	43.0
44.00 PALLIATIVE RADIATION THERAPY	C	o	44.0
45. 00 PALLIATIVE CHEMOTHERAPY	C	o	45.0
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	o	46.0
100. 00 TOTAL *	C	70, 915	100.0

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Provi der CCN: 15-0048 Peri od: Worksheet 0-4 From 01/01/2022 To 12/31/2022 INPATIENT CARE Date/Time Prepared: 5/23/2023 11:46 am Hospi ce CCN: 15-1524

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED		C	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0	C	0	0	0	26.00
27. 00 NURSE PRACTITIONER	0	C	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	C	0	510, 488	510, 488	28. 00
29. 00 LPN/LVN	0	C	0	13, 541	13, 541	29. 00
30. 00 PHYSI CAL THERAPY	0	C	0	0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	C	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	C	0	0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	0	C	0	0	0	33.00
34. 00 SPIRITUAL COUNSELING	0	C	0	0	0	34.00
35. 00 DI ETARY COUNSELING	0	C	0	0	0	35.00
36. 00 COUNSELING - OTHER	0	C	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	C	0	72, 748	72, 748	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C	0	o	0	38.00
39. 00 PATIENT TRANSPORTATION	0	C	0	o	0	39.00
40.00 I MAGING SERVICES	0	C	0	o	0	40.00
41. 00 LABS & DIAGNOSTICS	0	C	0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	C	0	42, 165	42, 165	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	C	0	o	0	42.50
43. 00 OUTPATIENT SERVICES	0	C	0	o	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	C	0	o	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	0	C	0	o	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	C	0	o	0	46.00
100. 00 TOTAL *	0		0	638, 942	638, 942	100.00

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 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 REGISTERED NURSE	0	510, 488	28.00
29. 00 LPN/LVN	0	13, 541	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 SPIRITUAL COUNSELING	0	0	34.00
35. 00 DI ETARY COUNSELING	0	0	35.00
36. 00 COUNSELING - OTHER	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	72, 748	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39. 00 PATIENT TRANSPORTATION	0	0	39.00
40.00 I MAGING SERVICES	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	42, 165	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	42. 50
43. 00 OUTPATIENT SERVICES	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100. 00 TOTAL *	0	638, 942	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Health Financial Systems	REID HOSPITAL & HEALTI	H CARE SERVICES	In Lie	u of Form CMS-2552-10
COST ALLOCATION - DETERMINATION	ON OF HOSPITAL-BASED HOSPICE NET	Provider CCN: 15-0048		Worksheet 0-5
EVDENSES FOR ALLOCATION			From 01/01/2022	

	EXPENSES FOR ALLOCATION		JN. 13-0040	From 01/01/2022	WOLKSHEET 0-3	
EXPENS	ES FOR ALLOCATION	Hospi ce CCN: 15-152		To 12/31/2022	Date/Time Prepared:	
					5/23/2023 11:	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
			1. 00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 12, 152	12, 152	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		16, 09	5 0	16, 095	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		146, 90	1 411, 534	558, 435	3.00
4.00	ADMINISTRATIVE & GENERAL		386, 76	9 1, 075, 430	1, 462, 199	4.00
5.00	PLANT OPERATION & MAINTENANCE			0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE			o o	0	6.00
7.00	HOUSEKEEPI NG			0 79, 778	79, 778	7. 00
8.00	DI ETARY		1, 37	7 0	1, 377	8. 00
9. 00	NURSI NG ADMI NI STRATI ON			o o	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 71	71	10.00
11. 00	MEDI CAL RECORDS			0 849	849	11.00
12. 00	STAFF TRANSPORTATION		103, 17		103, 171	12.00
13. 00	VOLUNTEER SERVICE COORDINATION			ol	0	13.00
14.00	PHARMACY		96, 12	8 132, 778	228, 906	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			ol , , ,	0	15.00
16. 00	OTHER GENERAL SERVICE			o o	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			74, 985	74, 985	17. 00
	LEVEL OF CARE			<u> </u>		
50.00	HOSPICE CONTINUOUS HOME CARE			ol	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		2, 045, 97	9	2, 045, 979	51.00
52.00	HOSPI CE I NPATI ENT RESPITE CARE		70, 91		70, 915	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		638, 94	2	638, 942	53.00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM			ol	0	60.00
61.00	VOLUNTEER PROGRAM			o	0	61.00
62.00	FUNDRAI SI NG			o	0	62.00
63.00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			ol	0	63.00
64. 00	PALLIATIVE CARE PROGRAM			0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES			Ö	0	65.00
66. 00	RESI DENTI AL CARE			o l	0	66.00
67. 00	ADVERTISING			o l	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
	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99. 00	NEGATIVE COST CENTER			Ō	n	99.00
100.00			3, 506, 27	7 1, 787, 577	5, 293, 854	
	I *		2,000,27	1, 10.7077	2,2,0,001	

Heal th FinancialSystemsREID HOSPITAL & HCOST ALLOCATION - HOSPITAL-BASED HOSPICEGENERAL SERVICE COSTS Provider CCN: 15-0048 Hospi ce CCN: 15-1524

						3/23/2023 11.	40 alli
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
					DEPARTMENT		
	T	0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS		T				
1. 00	CAP REL COSTS-BLDG & FIXT	12, 152	12, 152				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16, 095		16, 095			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	558, 435	l	'I "	558, 435		3. 00
4.00	ADMINISTRATIVE & GENERAL	1, 462, 199	12, 152	2 0	97, 086	1, 571, 437	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	C	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	79, 778	C	0	0	79, 778	7. 00
8.00	DI ETARY	1, 377	C	0	0	1, 377	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	C	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	71	C	0	0	71	10.00
11. 00	MEDI CAL RECORDS	849	C	0	0	849	11.00
12.00	STAFF TRANSPORTATION	103, 171	C	0	0	103, 171	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C	0	0	0	13.00
14.00	PHARMACY	228, 906	C	0	0	228, 906	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	C	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		C	0		74, 985	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	l		0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2, 045, 979			276, 402	2, 322, 381	
52.00	HOSPICE INPATIENT RESPITE CARE	70, 915			18, 476	90, 946	
53.00	HOSPICE GENERAL INPATIENT CARE	638, 942	C	14, 540	166, 471	819, 953	53.00
	NONREI MBURSABLE COST CENTERS						
60. 00	BEREAVEMENT PROGRAM	0	C	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	C	0	0	0	61.00
62. 00	FUNDRAI SI NG	0	C	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	C	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	C	0	0	0	65.00
66. 00	RESI DENTI AL CARE	0	C	0	0	0	66. 00
67.00	ADVERTI SI NG	0	C	0	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	C	0	0	0	68. 00
69. 00	THRI FT STORE	0	C	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	[C	0	0	0	71.00
99. 00	NEGATIVE COST CENTER	0	C	0	0		99.00
100.00	TOTAL	5, 293, 854	12, 152	16, 095	558, 435	5, 293, 854	100. 00

70.00

71.00

99.00

0

0

1, 958 100.00

0

113, 457

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2022 Part I Hospi ce CCN: 15-1524 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Hospi ce I ADMI NI STRATI V LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions PLANT E & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 1, 571, 437 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 33, 679 113, 457 7.00 8.00 DI ETARY 581 1, 958 8.00 NURSING ADMINISTRATION 9.00 0 9.00 0 0 ROUTINE MEDICAL SUPPLIES 0 0 10.00 30 10.00 11.00 MEDICAL RECORDS 358 0 11.00 0 12.00 STAFF TRANSPORTATION 43, 554 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 13.00 Ω 0 14.00 PHARMACY 96, 634 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 0 OTHER GENERAL SERVICE 0 16.00 16,00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 31, 655 C 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 980, 406 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 38, 393 C 0 10, 963 187 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 346, 147 0 0 102, 494 1, 771 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 60.00 VOLUNTEER PROGRAM 0 61.00 0 0 61.00 FUNDRAI SI NG 0 62.00 0000000 0 0 0 62.00 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 0 66.00 67 00 ADVERTI SI NG 0 67 00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD

0

1, 571, 437

0

0

0

70.00

71 00

100.00 TOTAL

OTHER NONREIMBURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER

0

0

146, 725

0 99.00

0 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2022 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2022 5/23/2023 11:46 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 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 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 000000 ROUTINE MEDICAL SUPPLIES 101 10.00 10.00 11.00 MEDICAL RECORDS 1, 207 11.00 12.00 STAFF TRANSPORTATION 146, 725 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 0 0 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 OTHER GENERAL SERVICE 0 16,00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 146, 725 0 50.00 0 HOSPICE ROUTINE HOME CARE 1, 106 92 51.00 51.00 0 0 52.00 HOSPICE INPATIENT RESPITE CARE 10 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 91 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 0 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 FUNDRAI SI NG 62.00 62.00 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG 0 67 00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 Ω 71.00

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1, 207

99. 00 NEGATI VE COST CENTER

100.00 TOTAL

0 71.00

0 99.00

5, 293, 854 100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2022 Part I Hospi ce CCN: 15-1524 12/31/2022 Date/Time Prepared: 5/23/2023 11:46 am Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES CARE SERVICES 14.00 15.00 16.00 17.00 18.00 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 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 325, 540 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 15.00 OTHER GENERAL SERVICE 16,00 0 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 106, 640 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 146, 725 50.00 0 HOSPICE ROUTINE HOME CARE 298. 407 3, 602, 392 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 2, 596 0 10, 203 153, 299 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 24, 537 0 96, 437 1, 391, 438 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 FUNDRAI SI NG 0 62.00 62.00 0000000 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 0 0 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00

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325, 540

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106, 640

71.00 OTHER NONREIMBURSABLE (SPECIFY)

99. 00 NEGATI VE COST CENTER

100.00 TOTAL

Health Financial Systems REID HOSPITAL & H
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

			Hospi ce cc	N: 15-1524 1	0 12/31/2022	5/23/2023 11:	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
	'	& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		,	VALUE)	(GROSS		COSTS)	
				SALARI ES)		ĺ	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	445					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445	5			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	C	2, 143, 364	Į.		3.00
4.00	ADMINISTRATIVE & GENERAL	445	C	372, 632	-1, 571, 437	3, 722, 417	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	ol c		0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	o c) c	0	0	6.00
7.00	HOUSEKEEPI NG	0	ol c		0	79, 778	7.00
8. 00	DI ETARY	0	ol c		0	1, 377	8.00
9. 00	NURSI NG ADMI NI STRATI ON	0			0	0	1
10.00	ROUTINE MEDICAL SUPPLIES	0			0	71	10.00
11. 00	MEDICAL RECORDS	0			0	849	
12. 00	STAFF TRANSPORTATION	0			0	103, 171	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0			o o	0	13.00
14. 00	PHARMACY					228, 906	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				o o	0	15.00
16. 00	OTHER GENERAL SERVICE		1		o o	Ö	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES) n		
17.00	LEVEL OF CARE			′1		14,703	17.00
50.00	HOSPICE CONTINUOUS HOME CARE				0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE			1, 060, 875	-	-	
52. 00	HOSPICE INPATIENT RESPITE CARE	0	43	1 ' '			
53. 00	HOSPICE GENERAL INPATIENT CARE						
33.00	NONREI MBURSABLE COST CENTERS		1 102	.] 030, 742	-	017, 755	33.00
60. 00	BEREAVEMENT PROGRAM	0	C		0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	ł .	1	-	1	61.00
62. 00	FUNDRAI SI NG	0			o o	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				o o	Ö	63.00
64. 00	PALLIATIVE CARE PROGRAM				o o	Ö	64.00
65. 00	OTHER PHYSICIAN SERVICES				o o	Ö	65.00
66. 00	RESI DENTI AL CARE					Ö	66.00
67. 00	ADVERTI SI NG					Ö	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
69. 00	THRIFT STORE					0	69.00
70. 00	NURSING FACILITY ROOM & BOARD			Ί	,	l o	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0				0	
99.00	NEGATIVE COST CENTER		1	Ί	ή		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	12, 152	16, 095	558, 435		1, 571, 437	
	UNIT COST MULTIPLIER	27. 307865	•			0. 422155	
101.00	UNIT COST MULTIPLIER	27.307803	JU. 108539	7 U. 20054 I	1	0.422133	1101.00

Health Financial Systems REID HOSPITAL & H
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

			Hospi ce cc	N: 15-1524 1	0 12/31/2022	5/23/2023 11:	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS.)	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	_					
1.00	CAP REL COSTS-BLDG & FLXT						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	445					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0)			6.00
7.00	HOUSEKEEPI NG	0		445			7.00
8.00	DI ETARY	0		0	1, 735		8. 00
9.00	NURSING ADMINISTRATION	0		0		0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE		<u> </u>				
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	43	l o	43	166	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	402		•			53.00
	NONREI MBURSABLE COST CENTERS				,		
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	l o	0	0	0	66.00
67.00	ADVERTI SI NG	0		0		O	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68.00
69. 00	THRI FT STORE	0		1 0		Ö	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	1	0	0	o	71.00
99. 00	NEGATI VE COST CENTER]				99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)) 0	0	113, 457	1, 958	0	100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000		·		
	1	1 2:220000	1 2. 22.000		3000		

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

COST CENTER HOSPITAL -BASED HOSPICE GENERAL SERVICE COSTS Hospice CON: 15-0048 Hosp	Heal t	h Financial Systems REID	HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
Hospice CCN: 15-1524 To 12/31/2022 Date/Time Prepared: 57:32/2023 11: 46 am	COST	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der C	CN: 15-0048	Peri od:		
COST Center Descriptions	STAT	STI CAL BASIS						
Cost Center Descriptions				Hospi ce CC	N: 15-1524	To 12/31/2022	Date/Time Pre	pared:
Cost Center Descriptions							5/23/2023 11:	<u>46 am</u>
MEDICAL SUPPLIES CAPTED SU						Hospi ce I		
SUPPLIES		Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
CATTLENT DAYS CMI LEAGE CHOURS OF SERVICE			MEDI CAL	RECORDS	TRANSPORTATI (SERVI CE	(CHARGES)	
CATTLENT DAYS CMI LEAGE CHOURS OF SERVICE			SUPPLI ES	(PATI ENT	l N	COORDI NATI ON		
DAYS SERVICE S				•	(MLLEAGE)			
CONTROL SERVICE COST CENTERS			· ·		(==)	,		
GENERAL SERVICE COST CENTERS				11 00	12 00		14 00	
1. 00		GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
2.00	1 00							1 00
3. 00 A.00								
4. 00								1
5.00								•
6. 00								1
7. 00 HOUSEKEEPING	5. 00	PLANT OPERATION & MAINTENANCE						5.00
8. 00 DI ETARY	6.00	LAUNDRY & LINEN SERVICE						6. 00
9. 00 NURSI NG ADMI NI STRATI ON	7.00	HOUSEKEEPI NG						7. 00
10. 00 ROUTINE MEDICAL SUPPLIES 20,816 20,816 10. 00 11. 00 12. 00 1	8.00	DI ETARY						8.00
10. 00 ROUTINE MEDICAL SUPPLIES 20,816 20,816 10. 00 11. 00 12. 00 1	9.00	NURSING ADMINISTRATION						9.00
11. 00 MEDI CAL RECORDS 20, 816 1, 000 12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 0 13. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 0 0 0 0 0 13. 00 14. 00 PHARNACY 0 0 0 0 0 0 16. 00 16. 00 16. 00 0 0 0 0 0 0 16. 00 16. 00 0 0 0 0 0 0 0 0 0			20 816					1
12. 00 13. 00 VOLUNTEER SERVI CE COORDI NATI ON 10. 0 0 13. 00 13. 00 14. 00 14. 00 14. 00 15. 00			20,010	20 816				
13. 00 VOLUNTEER SERVICE COORDINATION 0 0 0 20,816 14.00 14. 00 PHARMACY 0 0 0 0 20,816 14.00 15. 00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 0 15.00 16. 00 OTHER GENERAL SERVICE 0 0 0 0 16.00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 16.00 18. 00 DATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 16.00 19. 00 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				20, 610	1			
14. 00 PHARMACY 15. 00 PHYSICI AN ADMINISTRATIVE SERVICES 16. 00 OTHER GENERAL SERVICE 17. 00 PATIENT/RESI DENTIAL CARE SERVICES 17. 00 PHOSPICE CONTINUOUS HOME CARE 50. 00 HOSPICE CONTINUOUS HOME CARE 50. 00 HOSPICE CONTINUOUS HOME CARE 51. 00 HOSPICE GENERAL INPATIENT CARE 19, 081 19, 081 0 0 1, 000 0 19, 081 51. 00 52. 00 HOSPICE GENERAL INPATIENT CARE 166 166 0 0 166 52. 00 53. 00 HOSPICE GENERAL INPATIENT CARE 1, 569 1, 569 0 0 1, 569 53. 00 NONREI MBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAL SI NG 63. 00 HOSPICE PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 65. 00 OTHER PHYSICIAN SERVICES 66. 00 THER PHYSICIAN SERVICES 66. 00 THER PHYSICIAN SERVICES 66. 00 THEE PHYSICIAN SERVICES 66. 00 THEE PHYSICIAN SERVICES 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORING 69. 00 THEIR FORMSING O O O O 67. 00 68. 00 THEIR FORMSING O O O O 67. 00 69. 00 THEIR FORMSING O O O O O O O O O O O O O O O O O O O								•
15. 00 PHYSI CI AN ADMINI STRATI VE SERVI CES 0 0 0 0 15. 00 16. 00 11. 00 1					1			•
16. 00 OTHER GENERAL SERVICE					1	-	· ·	1
17. 00 PATIENT/RESIDENTIAL CARE SERVICES	15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	15. 00
LEVEL OF CARE	16.00	OTHER GENERAL SERVICE				0	0	16. 00
Dotation Hospice Continuous Home Care Dotation	17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
19,081 19,081 19,081 0 0 19,081 51.00 19,081 52.00 166 52.00 1		LEVEL OF CARE						
166 166	50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1, 00	0 0	0	50.00
166 166	51.00	HOSPICE ROUTINE HOME CARE	19, 081	19, 081		0	19, 081	51.00
HOSPICE GENERAL INPATIENT CARE 1,569 1,569 0 0 1,569 53.00 NONREI MBURSABLE COST CENTERS					•	0		52 00
NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l					1
60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THIS F STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 0 0 0 0 66. 00 0 0 0 66. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00. 0		1,007	1,007	1	<u> </u>	1,007	00.00
61. 00	60 0					0	0	60 00
62. 00 FUNDRAI SING 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 69. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 0 0 0 62. 00 0 0 62. 00 0 0 64. 00 0 0 0 64. 00 0 0 0 65. 00 0 0 0 0 66. 00 0 0 0 66. 00 0 0 0 0 66. 00 0 0 0 0 67. 00 0 0 0 0 0 68. 00 0 0 0 0 0 0 69. 00 0					•			•
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 64. 00 PALLIATIVE CARE PROGRAM 65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THRIFT STORE 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 0 0 0 63. 00 0 0 64. 00 0 0 0 65. 00 0 0 0 66. 00 0 0 0 67. 00 0 0 0 0 68. 00 0 0 0 0 0 68. 00 0								
64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THRI FT STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 0 0 0 64. 00 0 0 0 65. 00 0 0 0 0 66. 00 0 0 0 0 67. 00 0 0 0 0 0 68. 00 0 0 0 0 0 0 0 0 71. 00 0 71. 00 0 72. 00 0					•			1
65. 00 OTHER PHYSICIAN SERVICES 66. 00 RESIDENTIAL CARE 67. 00 ADVERTISING 68. 00 TELEHEALTH/TELEMONITORING 69. 00 THIFF T STORE 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 0 0 65. 00 0 0 66. 00 0 0 67. 00 0 0 0 68. 00 0 0 0 0 68. 00 0 0 0 0 0 69. 00 0 0 71. 00 0 71. 00 0 72. 00 0 0 0 71. 00 0								
66. 00 RESI DENTI AL CARE 0 0 0 0 66. 00 67. 00 68. 00 0 0 67. 00 68. 00 0 0 67. 00 68. 00 0 0 67. 00 68. 00 0 0 67. 00 68. 00 0 0 0 68. 00 0 0 0 68. 00 0 0 0 69. 00 0 0 69. 00 0 0 69. 00 0 0 69. 00 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1	-		1
67. 00 ADVERTISING 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 0 0 0 0 71. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71. 00 79. 00 NEGATIVE COST CENTER 0 0 325, 540 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 325, 540 100. 00 OTHER NONEIMBURSABLE (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00				1	٠		
68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 68. 00 69. 00 70. 00 THRI FT STORE 0 0 0 0 69. 00 70. 00 71. 00 NURSI NG FACI LI TY ROOM & BOARD 70. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 325, 540 100. 00	66.00	RESIDENTIAL CARE				0	0	66.00
69. 00 THRIFT STORE 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 99. 00 NEGATIVE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1, 207 146, 725 0 325, 540 100. 00	67.00	ADVERTI SI NG				0	0	67.00
70. 00	68.00	TELEHEALTH/TELEMONI TORI NG				0	0	68.00
70. 00	69. N	THRI FT STORE				0 0	0	69.00
71.00 OTHER NONREIMBURSABLE (SPECIFY) 99.00 NEGATIVE COST CENTER 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1,207 146,725 0 325,540 100.00								•
99.00 REGATIVE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1,207 146,725 0 325,540 100.00							0	ł
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 101 1,207 146,725 0 325,540 100.00		` ′				<u> </u>	0	
			101	1 207	146 70	5	225 540	•
101. 00 0111 COST MOETIFEIER 0. 004852 0. 057964 140. 725000 0. 000000 15. 638932 101. 00			l l					
	101.0	OU UNIT COST MULTIPLIER	0. 004852	0. 05/984	140. /2500	u. 000000	15. 038932	1101.00

Health Financial Systems REID HOSPITAL & H Provi der CCN: 15-0048 | Peri od: From 01/01/2022 | Part II |
Hospi ce CCN: 15-1524 | To 12/31/2022 | Date/Ti me Prepared: 5/23/2023 11: 46 am STATISTICAL BASIS

			·			5/23/2023 11:46 am
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
		E SERVICES	(SPECI FY	CARE SERVICE	S	
		(PATI ENT	BASIS)	(IN-FACILITY	/	
		DAYS)	,	DAYS)		
		15. 00	16. 00	17. 00		
	GENERAL SERVICE COST CENTERS					
1. 00	CAP REL COSTS-BLDG & FIXT		I	I		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP					2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4. 00	1		•			
	ADMI NI STRATI VE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7. 00	HOUSEKEEPI NG					7. 00
8.00	DI ETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDI CAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14. 00	PHARMACY					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	20, 816				15.00
16. 00	OTHER GENERAL SERVICE	20,010				16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		_	1, 73	o E	17.00
17.00	LEVEL OF CARE			1,73	າວ	17.00
FO 00				ı		50.00
50.00	HOSPICE CONTINUOUS HOME CARE	_	_	l .		50.00
51. 00	HOSPICE ROUTINE HOME CARE	19, 081	C	1		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	166				52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 569	C	1, 56	9	53.00
	NONREI MBURSABLE COST CENTERS				-	
60.00	BEREAVEMENT PROGRAM		[C			60.00
61.00	VOLUNTEER PROGRAM		C			61.00
62.00	FUNDRAI SI NG		C)		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			1		63.00
64.00	PALLIATIVE CARE PROGRAM					64.00
65.00	OTHER PHYSICIAN SERVICES					65.00
66. 00	RESI DENTI AL CARE		l c		0	66.00
67.00	ADVERTI SI NG				٥	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					68.00
	l control of the cont					· · · · · · · · · · · · · · · · · · ·
69.00	THRIFT STORE			Ί		69.00
70.00	NURSING FACILITY ROOM & BOARD	_	_			70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0	C	1	0	71.00
	NEGATI VE COST CENTER					99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1	(C	106, 64		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	61. 46397	77	101.00
		•	•	•	*	•

LEVEL OF CARE

LLVLL	OF CARE		Hospi ce CCI	N: 15-1524 1	To 12/31/2022	Date/Time Pre 5/23/2023 11:	
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
	·	Part I, Col.	Charge Ratio				
		9 line	·				
	ANOLILIARY OFFICE COOT OFFITTED	0	1.00	2. 00	3. 00	4. 00	
1. 00	ANCILLARY SERVICE COST CENTERS PHYSICAL THERAPY	66.00	0. 731266		0	0	1.00
2. 00	OCCUPATIONAL THERAPY	67.00			0	U	2.00
3. 00	SPEECH PATHOLOGY	68. 00					3.00
4. 00	DRUGS CHARGED TO PATIENTS	73.00			0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	1. 856119		0	0	5.00
6.00	LABORATORY	60.00			0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00			-	0	
8. 00	FAMILY PRACTICE	93.00			0	0	0.00
9. 00 10. 00	RADI OLOGY-THERAPEUTI C ANCI LLARY - OTHER	55. 00 76. 00			0	0	9. 00 10. 00
	CARDI AC REHABI LI TATI ON	76. 97			1	0	1
11. 00	Totals (sum of lines 1-11)	70.77	0. 030332			J	11.00
	,	Charges by		Shared Service	e Costs by LOC		
		LOC (from					
		Provi der					
	Cost Center Descriptions	Records) HGIP	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
	cost center bescriptions	погр	x col. 2)	x col. 3)	x col. 4)	x col. 5)	
		5. 00	6.00	7.00	8.00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0	(0	0	
2.00	OCCUPATIONAL THERAPY						2.00
3. 00 4. 00	SPEECH PATHOLOGY DRUGS CHARGED TO PATLENTS		0			0	3. 00 4. 00
4. 00 5. 00	DURABLE MEDICAL EQUIP-RENTED	0	0			0	
6. 00	LABORATORY	0	0			0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö	d	o o	0	1
8. 00	FAMILY PRACTICE	0	0	(0	0	8. 00
9. 00	RADI OLOGY-THERAPEUTI C						9. 00
10.00	ANCILLARY - OTHER	0	0	1	-	0	
10. 97	CARDIAC REHABILITATION	0	0		1	0	
11.00	Totals (sum of lines 1-11)	I	l 0	l (0	0	11.00

Health Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVICES	In Lie	eu of Form CMS-2552-10
OALOURATION OF HOODITAL BACEBURG	ODI OF DED DIEN OCCU	5 1 1 001 45 0040	n	W

CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der Co	CN: 15-0048	Peri od:	Worksheet 0-8	
		Hospi ce CCI	N: 15-1524	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/23/2023 11:	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7, col. 6,			146, 725	1.00
	line 11)					
2. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	3.00
4. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	ne 10)		0		4.00
5. 00	Program cost (line 3 times line 4)			0 0		5.00
	HOSPICE ROUTINE HOME CARE					
6. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7, col. 7,			3, 602, 392	6. 00
	line 11)					
7. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				19, 081	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				188. 79	8.00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	17, 3			9.00
10.00	Program cost (line 8 times line 9)		3, 267, 9	55 16, 236		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,			153, 299	11. 00
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.00
	Total average cost per diem (line 11 divided by line 12)				923. 49	13.00
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		50 0		14.00
	Program cost (line 13 times line 14)		138, 5	24 0		15. 00
	HOSPICE GENERAL INPATIENT CARE		ı			
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,			1, 391, 438	16.00
47.00	line 11)				4 5/0	47.00
	Total unduplicated days (Wkst. S-9, col. 4, line 13)				,	17.00
	Total average cost per diem (line 16 divided by line 17)	40)		40	886. 83	
	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	1, 2			19.00
20.00	Program cost (line 18 times line 19)		1, 099, 6	59 29, 265		20. 00
04 00	TOTAL HOSPICE CARE		ı		F 000 0F4	04 00
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				5, 293, 854	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				20, 816	
23.00	Average cost per diem (line 21 divided by line 22)		I		254. 32	∠3.00

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 01/01/2022 To 12/31/2022		paradi
			10 12/31/2022	5/23/2023 11:	
	Title XVIII Hospital				10 4111
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT			3, 544, 126	
	Capital DRG other than outlier				1.00
	Model 4 BPCI Capital DRG other than outlier			0	1. 01
	Capital DRG outlier payments			36, 529	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
	Total inpatient days divided by number of days in the cost reporting period (see instructions)			114. 42	3.00
				16. 58	4.00
5. 00				4. 17	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			147, 790	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0. 00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)			0.00	8.00
9.00	Sum of lines 7 and 8			0.00	9.00
10.00	0 Allowable disproportionate share percentage (see instructions)			0.00	10.00
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12.00	Total prospective capital payments (see instructions)			3, 728, 445	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	
	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	