This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost report	R 413.20(b)). F ting period bei	ailure to repo ng deemed over	rt can result i payments (42 US CCN: 150048 Pe Fr	n all interim GC 1395g). riod: rom 01/01/2014	FORM APPROVED OMB NO. 0938 Worksheet S Parts I-III Date/Time Pro) -0050 epared:
D. SETTLEMENT SUMMARY From 01/01/2014 Parts 1-11 To 1 / 2012/2014 Date: 3/30/2015 Time: 10:18 am ART I - COST REPORT STATUS Date: 3/30/2015 Time: 10:18 am To 01 der 1. [X] Electronically filed cost report Date: 3/30/2015 Time: 10:18 am 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [F] Medicare Utilization. Enter "F for full or "L" for 10w. Date: 3/30/2015 Time: 10:18 am ontractor 5. [1] Cost Report Status 6. Date Received: 10. MPR Date: 11. Contractor No. 11. Contractor No. 11. Contractor No. 12. [0] If fine 5. column 1 is 4: Enter (3) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If fine 5. column 1 is 4: Enter number of times reopened = 0-9. WINISTRATICATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND MINISTRATIVE ACTION, FINES AMD/OR IMPRISONMENT MAY RESULT. CERTIFICATION OF ANY INFORMATION CORTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND MINISTRATIVE ACTION, FINES AMD/OR IMPRISONMENT MAY ESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S) LEEGED CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically file dor manually submitted cost report and						
	ort			Date: 3/30/20)15 Time 1	0 [.] 18 am
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use only (1) As Submitted 7 Contr	actor No	for this Provi	11 Cont	ractor's Vend	or Code: olumn 1 is 4 [.]	4 Enter
SPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150048 Period: From 01/01/2014 To 12/31/2014 Worksheet S Parts I-11 Date/Time Prepared: 3/30/2015 10:18 am RT L - COST REPORT STATUS Date: 3/30/2015 10:18 am Date: 3/30/2015 10:18 am Vider 1 [] Manually submitted cost report a only Date: 3/30/2015 10:18 am STILLAW REPORT STATUS Date: 3/30/2015 10:18 am O] If this is an amended report enter the number of times the provider resubmitted this cost report A [F] Medicare Utilization. Enter "F" for full or "L" for low. Attractor [] IO NPR Date: 11. Soft edwithout Audit 8 [N] Initial Report for this Provider CCN (] Settled without Audit 8 [N] Initial Report for this Provider CCN [] [] [] [] I. [] Lo [] I [] I. [] Lo [] I. [] Lo [] I. [] I. [] Lo [] I. [] I. [] Lo [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] . [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I. [] LO [] I. [] I. [] LO [] I. [] I. [] LO [] I.] I. [] LO [] I. [] LO [] I. [] LO []						
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CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROV	'I DER(S)				
instructions, except as noted. I further c	certify that I a	am familiar wit	h the laws and	regulations r	egarding the	
provision of health care services, and that	the services i	dentified in 1	his cost repor	t were provide	din	
compliance with such laws and regulations.						
	(Si an	ed)				
	Corgin		or or Administr	ator of Provid	lor(c)	
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00	City: RICHMOND	State:			e: 47374		<u>nty: WAYNE</u>				(5	2. (
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. 00	Hospital-Based Health Clinic - RHC											15.
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00	Renal Dialysis											18.
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							Fro 1. (To: 2.00		
00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/	/31/2		20.
. 00	Type of Control (see instructions)						01/01/	2014		5172	014	20.
00	Inpatient PPS Information							-				21.
. 00	Does this facility qualify and is it	currently receiv	vina pavme	ents for	di spro	portionat	e Y			N		22.
	share hospital adjustment, in accord											
	for yes or "N" for no. Is this facil	ity subject to 42	2 CFR Sect	ion §41	2.06(c)	(2) (Pi ck)	e					
	amendment hospital?) In column 2, en			no.	.,	. , .						
. 01	Did this hospital receive interim un	compensated care	payments	no. for thi	s cost i	reporting				Y		22.
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Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150048 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: То 12/31/2014 3/27/2015 9:51 am Begi nni ng: Endi 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. 01/01/2014 12/31/2014 36.00 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status C 37.00 in effect in the cost reporting period. Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number 38.00 38.00 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 hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes "N" for no. Does the facility meet the mileage requirements in accordance with 42 lor CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) XVIII V XI X 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 Ν Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through 111 47.00 Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 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 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, 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 57 00 57 00 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 Worksheet D, Part III & IV and D-2, Part II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as Ν 58.00 defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5. Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I. 59.00 59.00 Ν 60.00 Are you claiming nursing school and/or allied health costs for a program that meets the 60.00 γ provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions) Y/N IME Direct GME IME Direct GME 1.00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 Ν 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 0.00 0. od 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 0.00 0. Od 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 0.00 0.00 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 0.00 0. Od 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 0.00 61.05 0.00 and/or general surgery FTEs and the current year' 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 0 00 0. Od 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted 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 and enter in column 4 direct GME FTE unweighted count.

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL	REID HOSPITAL EX IDENTIFICATION DAT			CCN: 150048	Peri od:	worksheet S-2	
					From 01/01/2014 To 12/31/2014		pared:
		Progran	n Name	Program Cod	e Unweighted IME FTE Count		
		1. (0	2.00	3.00	4.00	
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						1.00	
ACA Provisions Affecting the Heal 2.00 Enter the number of FTE residents					riod for which	0.00	62.0
your hospital received HRSA PCRE			this cost	reporting pe	riod for which	0.00	1 02.0
2.01 Enter the number of FTE residents during in this cost reporting per	s that rotated from a riod of HRSA THC prog	Teaching H ram. (see i	nstruction		o your hospital	0.00	62.0
Teaching Hospitals that Claim Res 3.00 Has your facility trained resider				cost reportin	a period? Enter	N	63.0
"Y" for yes or "N" for no in colu							
				Unwei ghted FTEs Nonprovi der Si te	FTES in	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	-
Section 5504 of the ACA Base Year							
<u>period that begins on or after Ju</u> 4.00 Enter in column 1, if line 63 is				0.	00 0.00	0. 000000	
in the base year period, the number resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2	tations occurring in a number of unweighted ur hospital. Enter in	all non-pro non-primar column 3 t	vider y care he ratio s)	Unwei ghted	Unwei ghted	Ratio (col. 3/	,
	, and the second s	Ũ		FTĔs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1.00	2.0	0	3.00	4.00	5.00 0.000000	
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)							
Section 5504 of the ACA Current beginning on or after July 1, 20	10				FTES in Hospital 2.00 for cost reporti		
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	Enter "Y" for yes or "N" for no					N		0	71.
	recent cost report filed on or be Column 2: Did this facility train §412.424 (d)(1)(iii)(D)? Enter " or 3 respectively in column 3. (: beginning of the fourth year, en the new teaching program in exis Inpatient Rehabilitation Facilit	n residents in a new Y" for yes or "N" for see instructions) If ter 4 in column 3, or tence, enter 5. (see	teaching program in no. Column 3: If co this cost reporting if the 5th or subse	accordance with lumn 2 is Y, er period covers t	n 42 CFR nter 1, 2 :he				
	Is this facility an Inpatient Red subprovider? Enter "Y" for yes a If line 75 yes: Column 1: Did thi recent cost reporting period end no. Column 2: Did this facility CFR §412.424 (d)(1)(iii)(D)? Entu 1, 2 or 3 respectively in column	and "N" for no. e facility have an ap ing on or before Nove train residents in a er "Y" for yes or "N"	proved GME teaching mber 15, 2004? Enter new teaching program for no. Column 3: I	program in the "Y" for yes on in accordance f column 2 is Y	"N" for with 42	Y N	N	0	75.
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00 00 00 00 00 00 00 00	the new teaching program in exis Long Term Care Hospital PPS Is this a long term care hospital TEFRA Providers Is this a new hospital under 42 of Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services Does this facility have title V and yes or "N" for no in the applical Is this hospital reimbursed for full or in part? Enter "Y" for yes Are title XIX NF patients occupy instructions) Enter "Y" for yes of Does this facility operate an ICC "Y" for yes or "N" for no in the Does title V or XIX reduce capital applicable column. If line 94 is "Y", enter the reduced Is many set of the reduced of the set of	ter 4 in column 3, or tence, enter 5. (see I (LTCH)? Enter "Y" CFR Section §413.40(f w Other subprovider (r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in t ing title XVIII SNF b or "N" for no in the F\MR facility for pur applicable column. al cost? Enter "Y" fo uction percentage in ting cost? Enter "Y"	for yes and "N" for for yes and "N" for (1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column. poses of title V and or yes, and "N" for n the applicable colum	quent academic no. r "Y" for yes of 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the n. o in the	years of pr "N" for V 1.00 N N N N N		N N 2. C Y Y N N N	X 00 0. 00	96.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	the new teaching program in exis Long Term Care Hospital PPS Is this a long term care hospital TEFRA Providers Is this a new hospital under 42 of Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for Title V and XIX Services Does this facility have title V and yes or "N" for no in the applical Is this hospital reimbursed for full or in part? Enter "Y" for yes Are title XIX NF patients occupy instructions) Enter "Y" for yes of Does this facility operate an IC "Y" for yes or "N" for no in the Does title V or XIX reduce capital applicable column. If line 94 is "Y", enter the redu Does title V or XIX reduce opera applicable column.	ter 4 in column 3, or tence, enter 5. (see I (LTCH)? Enter "Y" CFR Section §413.40(f w Other subprovider (r yes and "N" for no. and/or XIX inpatient ble column. title V and/or XIX th es or "N" for no in t ing title XVIII SNF b or "N" for no in the F\MR facility for pur applicable column. al cost? Enter "Y" fo uction percentage in ting cost? Enter "Y"	if the 5th or subse instructions) for yes and "N" for ()(1)(i) TEFRA? Ente excluded unit) under hospital services? E rough the cost repor he applicable column. eds (dual certificat applicable column. porses of title V and or yes, and "N" for n the applicable colum for yes or "N" for n the applicable colum	quent academic no. r "Y" for yes of 42 CFR Section nter "Y" for t either in ion)? (see XIX? Enter o in the n. o in the	years of pr "N" for V 1.00 N N N N N	0.00	N N 2. C Y Y N N N	X)0 0. 00	85. 86. 90. 91. 92. 93. 94. 95. 96.

Health Financial Systems REID HOSPITAL & HEA	ALTH CARE SERVI	CES	L	n Lieu	of For	m CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: com 01/01/ p 12/31/		Workshe Part I Date/Ti	me Pre	pared:
			V 1.00		3/27/20 XI 2 2. 0	Х	1 am
107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for n instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complet Column 2: If this facility is a CAH, do I&Rs in an approve train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions)	o in column 1. /orksheet B, Par e Worksheet D-2 ed medical educa	(see rt I, column 2, Part II. ation program	<u> </u>		2.0	10	107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
	Physi cal 1.00	Occupational 2.00	Speec 3.00		Respir 4.0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N		109.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of enter the method used (A, B, or E only) in column 2. If col either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital provider 15-1, §2208.1.	umn 2 is "E", e for long term	enter in column care (includes	3	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu Inc.			N" for	Y N			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy i	s	1			118.00
		Premi ums	Losse	S	Insura	ance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 549,082	2.00	6, 985	3.C		118.01
		549,082		0, 905		0	118.01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			1.00 N		2.0		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2 "Y" for yes or "N" for no.	n column 1 "Y" µalifies for th	for yes or ne Outpatient	Y		N		119.00 120.00
121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, e		fication date					126. 00
in column 1 and termination date, if applicable, in column 127.00 f this is a Medicare certified heart transplant center, en	ter the certifi	cation date					127. 00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date					128.00
129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2.		cation date in					129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co		ti fi cati on					130.00
131.00 If this is a Medicare certified intestinal transplant certe date in column 1 and termination date, if applicable, in co	er, enter the ce	ertification					131.00
132.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date					132.00
133.00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column	ter the certifi	cation date					133.00
134.00 If this is an organ procurement organization (OPO), enter t and termination date, if applicable, in column 2. All Providers		n column 1					134.00
 140.00 Are there any related organization or home office costs as chapter 10? Enter "Y" for yes or "N" for no in column 1. If are claimed, enter in column 2 the home office chain number 	yes, and home	office costs	Y				140. 00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider C	CN: 15004		~iod: om 01/01/2	Worksheet S	-2
				To	12/31/2		
1.00	2	2. 00			3.00		
If this facility is part of a cha			gh 143 t	he name			
home office and enter the home of		contractor number					
41.00 Name:	Contractor's Name:		Contr	actor'	s Number:		141.
42. 00 Street: 43. 00 Ci ty:	PO Box: State:		Zip (`odo`			142.
+3. 00 01 ty.	State.			Joue.			143. (
						1.00	
44.00 Are provider based physicians' cos						Y	144. (
45.00 If costs for renal services are cl services only? Enter "Y" for yes o	laimed on Worksheet A, li or "N" for no.	ine 74, are they o	costs foi	r inpat	ient	Y	145. (
				_	1 00		_
46.00 Has the cost allocation methodolog	and changed from the provi	involv filed post	ronor+2		1.00	2.00	146 1
Enter "Y" for yes or "N" for no in enter the approval date (mm/dd/yy	n column 1. (See CMS Pub.			yes,	N		146. (
47.00 Was there a change in the statisti		r yes or "N" for r	10.		Ν		147.0
48.00Was there a change in the order o					N		148.
49.00Was there a change to the simplifi	ed cost finding method?	Enter "Y" for yes	s or "N"	for	N		149. (
no.		Part A	Part	B	Title V	Title XIX	_
		1.00	2.00		3.00	4.00	_
Does this facility contain a prov	ider that qualifies for	an exemption from	the app	licatic	on of the I	ower of costs	
or charges? Enter "Y" for yes or	"N" for no for each comp			B. (Se			
55.00Hospi tal		N	N		N	N	155. (
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N	N N		N N	N	156. (157. (
58. 00 SUBPROVIDER		IN	IN		IN	IN	157.
59. 00 SNF		N	Ν		Ν	N	159. 0
60.00 HOME HEALTH AGENCY		N	Ν		N	N	160. 0
61.00 CMHC			N		N	N	161. (
						1.00	
Multicampus				66		N	
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.		•		_		N	165. (
	Name 0	County 1.00	State 2.00	Zip C			
66.00 fline 165 is yes, for each	0	1.00	2.00	3.0	0 4.0		00 166. (
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							
	<u> </u>		1	1		1.00	_
Health Information Technology (HI	T) incentive in the Amer	ican Recovery and	Rei nves	tment A	Act		
57.00 Is this provider a meaningful used 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a meani	ingful user (line				Y	167. (0168. (
reasonable cost incurred for the 1 69.00 If this provider is a meaningful of transition factor. (see instruction	user (line 167 is "Y") an	nd is not a CAH (I	ine 105	is "N"), enter t	he 0.	75169.
					Begi nni n		
70.00 Enter in columns 1 and 2 the EHR I					1.00	2.00	470
11 UUEDTOR ID COLUMPE 1 and 7 the EUD	pedinning date and ending	d date for the rem	portina		10/01/201	3 12/31/2013	170. (

Heal th	Financial Systems REID	HOSPITAL & HEALTH (CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			CCN: 150048	Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-2 Part II	2 epared:
					Y/N	Date	
	Company I potruption. Enton V for all VEC moor	anoon Enter N far			<u>1.00</u>	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	bonses. Enter N for		esponses. Enter	all dates in	the	
1 00	Provider Organization and Operation						1 1 00
1.00	Has the provider changed ownership immediated reporting period? If yes, enter the date of			instructions)	N		1.00
				Y/N	Date	V/I	
2.00	llos the provider terminated participation in	the Medicers Dream		1.00 N	2.00	3.00	2.00
2.00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel	, chain home offic d to the provider o	es, drug rits	Y			3.00
	of directors through ownership, control, or t relationships? (see instructions)						
				Y/N 1.00	Type 2.00	Date 3.00	
	Financial Data and Reports			1.00	2.00	3.00	
4.00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Co enter date availab	ompiled,	Y	A		4.00
5.00	Are the cost report total expenses and total	revenues di fferent		N			5.00
	those on the filed financial statements? If	yes, submit reconci	liation.		Y/N	Legal Oper.	
	<u> </u>				1.00	2.00	
6.00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool? Column 2: If	yes, is th	ne provider is	N	1	6.00
7 00	the legal operator of the program?				N		7 00
7.00 8.00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and/		d during the	N N		7.00 8.00
9.00	Are costs claimed for Intern-Resident program		urrent cos	st report? If	Ν		9.00
10. 00	yes, see instructions. Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the	current d	cost reporting	Ν		10.00
11.00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	proved	Ν		11.00
	Tredening Program of worksheet A: Trives, see					Y/N	
	Bad Debts					1.00	-
12. 00 13. 00	Is the provider seeking reimbursement for bac				st reporting	Y N	12.00 13.00
14.00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? I1	f yes, see inst	tructions.	N	14.00
15.00	Did total beds available change from the price	or cost reporting p	eriod?lf	f		N	15.00
		Descriptio	n	Y/N	rt A Date	Part B Y/N	
		0		1.00	2.00	3.00	
	PS&R Data	I I		1	1		
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 date of the PS&R Report used in columns 2 and 4. (see			N		N	16.00
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			Y	03/19/2015	Y	17.00
18.00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional			N		N	18.00
19. 00	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of			N		Ν	19. 00
20. 00	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		Ν	20.00

Heal th	Financial Systems RELD	HOSPITAL & HE	ALTH CARE SERVI	CES	In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-	2
					From 01/01/2014 To 12/31/2014		epared:
						3/27/2015 9:	
		_			rt A	Part B	
			<u>ription</u> 0	Y/N	Date 2.00	Y/N 3.00	
21.00	Was the cost report prepared only using the		0	1.00 N	2.00	S.00N	21.00
21.00	provider's records? If yes, see					iv.	21.00
	instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT					1.00	_
	Capital Related Cost	ALS UNLT (LAG	LFT CHILDRENS H	USFTTALS)			-
22.00	Have assets been relifed for Medicare purpose	es?lfyes, se	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durir	ng the cost	N	23.00
	reporting period? If yes, see instructions.						0.4.00
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases enter	ed into during	this cost repo	orting period?	N	24.00
25.00	Have there been new capitalized leases entere	ed into durina	the cost repor	tina period?	f ves, see	Ν	25.00
	instructions.	0	•	0.1	5		
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during t	he cost reporti	ng period? If	yes, see	N	26.00
27.00	instructions. Has the provider's capitalization policy char	and during th	a cast reportin	a pariod2 lf	ioc cubmit	Ν	27.00
27.00	copy.	iged dui riig tii		ig period? IT y	es, subili t	IN	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit e	ntered into dur	ing the cost r	reporting	N	28.00
20.00	period? If yes, see instructions.	account and (an	band funda (Da	ht Corvios Do	arua Fund)	V	20.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	ves see inst	ructions	ebt Service Res	serve Fund)	Y	29.00
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	Y	30.00
	instructions.		-	-			
31.00	Has debt been recalled before scheduled matur	rity without i	ssuance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni she	d through cont	ractual	Y	32.00
	arrangements with suppliers of services? If			0			
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 ap	plied pertainin	ng to competiti	ve bidding? If	Y	33.00
	no, see instructions. Provider-Based Physicians						
34.00	Are services furnished at the provider facili	ty under an a	rrangement with	provider-base	ed physi ci ans?	N	34.00
	If yes, see instructions.	5	5		1 5		
35.00	If line 34 is yes, were there new agreements		0 0	nts with the pr	rovi der-based	N	35.00
	physicians during the cost reporting period?	It yes, see i	nstructions.		Y/N	Date	
					1.00	2.00	
	Home Office Costs						
	Were home office costs claimed on the cost re				Ν		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been p	repared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end o	of the home of	fice different	from that of			38.00
50.00	the provider? If yes, enter in column 2 the 1						50.00
39.00	If line 36 is yes, did the provider render se						39.00
10.00	see instructions.						10.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	nome office?	IT yes, see			40.00
				-			
			1.	00	2.	00	
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title		BKD, LLP		BKD, LLP		41.00
	held by the cost report preparer in columns ' respectively.	i, ∠, and 3,					
42.00	Enter the employer/company name of the cost i	report	BKD, LLP				42.00
	preparer.						
	Enter the telephone number and email address		5025810435		LVCOSTREPORTS@	BKD. COM	43.00
	report preparer in columns 1 and 2, respectiv	very.	1		I		11

)SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provider CCN: 150048	Peri od: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepa 3/27/2015 9:51	
		Part B		·		
		Date				
		4.00				
	PS&R Data					
5.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see					16. 0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns	03/19/2015				17.0
3. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18. C
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. (
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. (
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21. (
		_	3.00			
	Cost Report Preparer Contact Information		3.00			
	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		KD, LLP			41. (
. 00	Enter the employer/company name of the cost r preparer.	report				42.0
3.00	Enter the telephone number and email address	of the cost				43. (

MCRI F32 - 6.6.157.1

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150048		eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-3 Part I Date/Time Pre 3/27/2015 9:5	pare
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e			I/P Days / O/P <u>Visits / Trips</u> Title V	
		1.00		2.00	3.00		4.00	5.00	<u> </u>
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00		135		75	0.00	<u> </u>	1.
3.00 4.00 5.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF							0 0	
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)			135	49, 2	75	0.00	0	7.
3.00 9.00 0.00 1.00 2.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	31.00		30	10, 9	50	0.00	0	8. 9. 10. 11. 12.
3.00	NURSERY	43.00						0	13.
4.00 5.00	Total (see instructions) CAH visits	10.00		165	60, 2	25	0.00	0	
6.00	SUBPROVIDER - IPF	40.00		38	13, 8	70		0	16.
7.00 8.00 9.00 0.00 1.00	SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE	41. 00		20				0	17. 18. 19. 20. 21.
2.00 3.00 4.00 4.10 5.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	116. 00 30. 00		0		0			22. 23. 24. 24. 25.
6.00 6.25 7.00 8.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days			223				0	26. 26. 27. 28.
9.00 0.00 1.00 2.00	Ambulance Trips Employee discount days (see instruction) Employee discount days – IRF Labor & delivery days (see instructions)			0		0			29. 30. 31. 32.
32. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days			0		J			32.

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Pre 3/27/2015 9:5	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	17, 828	1, 829				1.
00	HMO and other (see instructions)	2, 913	4, 330				2.
00	HMO IPF Subprovider	310	0				3.
00	HMO IRF Subprovider	218	76				4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		D		5.
00	Hospital Adults & Peds. Swing Bed NF		0		C		6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	17, 828	1, 829	30, 62	7		7.
00	INTENSIVE CARE UNIT	2, 338	328	5, 56	9		8
00	CORONARY CARE UNIT						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		112	1, 89	9		13
. 00	Total (see instructions)	20, 166	2, 269	38, 09	5 0.00	2, 127. 70	14
. 00	CAH visits	0	0		C		15
. 00	SUBPROVIDER - IPF	8, 312	0	12, 61	B 0.00	74.78	16
. 00	SUBPROVIDER - IRF	1, 981	0	2,90	0.00	20. 50	17
. 00	SUBPROVIDER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE	8, 260	0	27, 76	B 0.00	16.80	24
. 10	HOSPICE (non-distinct part)	0	0		C		24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER						26
. 00	Total (sum of lines 14-26)				0.00	2, 239. 78	
. 00	Observation Bed Days		0	2, 29	1		28
. 00	Ambul ance Trips	0					29
. 00	Employee discount days (see instruction)			35			30
. 00	Employee discount days - IRF				6		31
2. 00	Labor & delivery days (see instructions)	0	63				32
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)				C		32
3.00	LTCH non-covered days	0					33

	Financial Systems REID TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	HOSPI TAL & HEAL AL DATA		CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Pre 3/27/2015 9:5	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	5, 2	16 1, 561	9, 966	1.00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation heade) (see instructions)			7	23 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00	Total (see instructions) CAH visits	0.00	0	5, 2	16 1, 561	9, 966	
16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00 0. 00	0		98 53 34 7	684 199	16.00 17.00 18.00 19.00 20.00 21.00 22.00
23.00 24.00 24.10 25.00 26.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00					23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

REID HOSPITA	L &	HEALTH	CARE	SERVI CES	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems	REID	HOSPI TAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der	F	eriod: rom 01/01/2014 o 12/31/2014		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200.00	128, 105, 834	0	128, 105, 834	4, 658, 733. 68	27.50	1.00
	instructions)		-, -,,					
2.00	Non-physician anesthetist Part		C	0	0	0.00	0.00	2.00
3.00	A Non-physician anesthetist Part		C		0	0.00	0.00	3.00
5.00	B		C C	0		0.00	0.00	3.00
4.00	Physician-Part A -		C	0	0	0.00	0.00	4.00
4.01	Administrative Physicians – Part A – Teaching		C		0	0.00	0.00	4.01
5.00	Physician-Part B		C	0	0	0.00		•
6.00	Non-physician-Part B		C	0	0	0.00		•
7.00	Interns & residents (in an	21.00	C	0	0	0.00	0.00	7.00
7.01	approved program) Contracted interns and		C		0	0.00	0.00	7.01
7.01	residents (in an approved		C C	0		0.00	0.00	7.01
	programs)							
8.00 9.00	Home office personnel SNF	44.00	0	0	0	0.00 0.00		
9.00 10.00	Excluded area salaries (see	44.00	58, 451, 719	96, 731	58, 548, 450			•
10.00	instructions)		00, 101, 11	,0,,01		1,000,071.22	00.00	10.00
	OTHER WAGES & RELATED COSTS			_	·			
11.00	Contract Labor: Direct Patient Care		6, 240, 374	. 0	6, 240, 374	167, 775. 74	37. 19	11.00
12.00	Contract Labor: Top Level		C	0	0	0.00	0.00	12.00
	management and other							
	management and administrative services							
13.00	Contract Labor: Physician-Part		C	0	0	0.00	0.00	13.00
101.00	A - Administrative					0100		
14.00	Home office salaries &		C	0	0	0.00	0.00	14.00
15.00	wage-related costs Home office: Physician Part A		ſ	0	0	0.00	0.00	15.00
101.00	- Administrative					0100		
16.00	Home office and Contract		C	0	0	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
17.00	Wage-related costs (core) (see		16, 323, 879	0	16, 323, 879			17.00
	instructions)							
18.00	Wage-related costs (other) (see instructions)		C	0	0			18.00
19.00	Excluded areas		10, 341, 959	0	10, 341, 959			19.00
20.00	Non-physician anesthetist Part		C		0			20.00
21 00			~		0			01 00
21.00	Non-physician anesthetist Part B		Ĺ	0	0			21.00
22.00	- Physician Part A -		C	0	0			22.00
22.01	Administrative		~					22.01
22. 01 23. 00	Physician Part A - Teaching Physician Part B		(0			22.01 23.00
24.00	Wage-related costs (RHC/FQHC)		C	0	0			24.00
25.00	Interns & residents (in an		C	0	0			25.00
	approved program) OVERHEAD COSTS - DIRECT SALARIE						I	-
26.00	Employee Benefits Department	4.00	1, 621, 509	0	1, 621, 509	52, 208. 14	31.06	26.00
27.00	Administrative & General	5.00	10, 425, 781					
28.00	Administrative & General under		4, 394, 363	0	4, 394, 363	99, 442. 92	44. 19	28.00
29.00	contract (see inst.) Maintenance & Repairs	6.00	ſ	0	n	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 834, 776		1, 834, 776			30.00
31.00	Laundry & Linen Service	8.00	389, 237		320, 189			•
32.00 33.00	Housekeeping Housekeeping under contract	9.00	1, 532, 082	0	1, 532, 082 0			•
55.00	(see instructions)		Ĺ			0.00	0.00	33.00
34.00	Dietary	10.00	2, 548, 241	-1, 145, 272	1, 402, 969			
35.00	Dietary under contract (see		C	0	0	0.00	0.00	35.00
36.00	instructions) Cafeteria	11.00	r	934, 265	934, 265	127, 057. 03	7 35	36.00
	Maintenance of Personnel	12.00	C	0	0	0.00		37.00
	Nursing Administration	13.00	265, 634					38.00
39.00 40.00	Central Services and Supply Pharmacy	14.00 15.00	605, 359		605, 359 3, 580, 017			39.00
40.00		15.00	3, 580, 017	0	3, 300, 017	120, 386. 10	1 29.74	40.00

Health Financial Systems	REI D	HOSPI TAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der	CCN: 150048 F	Period:	Worksheet S-3	
					rom 01/01/2014		
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	447, 679	0	447, 679	23, 210. 18	19. 29	41.00
42.00 Social Service	17.00	1, 487, 879	0	1, 487, 879	30, 583. 21	48.65	42.00
43.00 Other General Service	18.00	C	0 0		0.00	0.00	43.00

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-1										
HOSPI	TAL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014					
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly				
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷				
				(from	(col.2 ± col.	Salaries in	col. 5)				
				Worksheet A-6)	3)	col. 4					
		1.00	2.00	3.00	4.00	5.00	6.00				
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1							
1.00	Net salaries (see		132, 500, 197	0	132, 500, 19	7 4, 758, 176. 60	27.85	1.00			
	instructions)										
2.00	Excluded area salaries (see instructions)		58, 451, 719	96, 731	58, 548, 45	0 1, 538, 374. 22	38.06	2.00			
3.00	Subtotal salaries (line 1		74, 048, 478	-96, 731	73, 951, 74	7 3, 219, 802. 38	22.97	3.00			
	minus line 2)										
4.00	Subtotal other wages & related		6, 240, 374	0	6, 240, 37	4 167, 775. 74	37.19	4.00			
	costs (see inst.)										
5.00	Subtotal wage-related costs (see inst.)		16, 323, 879	0	16, 323, 87	9 0.00	22.07	5.00			
6.00	Total (sum of lines 3 thru 5)		96, 612, 731	-96, 731	96, 516, 00	0 3, 387, 578. 12	28.49	6.00			
7.00	Total overhead cost (see		29, 132, 557	-148, 860	28, 983, 69	7 1, 234, 703. 05	23. 47	7.00			
	instructions)										

IOSPI T	AL WAGE RELATED COSTS	Provi der	CCN:	150048	Period: From 01/01/2014 To 12/31/2014		epare
						Amount	
						Reported	
						1.00	
	PART I V - WAGE RELATED COSTS						-
	Part A - Core List						-
	RETIREMENT COST					1	
. 00	401K Employer Contributions					2, 845, 745	
. 00	Tax Sheltered Annuity (TSA) Employer Contribution					3, 597, 245	
. 00	Nonqualified Defined Benefit Plan Cost (see instructions)					0	
. 00	Qualified Defined Benefit Plan Cost (see instructions)					0	4.
~~	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)					1	
. 00	401K/TSA Plan Administration fees					0	
. 00	Legal /Accounting/Management Fees-Pension Plan					0	
00	Employee Managed Care Program Administration Fees					0	7.
	HEALTH AND INSURANCE COST					1	1
00	Health Insurance (Purchased or Self Funded)					10, 305, 486	
00	Prescription Drug Plan					849, 975	
	Dental, Hearing and Vision Plan					227, 747	
	Life Insurance (If employee is owner or beneficiary)					527, 456	
	Accident Insurance (If employee is owner or beneficiary)					0	1
	Disability Insurance (If employee is owner or beneficiary)					0	1
	Long-Term Care Insurance (If employee is owner or beneficiary)					0	
5.00	'Workers' Compensation Insurance					0	1
5.00	Retirement Health Care Cost (Only current year, not the extrao	ordinary acc	rual	requi re	d by FASB 106.	0	16.
	Non cumulative portion) TAXES						
7 00						0 000 100	1 1 7
	FICA-Employers Portion Only					8, 023, 122	
	Medicare Taxes - Employers Portion Only					0	
	Unemployment Insurance					0	
	State or Federal Unemployment Taxes OTHER					0	u 20.
		monted on Li	1 10 00	1 + h = 0	ah 1 ahaya (aaa		21.
1.00	Executive Deferred Compensation (Other Than Retirement Cost Re instructions))	eported on T	rnes	i throu	gn 4 above. (See		21.
2 00	Day Care Cost and Allowances					0	22.
	Tuition Reimbursement					289, 062	
	Total Wage Related cost (Sum of lines 1 -23)					26, 665, 838	
T. UU	Total mage Nerated COSt (Juli OF FILES F =23)					20,000,000	<u> </u>

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-								
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150048	Peri od:	Worksheet S-3				
			From 01/01/2014					
			To 12/31/2014	Date/Time Pre 3/27/2015 9:5				
	Cost Center Description		Contract Labor					
	cost center bescription		1.00	2.00				
	PART V - Contract Labor and Benefit Cost		1.00	2.00				
	Hospital and Hospital-Based Component Identification:							
1.00	Total facility's contract labor and benefit cost		0	0	1.00			
2.00	Hospi tal		0	0	2.00			
3.00	Subprovider - IPF		0	0	3.00			
4.00	Subprovider - IRF		0	0	4.00			
5.00	Subprovider - (Other)		0	0	5.00			
6.00	Swing Beds - SNF		0	0	6.00			
7.00	Swing Beds - NF		0	0	7.00			
8.00	Hospital-Based SNF				8.00			
9.00	Hospital-Based NF				9.00			
10.00	Hospi tal -Based OLTC				10.00			
11.00	Hospital-Based HHA				11.00			
12.00	Separately Certified ASC				12.00			
13.00	Hospi tal -Based Hospi ce		0	0	13.00			
14.00	Hospital-Based Health Clinic RHC				14.00			
15.00	Hospital-Based Health Clinic FQHC				15.00			
16.00	Hospital-Based-CMHC				16.00			
17.00	Renal Dialysis		0	0	17.00			
18.00	Other		0	0	18.00			

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

HOSPI T	AL IDENTIFICATION DATA			Provi der		Period: From 01/01/2014	Worksheet S-9 Parts I & II	
_				Component		To 12/31/2014	Date/Time Prep 3/27/2015 9:51	
						Hospi ce I		
		Unduplicated						
		Days				- F		
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS	- 1	-	-		-	-	
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	7, 903	0	7, 275		0 0	7, 903	
3.00	Inpatient Respite Care	30	0	0		0 0	30	3.00
4.00	General Inpatient Care	327	0	0		0 0	327	4.00
5.00	Total Hospice Days	8, 260	0	7, 275		0 0	8, 260	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	208	0	96		0 0	208	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	39. 71	0.00	75.78	0.0	0.00	39. 71	8.00
	5/line 6)							
9.00	Unduplicated Census Count	208	0	96		0 0	208	9.00

Heal th	Financial Systems REID HOSPITAL & HEALTH CA	ARE SERVIC	CES	In Lie	eu of Form CMS-2	2552-10		
			CCN: 150048	Peri od:	Worksheet S-1	0		
				From 01/01/2014	Data /Tima Dra	norod.		
				To 12/31/2014	Date/Time Pre 3/27/2015 9:5			
			I		0/2//2010 /10	- cani		
					1.00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	8)	0. 312367	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				15, 680, 424	2.00		
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid?	a manta t	From Modionia	2	N	3.00 4.00		
4.00 5.00	If line 3 is "yes", does line 2 include all DSH or supplemental p If line 4 is "no", then enter DSH or supplemental payments from M		ITOM Medical	· · ·	0	4.00 5.00		
6.00	Medicaid charges	leur car u			75, 914, 661	6.00		
7.00	Medicaid cost (line 1 times line 6)				23, 713, 235	7.00		
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lir	es 2 and 5: if	8, 032, 811	8.00		
	< zero then enter zero)				-, , -			
	State Children's Health Insurance Program (SCHIP) (see instructio	ons for ea	ach line)					
9.00	Net revenue from stand-alone SCHIP				0			
10.00	Stand-alone SCHIP charges				0	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00		
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 mi	inus line 9;	if < zero then	0	12.00		
	enter zero) Other state or local government indigent care program (see instru	ictions fo	or each line)					
13.00	Net revenue from state or local indigent care program (Net includ				0	13.00		
14.00	Charges for patients covered under state or local indigent care p			·	0	14.00		
	10)				-			
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00		
16.00	Difference between net revenue and costs for state or local indig	gent care	program (lir	e 15 minus line	0	16.00		
	13; if < zero then enter zero)							
17.00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fund	ding chori	ty care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hos				0	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local	• •		s (sum of lines	-			
	8, 12 and 16)	rnai goint	our o program		0,002,011			
			Uni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col. 2)			
			1.00	2.00	3.00			
20.00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		17, 534, 63	7, 402, 892	24, 937, 530	20.00		
21.00	Cost of initial obligation of patients approved for charity care		5, 477, 24	2, 312, 419	7, 789, 661	21.00		
21.00	times line 20)		5, 477, 2-	2, 312, 417	7,707,001	21.00		
22.00	Partial payment by patients approved for charity care			0 0	0	22.00		
23.00	Cost of charity care (line 21 minus line 22)		5, 477, 24	2 2, 312, 419	7, 789, 661	23.00		
					1.00			
24.00	Does the amount in line 20 column 2 include charges for patient of		nd a length c	f stay limit	N	24.00		
25.00	imposed on patients covered by Medicaid or other indigent care program? .00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit							
25.00 26.00								
20.00								
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		s line 27)		33, 508, 931			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper			28)	10, 467, 084			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			,	18, 256, 745			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			26, 289, 556	31.00		

RECLAS	Financial Systems REID SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	HOSPI TAL & HEAL OF EXPENSES		CCN: 150048 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	3/27/2015 9:5 Reclassified Trial Balance (col. 3 +- col. 4)	
	L	1.00	2.00	3.00	4.00	5.00	
I. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	T T	0	0	26, 494, 545	26, 494, 545	1.00
I. 00	00101 NEW CAP BLDG & FIXT - OFFSITE		0				
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0	0	2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES	1, 621, 509	22, 487, 294				
5. 02	00550 DATA PROCESSI NG	242, 156 3, 350, 573	20, 967 17, 684, 277			263, 123 21, 337, 671	
6. 03	00560 PURCHASING RECEIVING AND STORES	798, 271	784, 705			1, 632, 598	
. 04		310, 565	1, 841, 826			2, 152, 391	
. 05 . 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMINI STRATI VE AND GENERAL	389, 781 5, 334, 435	4, 575, 243 15, 352, 556			4, 898, 514 21, 642, 382	
. 00	00700 OPERATION OF PLANT	1, 834, 776	2, 965, 221			4, 786, 296	
. 00	00800 LAUNDRY & LINEN SERVICE	389, 237	472, 084				
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 532, 082 2, 548, 241	563, 454 2, 694, 186			2, 095, 536 2, 085, 928	
1.00	01100 CAFETERI A	2, 540, 241	2,074,100			2, 934, 856	
3.00	01300 NURSI NG ADMI NI STRATI ON	265, 634	322, 713			892, 672	
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	605, 359	2, 338, 243 22, 634, 449			2, 943, 602	
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	3, 580, 017 447, 679	22, 634, 449 3, 440, 472			26, 229, 981 3, 868, 794	
7.00	01700 SOCIAL SERVICE	701, 151	1, 617, 242			2, 318, 393	
7.01	01701 I NSERVI CE EDUCATI ON	786, 728	1, 116, 361				
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	201, 704	31, 846	233, 550	0	233, 550	23.0
30.00	03000 ADULTS & PEDIATRICS	13, 429, 581	5, 507, 036	18, 936, 617	-16, 779	18, 919, 838	30.00
31.00	03100 I NTENSI VE CARE UNI T	3, 626, 044	1, 017, 509	4, 643, 553	0	4, 643, 553	
10.00 11.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	3, 642, 332	453, 031			4, 095, 363	
13.00	04100 SUBPROVIDER - TRF	1, 270, 182 537, 390	304, 469 105, 167			1, 574, 651 642, 557	
	ANCILLARY SERVICE COST CENTERS		,				
50.00	05000 OPERATING ROOM	2,035,318	36, 070, 576				
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	657, 686 5, 341, 593	194, 917 6, 359, 645				
9.00	05900 CARDI AC CATHETERI ZATI ON	1, 430, 115	8, 698, 221				
60.00	06000 LABORATORY	3, 452, 520	7, 132, 395			10, 530, 248	
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 490, 460 4, 644, 395	471, 387 1, 026, 277			1, 961, 847 5, 453, 249	
59.00	06900 ELECTROCARDI OLOGY	971, 950	644, 029			1, 615, 775	
0. 00	07000 ELECTROENCEPHALOGRAPHY	198, 975	82, 699	281, 674	-200		
'1.00 '2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-		0 12, 969, 087	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				
	07400 RENAL DI ALYSI S	0	679, 816				74.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
76.01 76.97	03952 NEURODI AGNOSTI C 07697 CARDI AC REHABI LI TATI ON	191, 742	0 88, 030	279, 772	-37, 939	0 241, 833	
0. 77	OUTPATIENT SERVICE COST CENTERS	171,742	00,000	217,112	57,757	241,033	/0. /
91.00	09100 EMERGENCY	4, 759, 856	2, 307, 193	7, 067, 049	-399, 303	6, 667, 746	
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	1, 362, 465	368, 610	1, 731, 075	59, 483	1, 790, 558	92.00
3.00	OTHER REIMBURSABLE COST CENTERS	1, 302, 403	308, 010	1,731,075	57, 485	1, 790, 338	93.0
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	785, 831	1, 566, 398	2, 352, 229	-40, 519	2, 311, 710	96.0
12 00	SPECIAL PURPOSE COST CENTERS		7 010 10/	7 012 104	7 010 702	1 402	1112 0
	11300 I NTEREST EXPENSE 11600 HOSPI CE	975, 466	7, 912, 106 666, 395			1, 403	113.0
18.00		75, 743, 799	182, 599, 045				
	NONREI MBURSABLE COST CENTERS	-T		-	-	-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 3, 924, 691				190.0
	07950 RENTAL SPACE	0	3, 924, 691 17, 563, 917			1, 985, 947	
94.01	07951 FOUNDATI ON	175, 677	224, 235	399, 912	0	399, 912	194.0
	207952 RETAIL SERVICES	86, 158	19, 603			105, 761	
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	342, 851 49, 816, 988	30, 324 39, 586, 957			483, 387 86, 941, 930	
	07955 OTHER NON REIMBURSABLE COST CENTERS	49,010,900	0, 300, 437				
94.06	07956 VACANT SPACE	0	0	-	0	0	194.0
94.07		627, 209	627, 398				
01 01	07958 CAMBRI DGE RHC	889, 750	871, 180			1, 332, 265 506, 348	
	07959 MALN STREET FAMILY RHC	392 6011	790 483				
94.09	07959 MAIN STREET FAMILY RHC 07960 REID URGENT CARE OF EATON	392, 601 30, 786	290, 483 22, 278				

ECLASSIFI	CATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES		Provi der	CCN: 150048	Peri od:	Worksheet A	
						From 01/01/2014 To 12/31/2014		
	Cost Center Description	Adjustments	Net	Expenses			3/27/2015 9:	51 am
		(See A-8)	For A	<u>Ilocation</u>				
CEN		6.00		7.00				_
	ERAL SERVICE COST CENTERS 00 NEW CAP REL COSTS-BLDG & FIXT	-7, 915, 527	1	8, 579, 018				1.0
	01 NEW CAP BLDG & FIXT - OFFSITE	0	1	1, 793, 058				1.0
	00 NEW CAP REL COSTS-MVBLE EQUIP	-2,964	1	-2, 964				2.0
	OO EMPLOYEE BENEFITS DEPARTMENT	-11, 227, 549	1	3, 161, 663				4.0
	40 NONPATI ENT TELEPHONES	0		263, 123				5.0
	50 DATA PROCESSING	-2, 320, 393	1	9,017,278				5.0
	60 PURCHASING RECEIVING AND STORES	-408, 443	1	1, 224, 155				5. C 5. C
	70 ADMI TTI NG 80 CASHI ERI NG/ACCOUNTS RECEI VABLE	-18		2, 152, 373 4, 898, 421				5.0
	90 OTHER ADMINISTRATIVE AND GENERAL	-3, 992, 387		7, 649, 995				5.0
	OO OPERATION OF PLANT	-841		4, 785, 455				7.0
00 008	00 LAUNDRY & LINEN SERVICE	0		751, 109				8.0
	00 HOUSEKEEPI NG	0		2,095,536				9.0
	00 DI ETARY	-717, 208		1, 368, 720				10.0
1	00 CAFETERIA 00 NURSING ADMINISTRATION	-2, 636, 360		298, 496 892, 672				11.0
	00 CENTRAL SERVICES & SUPPLY			2, 943, 602				14. (
	00 PHARMACY	-236, 534		5, 993, 447	1			15.0
	00 MEDICAL RECORDS & LI BRARY	-112, 118		3, 756, 676				16. (
7.00 017	00 SOCIAL SERVICE	-98		2, 318, 295				17. (
	01 I NSERVI CE EDUCATI ON	-867, 301		1, 029, 758				17. (
	OO PARAMED ED PRGM	-49, 570		183, 980				23. (
	ATIENT ROUTINE SERVICE COST CENTERS	-2, 848, 752	1	6,071,086				30. (
	00 INTENSIVE CARE UNIT	-2, 848, 752		4, 643, 520				31. (
	00 SUBPROVI DER – I PF	0	1	4, 095, 363				40.0
	00 SUBPROVI DER – I RF	-103, 445	1	1, 471, 206				41.
	00 NURSERY	-68		642, 489				43. (
	I LLARY SERVICE COST CENTERS				1			4
	OO OPERATING ROOM OO DELIVERY ROOM & LABOR ROOM	-5, 550, 662	1	4, 101, 025				50. 0 52. 0
	00 RADI OLOGY-DI AGNOSTI C	-150 -81, 690		852, 453 1, 494, 860				54.0
	00 CARDI AC CATHETERI ZATI ON	-61, 722		5, 253, 806				59.0
	00 LABORATORY	-892, 289	1	9, 637, 959				60.
. 00 065	00 RESPI RATORY THERAPY	0		1, 961, 847				65.
	00 PHYSI CAL THERAPY	-30, 407		5, 422, 842				66.
	00 ELECTROCARDI OLOGY	-59, 751		1, 556, 024				69.
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		281, 474 0	1			70. 71.
	00 IMPL. DEV. CHARGED TO PATIENTS	0	1	2,969,087				72.
	00 DRUGS CHARGED TO PATIENTS	0		2, 707, 007 0				73.
	00 RENAL DI ALYSI S	0	1	679, 816				74.
	50 OTHER ANCILLARY SERVICE COST CENTERS	0		0				76.
	52 NEURODI AGNOSTI C	0		0				76.
	97 CARDI AC REHABI LI TATI ON	0		241, 833				76.
	PATIENT SERVICE COST CENTERS	-798, 158		5, 869, 588				91.
	00 OBSERVATION BEDS (NON-DISTINCT PART)	-790, 100		5,007,500				92.
	40 PATIENT CARE CENTER - OCC	-587		1, 789, 971				93. (
OTH	ER REIMBURSABLE COST CENTERS							
	00 DURABLE MEDICAL EQUIP-RENTED	-781, 711		1, 529, 999				96.
	CIAL PURPOSE COST CENTERS	1 402	1	0				110
	00 I NTEREST EXPENSE 00 HOSPI CE	-1, 403 -317		0 1, 641, 544				113. 116.
8.00	SUBTOTALS (SUM OF LINES 1-117)	-41, 698, 549		7, 361, 658				118.
	REIMBURSABLE COST CENTERS	11/0/0/01/		110011000				
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	•	0				190.
2.00 192	00 PHYSICIANS' PRIVATE OFFICES	0		2, 131, 648				192.
	50 RENTAL SPACE	0		1, 985, 947				194.
	51 FOUNDATION	0		399, 912				194.
	52 RETAIL SERVICES			105, 761				194. 194.
	53 REID CONTRACTED SERVICES 54 REID PHYSICIAN ASSOC.	0		483, 387 6, 941, 930				194.
	55 OTHER NON REIMBURSABLE COST CENTERS			6, 941, 930 33, 643				194.
	56 VACANT SPACE	0		0, 040				194.
	57 LYNN RHC	0		840, 278				194.
	58 CAMBRI DGE RHC	0		1, 332, 265				194.
	59 MAIN STREET FAMILY RHC	0		506, 348				194. (
94.10079 00.00	60 REID URGENT CARE OF EATON	0		44, 619				194.
	TOTAL (SUM OF LINES 118-199)	-41, 698, 549	u 33	2, 167, 396	1			200.

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

					From 01/01/2014 To 12/31/2014	Date/Time Prepar
_						3/27/2015 9:51 a
_	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - ALLOCATION & SUPPORT RECL			0.07.000		
	EMPLOYEE BENEFITS DEPARTMENT	4.00 5.02	0	287, 802		
	DATA PROCESSING PURCHASING RECEIVING AND	5.02	0	315, 000 133, 781		
	STORES	5.05	0	155,761		
0	OTHER ADMINISTRATIVE AND	5.06	0	982, 379		
	GENERAL	45.00				
P	<u>PHARMACY</u>	<u> </u>	— — <u>0</u>	2 <u>4, 5</u> 00 1, 743, 462		
B	3 - CAPITAL EXPENSE RECLASS		U	1, 743, 402		
	NEW CAP REL COSTS-BLDG &	1.00	0	13, 895, 125		
	FI XT					
	NEW CAP BLDG & FIXT -	1.01	0	1, 633, 009		
	OFFSITE	1 00	0	25 017		
	NEW CAP REL COSTS-BLDG &	1.00	0	35, 817		
	NEW CAP BLDG & FIXT -	1.01	o	157, 612		
0	DFFSI TE					
	NEW CAP REL COSTS-BLDG &	1.00	0	4, 652, 900		
		1 01		0 407		
	NEW CAP BLDG & FIXT - DFFSITE	1.01	0	2, 437		
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			0	0		2
0	C - CAFETERIA RECLASS		0	20, 376, 900		
C		11.00	934, 265	2,000,591		
l			934, 265	2,000,591		
D) - LAUNDRY RECLASS					
	REID CONTRACTED SERVICES	194.03	69,048	41, 164		
C)		69, 048	41, 164	 	
	E - NURSING VP RECLASS	40.00	044 400			
N	NURSING ADMINISTRATION	<u>13.00</u>	314, 133	— — — <u>0</u>		
	F - QUAKER HILL RECLASS		314, 133	0		
	RENTAL SPACE	194.00	0	2, 901		
)		— — — 5	<u>2, 901</u> <u>2, 901</u>		
	G - OCCUPATIONAL MEDICINE REC	LASS		· · · · ·		
0	OTHER ADMINISTRATIVE AND	5.06	131, 195	234, 465		
	GENERAL					
	OTHER NON REIMBURSABLE COST	194.05	27, 683	5, 960		
	<u>CENTERS</u>	— — — +	158, 878	240, 425		
U H) 1 - IMPLANTABLE DEVICES RECLA	SS	138, 878	240, 425		
	MPL. DEV. CHARGED TO	72.00	n	12, 969, 087		
	PATIENT	72.00	5	12, 707, 007		
ľ		0.00	0	0		
		0.00	0	0		:
C)		0	12, 969, 087		
1	- DIETARY COUNSELING RECLAS PATIENT CARE CENTER - OCC					
P		93.00	211,007	0 0		

Heal th	Financial Systems	REI D	HOSPITAL & HE	ALTH CARE SERV	'I CES	In Lie	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 150048	Peri od:	Worksheet A-	5
						From 01/01/2014 To 12/31/2014	Date/Time Pro 3/27/2015 9:	epared: 51 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	J – INTEREST RECLASS							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	7, 910, 703	3			1.00
	FIXT							
	0		0	7, 910, 703	3			
500.00	Grand Total: Increases		1, 687, 331	45, 285, 233	3			500.00

Health Financial Systems RECLASSIFICATIONS

REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Provider CCN: 150048 Period: From 01/01/2014 Worksheet A-6

				TTOVICE		From 01/01/2014 To 12/31/2014	Date/Time Prepared 3/27/2015 9:51 am
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref	1	
	6.00	7.00	8.00	9.00	10.00	<u>.</u>	
	A - ALLOCATION & SUPPORT RECLA				1		
00	REID PHYSICIAN ASSOC.	194.04	0	809, 871		0	1.0
00	LYNN RHC	194.07	0	363, 428		0	2.0
00	CAMBRIDGE RHC	194.08	0	422, 613		0	3.0
00 00	MAIN STREET FAMILY RHC REID URGENT CARE OF EATON	194.09 194.10	0	139, 105 8, 445		0	4.0
00			0	1, 743, 462			5.0
	B - CAPITAL EXPENSE RECLASS			177107102			
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 393		9	1. (
00	DATA PROCESSING	5.02	0	12, 179		9	2.0
00	PURCHASING RECEIVING AND	5.03	0	84, 159	1	3	3. 0
	STORES	5 05					
00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	0	66, 510	1	3	4.0
00	OTHER ADMINI STRATI VE AND	5.06	0	78, 515	1	0	5.0
00	GENERAL	5.00	0	70, 313			5.0
00	OPERATION OF PLANT	7.00	0	10, 800	1	o	6.0
00	DI ETARY	10.00	0	10, 636		o	7.0
00	NURSING ADMINISTRATION	13.00	0	9, 808		0	8.0
00	PHARMACY	15.00	0	8, 985		0	9. (
). 00	MEDICAL RECORDS & LIBRARY	16.00	0	19, 357		0	10.0
1.00		17.01	0	6, 030		0	11.0
2.00 3.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	16, 779 307, 260		0	12.0
1. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	115, 356		0	14. 0
5.00	LABORATORY	60.00	Ő	54, 667		o	15.0
5.00	PHYSI CAL THERAPY	66.00	0	217, 423		0	16.0
7.00	ELECTROCARDI OLOGY	69.00	0	204		o	17.0
3.00	ELECTROENCEPHALOGRAPHY	70.00	0	200		o	18.0
9.00	CARDIAC REHABILITATION	76. 97	0	37, 939		0	19.0
). 00	PATIENT CARE CENTER - OCC	93.00	0	151, 524		0	20.0
1.00 2.00	DURABLE MEDICAL EQUIP-RENTED PHYSICIANS' PRIVATE OFFICES	96. 00 192. 00	0	40, 519 1, 793, 058		0	21.0
2.00 3.00	RENTAL SPACE	192.00	0	15, 580, 871			22.0
1. 00	REID PHYSICIAN ASSOC.	194.00	0	1, 652, 144		0	23.0
5.00	LYNN RHC	194.07	Ö	50, 901		o	25.0
5.00	CAMBRI DGE RHC	194.08	0	6, 052		0	26.0
7.00	MAIN_STREET_FAMILY_RHC	194.09	o	3 <u>7, 6</u> 31		o	27.0
	0		0	20, 376, 900			
	C - CAFETERIA RECLASS				I		
00	DI ETARY	<u>10.</u> 00	934, 265	2,000,591		<u>o</u>	1. (
			934, 265	2,000,591			
00	D - LAUNDRY RECLASS LAUNDRY & LINEN SERVICE	8.00	69, 048	41, 164		0	1.0
00			69, 048	4 <u>1,1</u> 64			1.0
	E - NURSING VP RECLASS	I	0,7010	11/101			
00	OTHER ADMINISTRATIVE AND	5.06	314, 133	0		0	1. (
	GENERAL						
	0		314, 133	0			
~~	F - QUAKER HILL RECLASS	7.00		2 001			
00	OPERATION_OF_PLANT	7.00	<u>0</u>	<u>2,901</u>		0	1.0
	G - OCCUPATIONAL MEDICINE RECL	٨٥٢	U	2, 901			
00	EMERGENCY	91.00	158, 878	240, 425		0	1.0
00	EMERGENCI	0.00	130, 070	240, 423		0	2.0
00			158, 878	240, 425			2.0
	H - IMPLANTABLE DEVICES RECLAS	SS		·			
00	OPERATING ROOM	50.00	0	8, 146, 947		0	1. (
00	RADI OLOGY-DI AGNOSTI C	54.00	0	9, 332		0	2.0
00	CARDIAC CATHETERIZATION	<u>59.00</u>	•	4,812,808	<u> </u>	<u>o</u>	3.0
			0	12, 969, 087			
00	I - DIETARY COUNSELING RECLASS		211 007			0	1 /
00	DI ETARY	<u>10.00</u>	<u>211, 007</u> 211, 007	0	├──	<u>-</u>	1. (
	J - INTEREST RECLASS		211,007	0	1	I	
00	INTEREST EXPENSE	113.00	0	7, 910, 703	1	1	1.0
-	0		_	7, 910, 703		1	
	Grand Total: Decreases		1, 687, 331	45, 285, 233			500.0

REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 150048 Period:

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

	TELATION OF CATTILE COSTS CENTERS		Trovider	CCN. 130040	Fron	n 01/01/2014 12/31/2014	Part I Date/Time Prep 3/27/2015 9:5	
				Acqui si ti on	S			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	11, 894, 138	1, 511, 827		0	1, 511, 827	0	1.00
2.00	Land Improvements	33, 424, 688	732, 718		0	732, 718	0	2.00
3.00	Buildings and Fixtures	222, 714, 678	11, 230, 792		0	11, 230, 792	0	3.00
4.00	Building Improvements	9, 940, 633	673, 053		0	673, 053	0	4.00
5.00	Fixed Equipment	2, 083, 496	0		0	0	0	5.00
6.00	Movable Equipment	136, 780, 543	11, 491, 170		0	11, 491, 170	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	416, 838, 176	25, 639, 560		0	25, 639, 560	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	416, 838, 176	25, 639, 560		0	25, 639, 560	0	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	13, 405, 965	0					1.00
2.00	Land Improvements	34, 157, 406	0					2.00
3.00	Buildings and Fixtures	233, 945, 470	0					3.00
4.00	Building Improvements	10, 613, 686	0					4.00
5.00	Fixed Equipment	2, 083, 496	0					5.00
6.00	Movable Equipment	148, 271, 713	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	442, 477, 736	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	442, 477, 736	0					10.00

Heal th Financia	I Syst	tems		
RECONCI LI ATI ON	OF CA	PITAL CO	OSTS	CENTERS

KEID HUSPITAL	ά	REALIN		SERVICES	
RELD HOSPITAL	8.		CAPE	SEDVICES	

 CARE SERVICES
 In Lieu of Form CMS-2552-10

 Provider CCN: 150048
 Period: From 01/01/2014
 Worksheet A-7

 Part II
 To 1/01/2014
 Period: From 01/01/2014

				From 01/01/2014 Fo 12/31/2014		pared: 1 am
		SU	MMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(0 0	0	1.00
1.01 NEW CAP BLDG & FIXT - OFFSITE	0	0	(0 0	0	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01 NEW CAP BLDG & FIXT - OFFSITE	0	0				1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	0	0				3.00

ECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Prep	
	COMI	PUTATION OF RA	TIOS	ALLOCATION OF	3/27/2015 9:51 OTHER CAPITAL	i am
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COS						
.00 NEW CAP REL COSTS-BLDG & FIXT .01 NEW CAP BLDG & FIXT - OFFSITE .00 NEW CAP REL COSTS-MVBLE EQUIP	294, 206, 023 148, 271, 713 0		,		0	1.0 1.0 2.0
.00 Total (sum of lines 1-2)	442, 477, 736		442, 477, 73	6 1.000000	0	3.0
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COS						
00 NEW CAP REL COSTS-BLDG & FIXT 01 NEW CAP BLDG & FIXT - OFFSITE 00 NEW CAP REL COSTS-MVBLE EQUIP 00 Total (sum of lines 1-2)	000000000000000000000000000000000000000			0 13, 891, 704 0 1, 633, 009 0 -2, 964 0 15, 521, 749	2, 437 0	1. (1. (2. (3. (
		SI	JMMARY OF CAPI		1,000,007	0.0
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COS						
. OO NEW CAP REL COSTS-BLDG & FIXT	-1,403					1. (
.01 NEW CAP BLDG & FIXT - OFFSITE	0	0	157, 61	2 0	1, 793, 058	1.0
. OO NEW CAP REL COSTS-MVBLE EQUIP	0		100.10	0	-2, 964	2.
.00 Total (sum of lines 1-2)	-1, 403	0	193, 42	9 U	20, 369, 112	3.

MCRIF32 - 6.6.157.1

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

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

55051	MENTS TO EXPENSES			F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet A-8 Date/Time Prep	
				Expense Classification on		3/27/2015 9:5	
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG &	1.00		1.
01	2) Investment income - NEW CAP		C	NEW CAP BLDG & FIXT -	1. 01	0	1.
00	BLDG & FIXT - OFFSITE (chapter 2) Investment income - NEW CAP		O	OFFSITE NEW CAP REL COSTS-MVBLE	2.00	0	2.
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
00	Investment income - other (chapter 2)		0		0.00		
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.
00	Television and radio service (chapter 21)		0		0.00	0	8.
00). 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -4, 895, 875		0.00	0	
. 00	adjustment Sale of scrap, waste, etc.		0		0.00		11.
. 00	(chapter 23) Related organization	A-8-1	-5, 531, 818		0.00		12.
. 00	transactions (chapter 10) Laundry and linen service		0,001,010		0.00		
. 00 . 00 . 00	Cafeteria-employees and guests Rental of quarters to employee		-2, 636, 360		11.00 0.00	0	14.
. 00	and others		0		0.00		15.
. 00	Sale of medical and surgical supplies to other than patients		U		0.00	0	10.
. 00	Sale of drugs to other than patients		0		0.00	0	17.
8. 00	Sale of medical records and	В	-112, 118	MEDICAL RECORDS & LIBRARY	16.00	0	18.
. 00	abstracts Nursing school (tuition, fees,	В	-49, 367	PARAMED ED PRGM	23.00	0	19.
0. 00	books, etc.) Vending machines	В	-6, 645	DI ETARY	10.00		
. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21.
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPIRATORY THERAPY	65.00		23.
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.
. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP BLDG &			FIXT NEW CAP BLDG & FIXT -	1.01	0	26.
. 00	FIXT - OFFSITE Depreciation - NEW CAP REL			OFFSITE NEW CAP REL COSTS-MVBLE	2.00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	EQUIP *** Cost Center Deleted ***	19.00		28.
. 00 . 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0.00 67.00		29. 30.
. 00	therapy costs in excess of limitation (chapter 14)	A-0-3	U		07.00		30.
). 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.

	Financial Systems	REID H	HOSPI TAL & HEA	ALTH CARE SERVICES		u of Form CMS-2	
ADJUSTN	MENTS TO EXPENSES				Period: From 01/01/2014	Worksheet A-8	
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
				Expense Classification on		0/2//2010 7.0	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
31 00	Adjustment for speech	1.00 A-8-3	2.00	3.00 *** Cost Center Deleted ***	4.00	5.00	31.00
	pathology costs in excess of		C C		00100		
	limitation (chapter 14) CAH HIT Adjustment for		O		0.00	0	32.00
	Depreciation and Interest		0		0.00		32.00
	MI SCELLANEOUS I NCOME	В	-709, 953		10.00		
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING	F 4.00 5.02	0	
	MI SCELLANEOUS I NCOME	В		PURCHASING RECEIVING AND	5.02		1
				STORES			
33.04	MI SCELLANEOUS I NCOME	В	-75	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	0	33.04
33. 05	MI SCELLANEOUS I NCOME	В	-605, 434	OTHER ADMINISTRATIVE AND	5.06	0	33.05
				GENERAL			
	MI SCELLANEOUS I NCOME	B B		OPERATION OF PLANT	7.00	0	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		SUBPROVI DER – I RF PHARMACY	41.00 15.00		
	MI SCELLANEOUS I NCOME	B		INSERVICE EDUCATION	17.01	0	
	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69.00	0	
	MI SCELLANEOUS I NCOME	В		PHYSICAL THERAPY	66.00		
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	
1	MI SCELLANEOUS I NCOME	B		CARDI AC CATHETERI ZATI ON	59.00	0	33.14
	MI SCELLANEOUS I NCOME	В		LABORATORY	60.00	0	1
	MI SCELLANEOUS I NCOME	В		EMERGENCY	91.00	0	
	MI SCELLANEOUS I NCOME	BB		DURABLE MEDI CAL EQUI P-RENTED		0	
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		INTEREST EXPENSE ADULTS & PEDIATRICS	113.00 30.00		
	MI SCELLANEOUS I NCOME	B		INTENSIVE CARE UNIT	31.00	0	
33. 21	CARRYFORWARD DEPRECIATION	A	-3, 333	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	33. 21
33. 22	PATI ENT ENTERTAI NMENT SYSTEM	А	-161, 578	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33. 22
33. 23	LI FELI NE SUPPORT	А	-2, 999	OTHER ADMI NI STRATI VE AND GENERAL	5.06	0	33. 23
33. 24	LI FELI NE SUPPORT	А	-2, 964	NEW CAP REL COSTS-MVBLE	2.00	9	33. 24
33. 25	LI FELI NE SUPPORT	A	-88	NEW CAP REL COSTS-BLDG &	1.00	9	33. 25
33. 26	COUNTRY CLUB DUES	А	-5, 598	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33. 26
33. 27	AHA/IHA LOBBYING	А	-12, 461	OTHER ADMI NI STRATI VE AND GENERAL	5.06	0	33. 27
33. 28	INTEREST INCOME	В	-3, 445, 722	NEW CAP REL COSTS-BLDG &	1.00	11	33. 28
33. 29	MARKETI NG/ADVERTI SI NG	A	-42, 782	EMPLOYEE BENEFITS DEPARTMENT	Г 4.00	0	33. 29
33. 30	MARKETI NG/ADVERTI SI NG	A	-34, 186	OTHER ADMINI STRATI VE AND	5.06	0	33.30
33. 31	MARKETING/ADVERTISING	А	-800	GENERAL INSERVICE EDUCATION	17.01	0	33. 31
1	MARKETI NG/ADVERTI SI NG	A		SUBPROVI DER – I RF	41.00		
33. 33	MARKETI NG/ADVERTI SI NG	A	-84	OPERATING ROOM	50.00	0	33. 3
	MARKETI NG/ADVERTI SI NG	A		PHYSICAL THERAPY	66.00		
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A A		PATIENT CARE CENTER - OCC DURABLE MEDICAL EQUIP-RENTED	93.00 96.00		
	NON-ALLOWABLE EXPENSES	A		EMPLOYEE BENEFITS DEPARTMENT			1
	NON-ALLOWABLE EXPENSES	A		PURCHASI NG RECEI VI NG AND STORES	5.03		1
1	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		ADMI TTI NG CASHI ERI NG/ACCOUNTS	5.04 5.05		
33. 41	NON-ALLOWABLE EXPENSES	А	-3, 170, 041	RECEI VABLE OTHER ADMI NI STRATI VE AND	5.06	0	33. 41
22 42			400		10.00	0	22 11
	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		DI ETARY PHARMACY	10.00 15.00		
	NON-ALLOWABLE EXPENSES	A		SOCIAL SERVICE	17.00		
33. 45	NON-ALLOWABLE EXPENSES	A	-576, 022	INSERVICE EDUCATION	17.01	0	33. 4
	NON-ALLOWABLE EXPENSES	A		PARAMED ED PRGM	23.00		
	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00		
33.48							

	Financial Systems MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
					10 12/31/2014	3/27/2015 9:5	1 am
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	<u> </u>
	· · · · · · · · · · · · · · · · · · ·	1.00	2.00	3.00	4.00	5.00	
3.50	NON-ALLOWABLE EXPENSES	A	-68	NURSERY	43.00	0	33.
3. 51	NON-ALLOWABLE EXPENSES	A		OPERATING ROOM	50.00	0	33.
3. 52	NON-ALLOWABLE EXPENSES	A	-150	DELIVERY ROOM & LABOR ROOM	52.00	0	33.
3.53	NON-ALLOWABLE EXPENSES	A		PHYSI CAL THERAPY	66.00	0	33.
3.54	NON-ALLOWABLE EXPENSES	A	-2, 599	EMERGENCY	91.00	0	33.
8. 55	NON-ALLOWABLE EXPENSES	A	-1, 977	DURABLE MEDICAL EQUIP-RENTE	96.00	0	33.
8. 56	NON-ALLOWABLE EXPENSES	A	-317	HOSPI CE	116.00	0	33.
3.57	SELF INSURANCE ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMEN			
8.58	UNNECESSARY BORROWING	A		NEW CAP REL COSTS-BLDG &	1.00	11	33
				FIXT		_	
3.59			0		0.00	0	
. 60			0		0.00	0	
8.61			0		0.00	0	
. 62			0		0.00	0	
3.63			0		0.00	0	
3.64			0		0.00	0	
3.65 3.67			0		0.00	0	
3.68			0		0.00	0	
3.69			0		0.00	0	
3.70			0		0.00	0	
3.70 3.71			0		0.00	0	
3.71 3.73			0		0.00	0	
3.73 3.74			0		0.00	0	
3.75			0		0.00	0	
3. 76			0		0.00	0	
. 77			0		0.00	0	
3. 78			Ő		0.00	0	
3.79			0		0.00	0	
3.80			0		0.00	0	
1. 81			0		0.00	0	
8. 82			0		0.00	0	
3.83			0		0.00	0	
8. 84			0		0.00	0	
. 85			0		0.00	0	33
8. 86			0		0.00	0	33
8. 87			0		0.00	0	33.
. 88			0		0.00	0	33
8. 89			0		0.00	0	33
8. 90			0		0.00	0	33
8. 91			0		0.00	0	33
. 00	TOTAL (sum of lines 1 thru 49)		-41, 698, 549				50
	(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.

Heal th	Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVICES	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 150048	Peri od:	Worksheet A-8	-1
OFFICE				From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	pared: 1 am
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	16, 578, 092	22, 109, 910	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4. 02
5.00	0		0	16, 578, 092	22, 109, 910	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

nao no c			it all on able of		or this parti	
				Related Organization(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	FD ORGANIZATION(S) AND/OR HO	ME OFFLCE:			

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

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

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

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

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

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

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

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

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

Health Financial Systems	s
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REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10 STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provi der CCN: 150048 Peri od: Worksheet A-8-1 From 01/01/2014 OFFICE COSTS 12/31/2014 Date/Time Prepared: То

					3/27/2015 9:	51 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRAN	SACTIONS WITH RELATED (ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-5, 531, 818	0				1.00
2.00	0	0				2.00
3.00	0	0				3.00
4.00	0	0				4.00
4.01	0	0				4.01
4.02	0	0				4. 02
5.00	-5, 531, 818					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

1103 1101	been posted to worksheet A,	condining i and/or z, the amount arrowable should be marcated in condining of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6.00 7.00 8.00 9.00 10.00 100.00	100.00

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

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

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

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

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

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

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

Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT

REID HOSPITAL	&	HEALTH	CARE	SERVI CES
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In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial System	ns REI	D HOSPITAL & HE	ALTH CARE SERV	ICES	In Li	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provi der		Peri od:	Worksheet A-8	3-2
						From 01/01/2014 To 12/31/2014	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	3/27/2015 9:5 Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	RUE AIIIOUITI	ider Component	
		rdentifier	Remarier at rom	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		THER ADMINISTRATIVE AND	90					1.00
		GENERAL				-	-	
2.00	10. 00 D		111	111	(o o	0	2.00
3.00	17.01	NSERVICE EDUCATION	256, 360	256, 360) (o o	0	3.00
4.00	30. 00 A	DULTS & PEDIATRICS	2, 842, 114	2, 842, 114	(o o	0	4.00
5.00	41.00 S	SUBPROVIDER – IRF	101, 813	101, 813	6 (o o	0	5.00
6.00	50.000	PERATING ROOM	16, 919	16, 919) (o o	0	6.00
7.00	60. 00 L	ABORATORY	819, 397	819, 397	(o o	0	7.00
8.00	69. OO E	LECTROCARDI OLOGY	64, 148	64, 148	3 (o o	0	8.00
9.00	91.00 E	MERGENCY	794, 923	794, 923	6 (o o	0	9.00
10.00	0.00		0	C C) (o o	0	10.00
200.00			4, 895, 875	4, 895, 875	5 (D	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		THER ADMINISTRATIVE AND	0	C) (0 0	0	1.00
		SENERAL						
2.00	10.00 D		0				0	
3.00		NSERVICE EDUCATION	0	-			0	
4.00		DULTS & PEDIATRICS	0	C		-	0	
5.00		SUBPROVIDER – IRF	0	C		-	0	
6.00		PERATING ROOM	0	C) (-	0	
7.00		ABORATORY	0	C	· · · · · · · · · · · · · · · · · · ·	-	0	
8.00		LECTROCARDI OLOGY	0	C) (°	0	8.00
9.00		MERGENCY	0	-			0	
10.00	0.00		0	C		-	0	
200.00			0	C	-		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15.00	16.00	17.00	18.00	-	
1.00		THER ADMINISTRATIVE AND	0					1.00
1.00		GENERAL	0					1.00
2.00	10. 00 D		0	(c) (111		2.00
3.00		NSERVICE EDUCATION	0					3.00
4.00		DULTS & PEDIATRICS	0					4.00
5.00		SUBPROVIDER – IRF	0					5.00
6.00		PERATING ROOM	0					6.00
7.00		ABORATORY	0					7.00
8.00		LECTROCARDI OLOGY	0	0				8.00
9.00		MERGENCY	0					9.00
10.00	0.00		0					10.00
200.00			0					200.00
					,			

Health Financial Systems REID	HOSPI TAL & HEAI	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			CCN: 150048 P	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I	pared:
		CAP	TAL RELATED C	OSTS	0/2//2010 //0	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP BLDG 8 FIXT - OFFSITE		EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	18, 579, 018	18, 579, 018				1.00
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE	1, 793, 058	C	1, 793, 058			1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P	-2,964	F/ 07/	2 (0)	-2, 964		2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATI ENT TELEPHONES	13, 161, 663 263, 123	56, 376 69, 768				
5. 02 00550 DATA PROCESSI NG	19,017,278	250, 066				
5. 03 00560 PURCHASING RECEIVING AND STORES	1, 224, 155	287, 485				
5. 04 00570 ADMI TTI NG	2, 152, 373	37, 254	12, 264	0	32, 461	5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 898, 421	164, 868				
5. 06 00590 OTHER ADMINI STRATI VE AND GENERAL	17, 649, 995	590, 456				
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	4, 785, 455 751, 109	3, 422, 743 226, 590				
9. 00 00900 HOUSEKEEPING	2,095,536	124, 473				1
10. 00 01000 DI ETARY	1, 368, 720	230, 870				1
11. 00 01100 CAFETERIA	298, 496	181, 364		0		
13.00 01300 NURSING ADMINISTRATION	892, 672	35, 913	3 C	0 0	60, 600	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 943, 602	154, 507				
15.00 01500 PHARMACY	25, 993, 447	133, 566				
16.00 01600 MEDI CAL RECORDS & LI BRARY	3, 756, 676	172, 491				
17. 00 01700 SOCI AL SERVI CE 17. 01 01701 I NSERVI CE EDUCATI ON	2, 318, 295 1, 029, 758	22, 797 191, 210		-		
23. 00 02300 PARAMED ED PRGM	183, 980	68, 721				
INPATIENT ROUTINE SERVICE COST CENTERS	1007700	00,721	1 .,,	<u> </u>	21,000	20100
30. 00 03000 ADULTS & PEDI ATRI CS	16, 071, 086	2, 006, 812	2 C	0 0	1, 403, 714	30.00
31.00 03100 INTENSIVE CARE UNIT	4, 643, 520	451, 012				
40. 00 04000 SUBPROVIDER - IPF	4, 095, 363	410, 378				
41.00 04100 SUBPROVIDER - IRF	1, 471, 206	328, 780		-		1
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	642, 489	49, 249) C	0 0	56, 170	43.00
50. 00 05000 OPERATING ROOM	24, 101, 025	1, 130, 781	85, 215	j 0	212, 740	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	852, 453	152, 762				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 494, 860	1, 145, 899	10, 415	5 0	558, 325	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 253, 806	249, 442				
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	9,637,959	256, 165				
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 961, 847 5, 422, 842	30, 255 925, 831				
69. 00 06900 ELECTROCARDI OLOGY	1, 556, 024	128, 790				
70. 00 07000 ELECTROENCEPHALOGRAPHY	281, 474	71, 495		-		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	C	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 969, 087	C				1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		-	0	
74. 00 07400 RENAL DIALYSIS 76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	679, 816	27, 371 (
76. 01 03952 NEURODI AGNOSTI C	0	(1
76. 97 07697 CARDI AC REHABI LI TATI ON	241, 833	83, 086				
OUTPATIENT SERVICE COST CENTERS	· · ·					
91.00 09100 EMERGENCY	5, 869, 588	418, 314	L C	0 0	480, 913	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				_		92.00
93.00 04040 PATIENT CARE CENTER - OCC	1, 789, 971	179, 692	2 5, 513	8 0	164, 466	93.00
0THER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1, 529, 999	85, 345	18, 695	5 O	82 138	96.00
SPECIAL PURPOSE COST CENTERS	1, 527, 777	00, 040	10,070		02,130	70.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	1, 641, 544	8, 174	L C	0 0	101, 960	
118.00 SUBTOTALS (SUM OF LINES 1-117)	237, 361, 658	14, 561, 151	624, 468	3 0	7, 737, 449	118.00
NONREI MBURSABLE COST CENTERS			-	-	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		-		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE	2, 131, 648 1, 985, 947	49, 690 349, 575				192.00 194.00
194. 01 07951 FOUNDATI ON	399, 912	3, 784				194.00
194. 02 07952 RETAIL SERVICES	105, 761	42, 985				194.02
194. 03 07953 RELD CONTRACTED SERVICES	483, 387	с., так		0		194.03
194.0407954 RELD PHYSICIAN ASSOC.	86, 941, 930	3, 221, 248			5, 207, 065	194.04
194.05 07955 OTHER NON REIMBURSABLE COST CENTERS	33, 643	9, 773		-		194.05
194. 06 07956 VACANT_SPACE	0	340, 812				194.06
194. 07 07957 LYNN RHC 194. 08 07958 CAMBRI DGE RHC	840, 278 1, 332, 265	C		-		194. 07 194. 08
194. 09 07959 MAIN STREET FAMILY RHC	1, 332, 265 506, 348					194.08 194.09
	1 500, 540	(้า เ	ή U	41,030	1, 1, 1, 1, 0, 2

Health Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	1	Period: From 01/01/2014 Fo 12/31/2014		
		CAP	ITAL RELATED C	OSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		NEW CAP BLDG { FIXT - OFFSITI		EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
194.1007960RELD URGENT CARE OF EATON200.00Cross Foot Adjustments201.00Negative Cost Centers	44, 619	0	() 0 -2, 964		194. 10 200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	332, 167, 396	18, 579, 018	1, 793, 058			

	LOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	
		5.01	5.02	5.03	5.04	5.05	
	ENERAL SERVICE COST CENTERS	1		1			1 1
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE						1. 1.
	0200 NEW CAP REL COSTS-MVBLE EQUIP						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT	250 202					4. 5.
	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	358, 202 29, 433	19, 654, 120				э. 5.
	00560 PURCHASING RECEIVING AND STORES	29, 433	2, 048, 918				5.
	0570 ADMITTING	10, 992	301, 312		2, 549, 145		5.
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	17, 220	129, 134		2, 549, 145	5, 308, 081	5.
	0590 OTHER ADMINI STRATI VE AND GENERAL	14, 411	241, 049		0	3, 300, 001	
	00700 OPERATION OF PLANT	7, 083	241, 042		0	0	
	00800 LAUNDRY & LINEN SERVICE	733	17, 218		0	0	8.
	00900 HOUSEKEEPI NG	733	25, 827		0	0	9.
	1000 DI ETARY	10, 747	292, 703		0	0	10.
	1100 CAFETERI A	0	(0	0	11.
	1300 NURSI NG ADMI NI STRATI ON	2, 198	120, 525	2, 198	0	0	13.
	1400 CENTRAL SERVICES & SUPPLY	1, 221	103, 307		0	0	14.
	1500 PHARMACY	5, 252	344, 356		0	0	15.
6.00 0	1600 MEDI CAL RECORDS & LI BRARY	8, 305	723, 148		0	0	16.
	1700 SOCIAL SERVICE	4, 152	241, 049	10, 915	0	0	17.
7.01 0	1701 I NSERVI CE EDUCATI ON	5, 618	1, 274, 117	7, 270	0	0	17.
3.00 0	2300 PARAMED ED PRGM	366	86, 089	1, 236	0	0	23.
17	NPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	27, 845	2, 048, 918	3 254, 070	154, 269	321, 227	30.
	03100 INTENSIVE CARE UNIT	6, 351	301, 312		40, 544	84, 424	31.
	04000 SUBPROVI DER – I PF	2, 687	129, 134		47, 608	99, 131	40.
	04100 SUBPROVI DER – I RF	3, 908	241, 049		11, 468	23, 879	
	04300 NURSERY	0		16, 906	7, 416	15, 442	43.
	NCI LLARY SERVI CE COST CENTERS	1		1			
	05000 OPERATING ROOM	23, 082	748, 974		449, 569	936, 231	50.
1	D5200 DELIVERY ROOM & LABOR ROOM	5, 252	275, 485		22, 950	47, 788	
	05400 RADI OLOGY-DI AGNOSTI C	18, 686	1, 308, 553		403, 311	839, 796	
	05900 CARDI AC CATHETERI ZATI ON	3, 542	86, 089		212, 033	441, 506	
	6000 LABORATORY	7,816	499, 316		317, 125	660, 335	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	733	103, 307		34, 434	71, 700	
	66000 ELECTROCARDI OLOGY	10, 992 1, 099	895, 326 421, 836		62, 744 89, 044	130, 649 185, 412	
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	855	68, 871		11, 109	23, 133	
	071000 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	00, 07 1		47, 492	23, 133 98, 891	
	7200 IMPL. DEV. CHARGED TO PATIENT	0	0	-	97, 806	203, 657	
	7300 DRUGS CHARGED TO PATIENTS	0	(341, 660	711, 424	
	07400 RENAL DI ALYSI S	611	17, 218		2, 791	5, 811	
	3950 OTHER ANCI LLARY SERVICE COST CENTERS	0	(2, 7, 7	0,011	
	3952 NEURODI AGNOSTI C	0	(0	0	0	
	07697 CARDI AC REHABI LI TATI ON	1, 466	17, 218	2, 484	3, 763	7, 835	
0	UTPATIENT SERVICE COST CENTERS			· · · ·			
1.00 0	09100 EMERGENCY	10, 015	645, 668	3 129, 831	150, 492	313, 362	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.
	04040 PATIENT CARE CENTER - OCC	6, 961	335, 747	7 19, 794	9, 875	20, 562	93.
	THER REIMBURSABLE COST CENTERS						
	9600 DURABLE MEDICAL EQUIP-RENTED	3, 053	103, 307	114, 841	22, 206	46, 239	96.
	PECIAL PURPOSE COST CENTERS			1			1
	1300 INTEREST EXPENSE	1 500	05 005	100.170			113.
	1600 HOSPI CE	1, 588	25, 827		9, 436		
18.00	SUBTOTALS (SUM OF LINES 1-117)	258, 914	14, 221, 907	3, 292, 300	2, 549, 145	5, 308, 081	1118.
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0	0	190.
	9200 PHYSICIANS' PRIVATE OFFICES	7, 938	8, 609	-	0		190.
	17950 RENTAL SPACE		0,009		0		192.
11 000	07950 RENTAL SPACE	11, 846 855	51, 653	27,606 3 1,985	0		194.
		855	309, 920		0		194.
4.010		. U	309, 920		0		194.
94.010 94.020	17952 RETAIL SERVICES			1 0	0		194.
94.010 94.020 94.030	07953 REI D CONTRACTED SERVI CES	0		002 001			1174.
94.010 94.020 94.030 94.040	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	0 78, 649 0	5, 062, 031	293, 231	0		101
94.010 94.020 94.030 94.040 94.050	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS	0 78, 649 0		293, 231 0 0	0	0	
94.010 94.020 94.030 94.040 94.050 94.050	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE	0 78,649 0 0		0 0 0 0	0 0 0	0 0	194.
94.01 0 94.02 0 94.03 0 94.04 0 94.05 0 94.06 0 94.07 0	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC	0 78, 649 0 0 0		0 0 0 0 9, 423	0 0 0 0	0 0 0	194. 194.
94.01 0 94.02 0 94.03 0 94.04 0 94.05 0 94.05 0 94.06 0 94.07 0 94.08 0	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC	0 78,649 0 0 0 0		0 0 0 9, 423 0 9, 730		0 0 0	194. 194. 194.
94.01 0 94.02 0 94.03 0 94.04 0 94.05 0 94.05 0 94.07 0 94.08 0 94.08 0 94.09 0	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC	0 78,649 0 0 0 0 0		0 0 0 9, 423 0 9, 730 0 4, 599		0 0 0 0	194. 194. 194. 194.
94.01 94.02 94.03 94.04 94.05 94.05 94.06 94.07 94.07 94.08 94.09 94.09 94.09 94.09	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC 07960 REID URGENT CARE OF EATON	0 78,649 0 0 0 0 0 0		0 0 0 9, 423 0 9, 730	0 0 0 0 0 0	0 0 0 0 0	194. 194. 194. 194. 194. 194. 200
94.01 0 94.02 0 94.03 0 94.04 0 94.05 0 94.05 0 94.07 0 94.08 0 94.08 0 94.09 0	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC	0 78,649 0 0 0 0 0 0		0 0 0 9, 423 0 9, 730 0 4, 599		0 0 0 0 0 0	194. 194. 194. 194.

	Financial Systems REID LLOCATION - GENERAL SERVICE COSTS	HOSPI TAL & HEA		CCN: 150048 P	In Lie eriod: rom 01/01/2014 o 12/31/2014	u of Form CMS- Worksheet B Part I Date/Time Pre 3/27/2015 9:5	epared:
	Cost Center Description		OTHER ADMI NI STRATI VE AND GENERAL		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5A. 05	5.06	7.00	8.00	9.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	19, 113, 136 8, 492, 901 1, 030, 263 2, 461, 020 2, 085, 709 577, 513 1, 114, 106 3, 532, 320 27, 099, 420	518, 517 62, 901 150, 253 127, 339 35, 259 68, 020 215, 659	9, 011, 418 179, 206 94, 289 160, 320 143, 438 28, 403 122, 197	1, 272, 370 0 0 0 0 0 0 0	2, 705, 562 46, 574 0 132, 949 1, 652	10.00 11.00 13.00 14.00
16. 00 17. 00 17. 01	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 I NSERVI CE EDUCATI ON 02300 PARAMED ED PRGM	4, 751, 847 2, 670, 495 2, 590, 205 378, 920	290, 115 163, 042 158, 140	16, 882 6, 363 135, 433	0 0 0	11, 065 7, 927 24, 278 0	16.00 17.00 17.01
	INPATIENT ROUTINE SERVICE COST CENTERS			I		750 7/5	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	22, 287, 941 6, 096, 644	1, 360, 746 372, 218				
	04000 SUBPROVIDER - IPF	5, 211, 802	318, 196	324, 562	89, 146	135, 757	40.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 229, 462 787, 672	136, 115 48, 090			89, 183 9, 249	
	05000 OPERATI NG ROOM	28, 296, 396				251, 696	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	1, 458, 011 16, 209, 766	89, 016 989, 655			56, 648 132, 289	
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 780, 444	413, 966	66, 728	58, 878	25, 103	59.00
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	11, 780, 971 2, 450, 765	719, 264 149, 627			75, 641 13, 873	
66.00	06600 PHYSI CAL THERAPY	8, 229, 826				128, 655	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 530, 405 504, 897	154, 489 30, 825			35, 013 0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	146, 383	8, 937			20, 479	
	07200 I MPL. DEV. CHARGED TO PATI ENT	13, 270, 550	810, 207			0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 053, 084 739, 032	64, 294 45, 120		0	31, 875 39, 967	73.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	76.00
	03952 NEURODI AGNOSTI C 07697 CARDI AC REHABI LI TATI ON	0 377, 727	0 23, 061	0	0	0 9, 909	
70. 77	OUTPATIENT SERVICE COST CENTERS	577,727	23,001		0	7, 707	/0. //
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 018, 183	489, 534	330, 838	179, 098	214, 866	
	04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS	2, 532, 581	154, 622	5, 884	3, 980	99, 258	92.00 93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2,005,823	122, 462	54, 510	0	1, 652	96.00
113.00	SPECIAL PURPOSE COST CENTERS			1			113.00
116. 00 118. 00		1, 911, 646 220, 807, 866			0 1, 272, 169	17, 672 2, 536, 278	116.00
190.00	NONREIMBURSABLE COST CENTERS	0	0	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 218, 755	135, 462			0	192.00
	07950 RENTAL SPACE 07951 FOUNDATI ON	2, 498, 848 476, 551	152, 562 29, 095				194.00 194.01
	07952 RETAIL SERVICES	470, 766				0	194. 02
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	526, 440 101, 721, 129	32, 141		0 201	0 145, 666	194.03
	07954 RELD PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS	46, 310	6, 210, 429 2, 827				194.04
194.06	07956 VACANT SPACE	452, 566	27, 631	343, 856		0	194. 06
	O7957 LYNN RHC O7958 CAMBRI DGE RHC	915, 259 1, 434, 995	55, 879 87, 611				194. 07 194. 08
194.09	07959 MAIN STREET FAMILY RHC	551, 983	33, 700	0	0	0	194. 09
194 10	07960 REID URGENT CARE OF EATON Cross Foot Adjustments	48, 892	2, 985	0	0	0	194. 10 200. 00
200.00							

	ALLOCATION - GENERAL SERVICE COSTS	HOSPITAL & HEAL	Provi der	CCN: 150048 Pe Fr To	riod: om 01/01/2014 12/31/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre 3/27/2015 9:5	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 01\\ 23. \ 00\end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02300 PARAMED ED PRGM	2, 419, 942 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	756, 210 1, 753 9, 032 25, 777 0 0 6, 548 1, 198	1,345,231 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 880, 860 797 0 163 23	28, 882, 774 0 0 0 0 0	16.00 17.00 17.01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 382, 418	107, 045	430, 150	424	9, 256	30.00
31.00		251, 369	27, 343		718	2, 533	•
40.00	04000 SUBPROVI DER – I PF	569, 541	33, 304		0	1, 371	
41.00	04100 SUBPROVI DER – I RF	130, 898	9, 131		64 0	471	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	85, 716	3, 783	15, 202	0	0	43.00
50.00	05000 OPERATI NG ROOM	0	43, 820	176, 088	1, 764, 226	205, 154	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 837		878	1, 867	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	41, 205		3, 299	534, 111	•
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	10, 773 33, 246		1, 465, 287 298, 458	3, 261 46	
65.00	06500 RESPIRATORY THERAPY	0	11, 533		1, 067	22, 644	
66.00	06600 PHYSI CAL THERAPY	0	34, 990		848	339	•
69.00		0	7, 585		0	230, 679	•
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 509 0		0	5 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	C	0 0	0	23, 575, 247	
	07400 RENAL DIALYSIS 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	481 0	74.00
76.00	03952 NEURODI AGNOSTI C	0	0		0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 585	6, 370	0	0	76.97
01 00	OUTPATIENT SERVICE COST CENTERS	0	40,407	1/0 071	17/	02.022	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	40, 407	162, 371	176	82, 022	91.00 92.00
	04040 PATIENT CARE CENTER - OCC	0	14, 040	0	0	1, 096	•
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	0	9, 401	0	179, 464	0	96.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	7, 482		20	158, 505	
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	2, 419, 942	487, 327	1, 345, 231	3, 715, 912	24, 829, 088	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	07950 RENTAL SPACE	0	0	0	0		194.00
	I 07951 FOUNDATI ON 207952 RETALL SERVICES	0	1, 898 1, 193		0		194. 01 194. 02
	307953 REID CONTRACTED SERVICES	0	4, 827		0		194.02
194.04	107954 REID PHYSICIAN ASSOC.	0	247, 536		164, 540	3, 967, 362	
	07955 OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0		194.05
	507956 VACANT SPACE 707957 LYNN RHC	0	5, 390		0 220		194.06 194.07
	3 07958 CAMBRI DGE RHC	0	5, 535		188		194.08
	07959 MAIN STREET FAMILY RHC	0	2, 286		0		194.09
	07960 REID URGENT CARE OF EATON	0	218	8 0	0	2, 642	194.10
200.00	5	0	0		Ω	Ο	200.00
201.00							

COST ALLO	nancial Systems REID CATION - GENERAL SERVICE COSTS	HOSPITAL & HEA	Provi der 0	CN: 150048	Period: From 01/01/2014	u of Form CMS- Worksheet B	2002-
					To 12/31/2014	Part I Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	PARAMED ED PRGM	Subtotal	
CEN	ERAL SERVICE COST CENTERS	16.00	17.00	17.01	23.00	24.00	
	00 NEW CAP REL COSTS-BLDG & FIXT						1.0
	01 NEW CAP BLDG & FIXT - OFFSITE						1.0
1	00 NEW CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT						2.0
1	40 NONPATIENT TELEPHONES						5.0
	550 DATA PROCESSING						5.0
1	60 PURCHASING RECEIVING AND STORES						5.0
	70 ADMI TTI NG 80 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.0
	90 OTHER ADMINISTRATIVE AND GENERAL						5.
	OO OPERATION OF PLANT						7.
1	BOO LAUNDRY & LINEN SERVICE						8.
	000 HOUSEKEEPI NG 000 DI ETARY						9. 10.
1	00 CAFETERIA						111. (
1	00 NURSI NG ADMI NI STRATI ON						13. (
	00 CENTRAL SERVICES & SUPPLY						14.
	00 PHARMACY 00 MEDICAL RECORDS & LIBRARY	5,069,909					15.
	00 SOCIAL SERVICE	5,009,909	2, 847, 827				17.
7.01 017	01 I NSERVI CE EDUCATI ON	0	0	2, 914, 76	7		17.
	OO PARAMED ED PRGM	0	0	10, 22	9 454, 285		23.
	ATIENT ROUTINE SERVICE COST CENTERS	306, 782	1, 542, 730	795, 95	6 0	30, 921, 840	30.
	00 INTENSIVE CARE UNIT	80, 627	366, 351	196, 520		8, 118, 028	
0. 00 040	000 SUBPROVIDER - IPF	94, 673	0	207, 69		7, 119, 870	
	00 SUBPROVIDER - IRF	22,806	0	55, 84		3, 016, 010	
	OO NURSERY	14, 748	0	28, 04	1 0	1, 094, 274	43.
	OOO OPERATI NG ROOM	894, 657	0	50, 67	3 0	34, 242, 544	50.
	OO DELIVERY ROOM & LABOR ROOM	45, 639	15, 088	37, 85		1, 850, 097	
	00 RADI OLOGY-DI AGNOSTI C	802, 032	0	140, 43		20, 224, 799	
	200 CARDI AC CATHETERI ZATI ON 200 LABORATORY	421, 652 630, 640	0	48, 32: 77, 24		9, 337, 705 13, 801, 126	
	00 RESPI RATORY THERAPY	68, 475	0	68, 77		2, 850, 455	
	00 PHYSI CAL THERAPY	124, 774	0	98, 05		9, 831, 913	
1	000 ELECTROCARDI OLOGY	177,074	0	30, 21		3, 173, 553	1
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 092 94, 444	0	3, 46	8 0 0 0	645, 246 270, 243	
	OO IMPL. DEV. CHARGED TO PATIENTS	194, 499	0		0 0	14, 275, 256	
3.00 073	OO DRUGS CHARGED TO PATIENTS	679, 432	0		0 0	25, 403, 932	73.
	00 RENAL DIALYSIS	5, 550	0	8, 70		860, 497	
	250 OTHER ANCI LLARY SERVICE COST CENTERS 252 NEURODI AGNOSTI C	0	0	(0 0 0 0	C C	
	97 CARDI AC REHABILI TATI ON	7, 483	0	8, 99		435, 129	
	PATIENT SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0, //		100,12,	
	00 EMERGENCY	299, 270	923, 658	197, 75	5 0	10, 938, 178	
	000 OBSERVATION BEDS (NON-DISTINCT PART) 040 PATIENT CARE CENTER - OCC	19, 637	0	43, 32	5 0	2, 874, 423	92. 93.
	ER REIMBURSABLE COST CENTERS	19,037	<u> </u>	43, 32	5 0	2,074,423	93.
	00 DURABLE MEDICAL EQUIP-RENTED	44, 159	0	17, 51	8 0	2, 434, 989	96.
	CIAL PURPOSE COST CENTERS	1					1
	000 I NTEREST EXPENSE 000 HOSPI CE	18, 764	0	31, 92	1 0	2, 262, 722	113.
18.00	SUBTOTALS (SUM OF LINES 1-117)	5, 069, 909	-	2, 157, 54		205, 982, 829	
NON	REIMBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.
	200 PHYSI CI ANS' PRI VATE OFFI CES 250 RENTAL SPACE	0	0	(0 0	2, 389, 898 2, 996, 953	
	150 RENTAL SPACE 151 FOUNDATION	0	0 0	5, 05	6 0	2, 996, 953 519, 392	
	252 RETAIL SERVICES	0	0	1, 70		512, 343	
	53 REI D CONTRACTED SERVICES	0	О		0 0	563, 408	
	754 REID PHYSICIAN ASSOC.	0	0	467, 640		114, 810, 335	
	255 OTHER NON REIMBURSABLE COST CENTERS 256 VACANT SPACE	0	0	245, 48		302, 355 824, 053	
	150 VACANT SPACE	0	o	13, 22	7 0	1, 007, 310	
94. 08 079	258 CAMBRI DGE RHC	0	Ö	21, 92		1, 598, 137	194.
	959 MAIN STREET FAMILY RHC	0	0	(0 0	606, 435	
94. 10 079 00. 00	COREID URGENT CARE OF EATON Cross Foot Adjustments	0	0	2, 17	b 0	56, 912	200.
200.00	Negative Cost Centers	0	о	(0 0	-2, 964	
	TOTAL (sum lines 118-201)	5,069,909	2, 847, 827	2, 914, 76	-	332, 167, 396	

alth Financial Systems REI ST ALLOCATION - GENERAL SERVICE COSTS	D HOSPITAL & HEALT	Provider CCI	Period: From 01/01/2014	ı of Form CMS-255 Worksheet B Part I Date/Time Prepa
			 To 12/31/2014	3/27/2015 9:51 a
Cost Center Description	Intern & Residents Cost & Post Stepdown	Total		
	Adjustments			
GENERAL SERVICE COST CENTERS	25.00	26.00		
00 00100 NEW CAP REL COSTS-BLDG & FIXT				
01 00101 NEW CAP BLDG & FIXT - OFFSITE				
00 00200 NEW CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT				
01 00540 NONPATIENT TELEPHONES				
00550 DATA PROCESSI NG				
00560 PURCHASING RECEIVING AND STORES				
05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 06 00590 OTHER ADMINI STRATI VE AND GENERAL				
00 00700 OPERATION OF PLANT				
00 00800 LAUNDRY & LINEN SERVICE				
00 00900 HOUSEKEEPI NG				
. 00 01000 DI ETARY				1
00 01100 CAFETERIA 00 01300 NURSI NG ADMI NI STRATI ON				1
00 01400 CENTRAL SERVICES & SUPPLY				1
00 01500 PHARMACY				1
. 00 01600 MEDI CAL RECORDS & LI BRARY				1
. 00 01700 SOCIAL SERVICE				1
. 01 01701 INSERVICE EDUCATION . 00 02300 PARAMED ED PRGM				1
INPATIENT ROUTINE SERVICE COST CENTERS		I		2
. 00 03000 ADULTS & PEDI ATRI CS	0	30, 921, 840		3
. 00 03100 I NTENSI VE CARE UNI T	0	8, 118, 028		3
00 04000 SUBPROVI DER - I PF 00 04100 SUBPROVI DER - I RF	0	7, 119, 870 3, 016, 010		4
. 00 04300 NURSERY	0	1, 094, 274		4
ANCILLARY SERVICE COST CENTERS		I.		
. 00 05000 OPERATING ROOM	0	34, 242, 544		5
. 00 05200 DELI VERY ROOM & LABOR ROOM . 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 850, 097 20, 224, 799		5
. 00 05900 CARDI AC CATHETERI ZATI ON	0	9, 337, 705		5
. 00 06000 LABORATORY	0	13, 801, 126		6
. 00 06500 RESPI RATORY THERAPY	0	2,850,455		6
. 00 06600 PHYSI CAL_THERAPY . 00 06900 ELECTROCARDI OLOGY	0	9, 831, 913 3, 173, 553		6
. 00 07000 ELECTROENCEPHALOGRAPHY	0	645, 246		7
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	270, 243		7
.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	14, 275, 256		7
. 00 07300 DRUGS CHARGED TO PATIENTS	0	25, 403, 932		7
00 07400 RENAL DIALYSIS 00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	860, 497 0		7
. 01 03952 NEURODI AGNOSTI C	0	0		7
. 97 07697 CARDIAC REHABILITATION	0	435, 129		7
OUTPATIENT SERVICE COST CENTERS	0	10, 938, 178		9
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	10, 750, 170		9
. 00 04040 PATIENT CARE CENTER - OCC	0	2, 874, 423		9
OTHER REIMBURSABLE COST CENTERS		0.404.000		
. 00 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	0	2, 434, 989		9
3. 00 11300 I NTEREST EXPENSE				11
6. 00 11600 HOSPI CE	0	2, 262, 722		11
B. 00 SUBTOTALS (SUM OF LINES 1-117)	0	205, 982, 829		11
NONREI MBURSABLE COST CENTERS 0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		19
2. 00 19000 PHYSI CLANS' PRI VATE OFFICES	0	2, 389, 898		19
4.0007950 RENTAL SPACE	0	2, 996, 953		19
4. 01 07951 FOUNDATI ON	0	519, 392		19
4. 02 07952 RETAIL SERVICES	0	512, 343		19
4.0307953 REID CONTRACTED SERVICES 4.0407954 REID PHYSICIAN ASSOC.	0	563, 408 114, 810, 335		19 19
4. 05 07955 OTHER NON REIMBURSABLE COST CENTERS	0	302, 355		19
4.0607956 VACANT SPACE	0	824, 053		19
4.0707957 LYNN RHC	0	1,007,310		19
4. 08 07958 CAMBRIDGE RHC	0	1, 598, 137		19
4.0907959MAIN STREET FAMILY RHC	0	606, 435 56, 912		19 19
4.1007960 REID URGENT CARE OF EATON				

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150048	Period: From 01/01/2014 To 12/31/2014		pared: 1 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25.00	26.00				
201.00 Negative Cost Centers	0	-2, 964				201.00
202.00 TOTAL (sum lines 118-201)	0	332, 167, 396				202.00

неаі тп	Financial Systems REID	HOSPITAL & HEAI	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS			CCN: 150048 P F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 3/27/2015 9:5	pared:
			CAP	I TAL RELATED CO	OSTS	0/2//2010 /.0	
	Cost Center Description	Directly Assigned New Capital		NEW CAP BLDG & FIXT - OFFSITE		Subtotal	
		Related Costs	1.00	1.01	2.00	2A	
	GENERAL SERVICE COST CENTERS				2.00	2.11	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		E / 07/				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	24, 398	56, 376			83, 378	4.00
5.01 5.02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	1, 847 3, 464, 467	69, 768 250, 066		-	71, 615 3, 721, 661	5. 01 5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	14, 313	287, 485			301, 798	1
5.04	00570 ADMI TTI NG	8, 902	37, 254		0	58, 420	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	24, 386	164, 868	53, 117	0	242, 371	5.05
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	151, 167	590, 456			787, 547	5.06
7.00	00700 OPERATION OF PLANT	93, 956	3, 422, 743			3, 543, 765	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	105, 512 12, 834	226, 590 124, 473		0	332, 102 137, 307	8.00 9.00
9.00 10.00	01000 DI ETARY	12, 634	230, 870		0	429, 568	
10.00	01100 CAFETERI A	0	181, 364		0	181, 364	
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 933	35, 913		0	40, 846	1
14.00	01400 CENTRAL SERVICES & SUPPLY	169, 595	154, 507		0	324, 102	
	01500 PHARMACY	87, 557	133, 566		0	221, 123	15.00
	01600 MEDI CAL RECORDS & LI BRARY	31,077	172, 491			241, 863	
	01700 SOCIAL SERVICE	7,020	22, 797		-	29, 817	17.00
17.01 23.00	01701 I NSERVI CE EDUCATI ON 02300 PARAMED ED PRGM	23, 864 5, 744	191, 210 68, 721		-	215, 074 91, 910	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	5,744	00,721	17, 445	0	91, 910	23.00
30.00	03000 ADULTS & PEDIATRICS	395, 848	2,006,812	0	0	2, 402, 660	30.00
	03100 I NTENSI VE CARE UNI T	195, 748	451, 012			646, 760	
	04000 SUBPROVIDER - IPF	31, 621	410, 378	0	0	441, 999	40.00
	04100 SUBPROVI DER – I RF	41, 799	328, 780		0	370, 579	
43.00	04300 NURSERY	6, 690	49, 249	0	0	55, 939	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	926, 863	1, 130, 781	85, 215	0	2, 142, 859	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	37,874	152, 762			190, 636	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 192, 567	1, 145, 899			2, 348, 881	
59.00	05900 CARDI AC CATHETERI ZATI ON	412, 057	249, 442	0	0	661, 499	
60.00	06000 LABORATORY	350, 842	256, 165		-	607, 007	
65.00	06500 RESPI RATORY THERAPY	44, 093	30, 255		0	74, 348	
66.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	94, 277	925, 831		0	1, 295, 560	
	07000 ELECTROENCEPHALOGRAPHY	129, 004 43, 910	128, 790 71, 495		0	257, 794 140, 740	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43, 910	/1, 493			140, 740	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	-		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DIALYSIS	3, 503	27, 371	0	0	30, 874	
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
	03952 NEURODI AGNOSTI C 07697 CARDI AC REHABI LI TATI ON	24.054	02 004	0	0	0	
10.91	OUTPATIENT SERVICE COST CENTERS	24, 854	83, 086	ں 1000 ا	0	107, 940	76.97
91.00	09100 EMERGENCY	220, 279	418, 314	0	0	638, 593	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		, 511			0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	29, 674	179, 692	5, 513	0	214, 879	93.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	33, 818	85, 345	18, 695	0	137, 858	96.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	1, 150	8, 174		0	0 221	113.00 116.00
118.00		8, 646, 741	14, 561, 151		-	23, 832, 360	
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	41, 881	49, 690			107, 558	
101 00	07950 RENTAL SPACE	297,032	349, 575			770, 481	
	07951 FOUNDATI ON	1, 832	3, 784		0		194.01
194.01		0	42, 985	0	0	42, 985	194.02 194.03
194. 01 194. 02	07952 RETAIL SERVICES	0	<u>^</u>				
194.01 194.02 194.03	07952 RETAI L SERVI CES 07953 REI D CONTRACTED SERVI CES	0	0 3 221 249	016 Q75	0		
194.01 194.02 194.03 194.04	07952 RETALL SERVICES 07953 RELD CONTRACTED SERVICES 07954 RELD PHYSICIAN ASSOC.	0 1, 430, 585 0	0 3, 221, 248 9, 773		0	5, 568, 808	194.04
194. 01 194. 02 194. 03 194. 04 194. 05	07952 RETAI L SERVI CES 07953 REI D CONTRACTED SERVI CES	0	0 3, 221, 248 9, 773 340, 812	0	0	5, 568, 808	194. 04 194. 05
194.01 194.02 194.03 194.04 194.05 194.06 194.07	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC	0	9, 773	0	0	5, 568, 808 9, 773 452, 566	194. 04 194. 05
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC	0 1,430,585 0 0 16,204 15,144	9, 773	0	0	5, 568, 808 9, 773 452, 566 16, 204 15, 144	194. 04 194. 05 194. 06 194. 07 194. 08
194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08 194. 09	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC	0 1, 430, 585 0 0 16, 204	9, 773	0 111, 754 0 0 0 0 0	0 0 0 0	5, 568, 808 9, 773 452, 566 16, 204 15, 144 5, 788	194. 04 194. 05 194. 06 194. 07

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
			F	From 01/01/2014		
			1	Fo 12/31/2014		pared:
	1				3/27/2015 9:5	<u>1 am</u>
		CAP	ITAL RELATED C	OSTS		
Cost Center Description	Directly	NEW BLDG &	NEW CAP BLDG 8	NEW MVBLE	Subtotal	
	Assigned New	FLXT	FIXT - OFFSITE	E EQUI P		
	Capi tal					
	Related Costs					
	0	1.00	1.01	2.00	2A	
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		C		-2, 964	-2, 964	201.00
202.00 TOTAL (sum lines 118-201)	10, 455, 943	18, 579, 018	1, 793, 058	-2, 964	30, 825, 055	202.00

	n Financial Systems REID ATION OF CAPITAL RELATED COSTS	HOSPI TAL & HEA		CCN: 150048 P	Period: From 01/01/2014 Fo 12/31/2014	u of Form CMS- Worksheet B Part II Date/Time Pre	epared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	3/27/2015 9:5 ADMI TTI NG	
		4.00	5.01	5.02	5.03	5.04	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	83, 378					4.00
5.01 5.02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	160 2, 208	71, 775 5, 898		,		5.01
5.02	00560 PURCHASING RECEIVING AND STORES	526	5, 898 783				5.02
5.04	00570 ADMI TTI NG	205	2, 202	57, 180		118, 479	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	257	3, 450	24, 506	869	0	5.05
5.06	00590 OTHER ADMINI STRATI VE AND GENERAL	3, 395	2, 888			0	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 209 211	1, 419 147			0	
8.00 9.00	00900 HOUSEKEEPING	1,010	147			0	
10.00	01000 DI ETARY	925	2, 153			0	
11.00	01100 CAFETERI A	616	0	C		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	382	440	22, 872		0	
14.00 15.00		399 2, 359	245 1, 052			0	
16.00		2, 359	1, 052	65, 349 137, 232		0	
17.00		462	832	45, 744		0	
17.01	01701 I NSERVI CE EDUCATI ON	518	1, 126	241, 790	1, 379	0	17.01
23.00		133	73	16, 337	234	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0.050	E E00	200 024	49 102	7 102	30.00
30.00 31.00		8, 850 2, 390	5, 580 1, 273			7, 183 1, 888	
40.00		2,400	538			2, 217	
41.00	04100 SUBPROVI DER – I RF	837	783	45, 744	3, 112	534	41.00
43.00		354	0	C	3, 207	345	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	1 241	4 (25	140 100	115 470	20 722	50.00
50.00 52.00		1, 341 433	4, 625 1, 052			20, 723 1, 069	
54.00		3, 520	3, 744			18, 778	
59.00		942	710			9, 872	59.00
60.00	06000 LABORATORY	2, 275	1, 566			14, 765	
65.00 66.00		982 3, 061	147 2, 202	19, 605 169, 906		1, 603 2, 921	
69.00		641	2,202			4, 146	
70.00		131	171	13, 070		517	
71.00		0	0	C	-	2, 211	
72.00		0	0	C		4, 554	
73.00 74.00		0	0 122	C 3, 267		15, 908 130	73.00
76.00		0	0			0	
76.01		0	0	C	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	126	294	3, 267	471	175	76.9
91.00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	3, 032	2,007	122, 528	24, 626	7,007	91.00
92.00		5,052	2,007	122, 520	24,020	7,007	92.00
93.00	04040 PATIENT CARE CENTER - OCC	1, 037	1, 395	63, 715	3, 754	460	93.00
	OTHER REIMBURSABLE COST CENTERS	540	(10)	10 (05			
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	518	612	19, 605	21, 783	1, 034	96.00
113.00	0 11300 I NTEREST EXPENSE						113.00
	0 11600 HOSPI CE	643	318	4, 901	19, 626	439	116.00
118.00		48, 783	51, 878	2, 698, 895	624, 480	118, 479	118.00
100.0	NONREI MBURSABLE COST CENTERS						100.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0	0 1, 591		-		190. 00 192. 00
	0 07950 RENTAL SPACE	0	2, 374				194.00
	107951 FOUNDATI ON	116	171	9, 802			194.0
	2 07952 RETAIL SERVICES	57	0	58, 814			194. 0
	3 07953 REID CONTRACTED SERVICES	271	15 7(1		-		194.0
	4 07954 RELD PHYSICIAN ASSOC. 5 07955 OTHER NON REIMBURSABLE COST CENTERS	32, 855 18	15, 761 0	960, 622 C			194. 04 194. 0
	607955 VACANT SPACE	0	0		-		194.0
194.0	707957 LYNN RHC	413	0	C	1, 787	0	194. 0
	8 07958 CAMBRI DGE RHC	586	0	C	1, 846		194. 08
	907959 MAIN STREET FAMILY RHC	259	0	C	872		194.0
	007960 REID URGENT CARE OF EATON	20	0	C	200	0	194.1
200.00		0	0	0	0	Ω	200.00
	D TOTAL (sum lines 118-201)	83, 378	71, 775	3, 729, 767	-	118, 479	

	Financial Systems REID TION OF CAPITAL RELATED COSTS	HOSPI TAL & HEA		CCN: 150048 P	eriod: rom 01/01/2014	u of Form CMS-: Worksheet B Part II Date/Time Pre 3/27/2015 9:5	pared:
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	ADMI NI STRATI VE AND GENERAL		LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.05	5.06	7.00	8.00	9.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	271, 453 0 0 0	845, 804 22, 948 2, 784	3, 580, 490 71, 204	409, 932	107 791	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 8.\ 00\\ \end{array}$
15. 00 16. 00 17. 00 17. 01	00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02300 PARAMED ED PRGM		6, 999	63, 700 56, 992 11, 285 48, 552 40, 638 6, 708 2, 528	0 0 0 0 0 0 0 0 0	197, 781 3, 405 0 9, 719 121 0 809 580 1, 775 0	10.00 11.00 13.00 14.00 15.00 16.00 17.00 17.01
	INPATIENT ROUTINE SERVICE COST CENTERS	-	1				1
31.00 40.00 41.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	16, 440 4, 321 5, 074 1, 222	16, 473 14, 082 6, 024	624, 238 141, 726 128, 958 103, 316	120, 347 28, 302 28, 721 14, 600	55, 101 12, 375 9, 924 6, 519	31.00 40.00 41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	790	2, 128	15, 476	20, 240	676	43.00
$\begin{array}{c} 54.\ 00\\ 59.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ \end{array}$	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03950 OTHER ANCI LLARY SERVICE COST CENTERS	47, 701 2, 446 42, 981 22, 596 33, 796 3, 670 6, 687 9, 489 1, 184 5, 061 10, 423 36, 411 297 0	43, 799 18, 321 31, 832 6, 622 22, 237 6, 837 1, 364 396 35, 857 2, 845 1, 997	253, 528 26, 513 73, 744 6, 892 278, 350 3, 215 31, 171 0 0 0 8, 601	77, 986 0 36, 746 18, 969 6 0 3, 678 0 1, 288 0 0 0 0 0 0 0 0		$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 59.\ 00\\ 65.\ 00\\ 65.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ \end{array}$
	03952 NEURODI AGNOSTI C	0		0	0	0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	401	1, 021	0	0	724	76. 97
92.00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS	16, 038 1, 052			57, 702 1, 282	15, 707 7, 256	92.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	2,367	5, 420	21, 658	0	121	96.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 006 271, 453			0 409, 867	1, 292 185, 406	113. 00 116. 00 118. 00
192.00 194.00 194.01 194.02 194.03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES		0 5, 995 6, 752 1, 288 1, 272 1, 422	129, 419 1, 189 3, 948 0		0 1, 449 278 0 0	190.00 192.00 194.00 194.01 194.02 194.03
194.05 194.06 194.07 194.08 194.09	07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC 07960 REID URGENT CARE OF EATON Cross Foot Adjustments		274, 774 125 1, 223 2, 473 3, 877 1, 491 132	749, 297 3, 071 136, 623 0 0 0 0 0	65 0 0 0 0 0 0	0 0 0 0 0	194. 04 194. 05 194. 06 194. 07 194. 08 194. 09 194. 10 200. 00
200.00 201.00 202.00	Negative Cost Centers	0 271, 453	0 845, 804	0 3, 580, 490	0 409, 932	0 197, 781	201.00

	ION OF CAPITAL RELATED COSTS	HOSPITAL & HEAL	Provi der	CCN: 150048 Pe	eriod: com 01/01/2014 0 12/31/2014	u of Form CMS- Worksheet B Part II Date/Time Pre 3/27/2015 9:5	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 1.01 2.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00	DOITOO NEW CAP REL COSTS CLINERS DOITOO NEW CAP REL COSTS-BLDG & FIXT DOITOO NEW CAP REL COSTS-BLDG & FIXT DO200 NEW CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT D0540 NONPATIENT TELEPHONES D0550 DATA PROCESSING D0560 PURCHASING RECEIVING AND STORES D0570 ADMITTING D0580 CASHIERING/ACCOUNTS RECEIVABLE D0590 OTHER ADMINISTRATIVE AND GENERAL D0590 OTHER ADMINISTRATIVE AND GENERAL D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING						$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$
10.00 (1.00) 11.00 (1.00) 13.00 (1.00) 14.00 (1.00) 15.00 (1.00) 16.00 (1.00) 17.00 (1.00) 23.00 (1.00)	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 I NSERVI CE EDUCATI ON 02300 PARAMED ED PRGM NPATI ENT ROUTI NE SERVI CE COST CENTERS	567, 766 0 0 0 0 0 0 0 0 0	240, 532 558 2, 873 8, 199 0 0 2, 083 381	89, 529 0 0 0 0	455, 973 94 0 0 19 3	459, 192 0 0 0 0 0	10.00 11.00 13.00 14.00 15.00 16.00 17.00 17.01
30.00 (31.00 (40.00 (41.00 (43.00 (03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY NICILLARY SERVICE COST CENTERS	324, 342 58, 976 133, 626 30, 711 20, 111	34, 049 8, 697 10, 593 2, 904 1, 203	7, 313 8, 907 2, 442	50 84 0 8 0	147 40 22 7 0	40.00 41.00
50.00 0 52.00 0 54.00 0 59.00 0 60.00 0 65.00 0 66.00 0 69.00 0 70.00 0 71.00 0 73.00 0 74.00 0 76.01 0 76.07 0 76.97 0	305000 OPERATING ROOM 055000 OPERATING ROOM 055000 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PLECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 OTHER ANCILLARY SERVICE COST CENTERS 03952 NEURODIAGNOSTIC 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS		13, 938 1, 539 13, 107 3, 427 10, 575 3, 668 11, 130 2, 412 480 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 294 11, 020 2, 881 0 3, 084 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	207, 280 103 388 172, 163 35, 067 125 100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 262 30 8, 492 52 1 360 5 3, 667 0 0 374, 810 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 59.\ 00\\ 65.\ 00\\ 66.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 00\\ 76.\ 01\\ \end{array}$
91.00 92.00 93.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC 0THER REIMBURSABLE COST CENTERS	0	12, 852 4, 466		21 0	1, 304 17	92.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	2, 990	0	21, 086	0	96.00
113.00 116.00 118.00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 567, 766	2, 380 155, 008		2 436, 593	2, 520 394, 744	113. 00 116. 00 118. 00
190.00 192.00 194.00 194.00 194.02 194.03 194.03 194.05 194.05 194.06 194.06 194.06 194.08 194.09 194.09 194.00	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 77950 RENTAL SPACE 07951 FOUNDATI ON 07952 RETAI L SERVI CES 07953 REI D CONTRACTED SERVI CES 07954 REI D PHYSI CI AN ASSOC. 07955 OTHER NON REI MBURSABLE COST CENTERS 07956 VACANT SPACE 07957 LYNN RHC 07958 CAMBRI DGE RHC 079590 REI D URGENT CARE OF EATON	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 604 379 1, 535 78, 736 0 0 1, 714 1, 760 727 69	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 19, 332 0 0 26 22 0 0 0 0 0	0 0 0 63, 075 0 276 761 294	190.00 192.00 194.01 194.02 194.03 194.03 194.05 194.05 194.05 194.07 194.08 194.09 194.09
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum Lines 118-201)	0 567, 766	0 240, 532	0 89, 529	0 455, 973	0 459, 192	200. 00 201. 00 202. 00

	Financial Systems REID TION OF CAPITAL RELATED COSTS	HOSPITAL & HEA	LTH CARE SERVIC Provider (CCN: 150048 P	In Lie eriod: rom 01/01/2014	u of Form CMS-: Worksheet B Part II	2552-10
				Te		Date/Time Pre	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	PARAMED ED PRGM	<u>3/27/2015 9:5</u> Subtotal	01 am
		16.00	17.00	17.01	23.00	24.00	
1 00	GENERAL SERVICE COST CENTERS						1.00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATIENT TELEPHONES						5.01
5.02	00550 DATA PROCESSING						5.02
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
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	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	100 574					15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	402, 574	90.240				16.00
17.00	01701 I NSERVI CE EDUCATI ON	0	89, 249 0	524, 574			17.00
23.00	02300 PARAMED ED PRGM	0	0	1, 841	128, 139		23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	24, 341	48, 348	143, 248		4, 340, 789	
31.00	03100 I NTENSI VE CARE UNI T	6, 397	11, 481	35, 368		1,077,173	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	7, 512	0	37, 378 10, 051		865, 332 601, 202	
43.00	04300 NURSERY	1, 170	0	5, 047		127, 698	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	71, 292	0	9, 120		3, 198, 810	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 621	473	6, 813		324, 052	1
54.00 59.00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	63, 637 33, 456	0	25, 275 8, 697		3, 213, 438 1, 071, 210	
60.00	06000 LABORATORY	50, 038	0	13, 902		982, 708	
65.00	06500 RESPI RATORY THERAPY	5, 433	0	12, 378		157, 514	
66.00	06600 PHYSI CAL THERAPY	9, 900	0	17, 647		1, 836, 685	
69.00		14,050	0	5, 438		399, 361	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 753 7, 494	0	624 0		192, 839 16, 659	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	15, 432	0	0		66, 266	
73.00	07300 DRUGS CHARGED TO PATIENTS	53, 909	0	0		486, 213	73.00
	07400 RENAL DIALYSIS	440	0	1, 566			74.00
76.00 76.01	03950 OTHER ANCI LLARY SERVI CE COST CENTERS 03952 NEURODI AGNOSTI C	0	0	0		0	
	07697 CARDI AC REHABI LI TATI ON	594	0	1, 619		117, 560	
/0///	OUTPATIENT SERVICE COST CENTERS			1,017		,	
	09100 EMERGENCY	23, 745	28, 947	35, 590		1, 153, 621	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	1 550				217 040	92.00
93.00	OTHER REIMBURSABLE COST CENTERS	1, 558	0	7, 797	I	317, 849	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	3, 504	0	3, 153		241, 709	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
116.00 118.00	11600 HOSPICE	1,489		5, 745	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	402, 574	89, 249	388, 297	0	20, 894, 789	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		131, 881	
	07950 RENTAL SPACE	0	0	0		915, 711	
	07951 FOUNDATI ON 07952 RETAI L SERVI CES	0	0	910 307		20, 351 108, 349	194.01
	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES		0	307			194.02
	07954 REID PHYSICIAN ASSOC.	0	0	84, 162		7, 913, 755	
	07955 OTHER NON REIMBURSABLE COST CENTERS	0	0	44, 181			194.05
	07956 VACANT SPACE	0	0	0		590, 412	
	07957 LYNN RHC 07958 CAMBRI DGE RHC	0	0	2, 380 3, 946			194.07 194.08
	07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC		0	3, 940 0			194.08
	07960 REID URGENT CARE OF EATON	0	0	391			194.10
194.10		1					
200.00					128, 139	128, 139	
	Negative Cost Centers	0 402, 574	0 89, 249	0 524, 574	128, 139 0 128, 139		201.00

	Financial Systems REI	D HOSPITAL & HEALT	Provider CCN		Period:	u of Form CMS Worksheet B	-2552-10
ALLUUAI	TON OF ONE THE REATED COSTS			. 150040	From 01/01/2014 To 12/31/2014	Part II	epared.
					10 12/31/2014	3/27/2015 9:	
	Cost Center Description	Intern & Residents Cost	Total				
		& Post					
		Stepdown					
		Adjustments 25.00	26.00				
	GENERAL SERVICE COST CENTERS						
	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO540 NONPATI ENT TELEPHONES						5. 01
	DO550 DATA PROCESSING						5.02
	DO560 PURCHASING RECEIVING AND STORES						5.03
	DO580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
	00590 OTHER ADMINISTRATIVE AND GENERAL						5.06
	00700 OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING						8. 00 9. 00
	D1000 DI ETARY						10.00
	D1100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
1	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	D1600 MEDICAL RECORDS & LIBRARY						16.00
	D1700 SOCIAL SERVICE						17.00
	D1701 I NSERVI CE EDUCATI ON						17.01
	D2300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS						23.00
	D3000 ADULTS & PEDI ATRI CS	0	4, 340, 789				30.00
	D3100 INTENSIVE CARE UNIT	0	1,077,173				31.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	865, 332 601, 202				40.00
	04300 NURSERY	0	127, 698				43.00
	ANCI LLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	0	3, 198, 810				50.00 52.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	324, 052 3, 213, 438				54.00
	05900 CARDI AC CATHETERI ZATI ON	0	1, 071, 210				59.00
		0	982, 708				60.00
	D6500 RESPI RATORY THERAPY D6600 PHYSI CAL THERAPY	0	157, 514 1, 836, 685				65.00 66.00
	D6900 ELECTROCARDI OLOGY	0	399, 361				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	192, 839				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	16, 659 66, 266				71.00
	D7300 DRUGS CHARGED TO PATIENTS	0	486, 213				73.00
	07400 RENAL DIALYSIS	0	51, 251				74.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.00
	03952 NEURODI AGNOSTI C 07697 CARDI AC REHABI LI TATI ON	0	0 117, 560				76.01
	DUTPATIENT SERVICE COST CENTERS		117, 500				/0. //
	D9100 EMERGENCY	0	1, 153, 621				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	0	317, 849				92.00 93.00
	OTHER REIMBURSABLE COST CENTERS	0	517,047				- 75.00
	D9600 DURABLE MEDICAL EQUIP-RENTED	0	241, 709				96.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	54, 850				116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20, 894, 789				118. 00
	NONREI MBURSABLE COST CENTERS						400 -
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 131, 881				190.00 192.00
	07950 RENTAL SPACE	0	915, 711				192.00
194.01	D7951 FOUNDATI ON	0	20, 351				194.01
	07952 RETAIL SERVICES	0	108, 349				194.02
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	0	3, 228 7, 913, 755				194.03 194.04
	07955 OTHER NON REIMBURSABLE COST CENTERS	0	57, 168				194.04
194.06	D7956 VACANT SPACE	0	590, 412				194.06
	D7957 LYNN RHC	0	25, 273				194.07
	07958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC	0	27, 942 9, 431				194.08 194.09
	07959 MAIN STREET FAMILY RHC 07960 REID URGENT CARE OF EATON	0	1, 590				194.09
200.00	Cross Foot Adjustments	0	128, 139				200.00

Health Financial Systems	REID HOSPITAL & HEAL	TH CARE SERVIO	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150048	Period: From 01/01/2014	Worksheet B Part II	
						pared: 1 am
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
201.00 Negative Cost Centers	0	-2, 964				201.00
202.00 TOTAL (sum lines 118-201)	0	30, 825, 055				202.00

In Lieu of Form CMS-2552-10 od: 01/01/2014 Worksheet B-1

COST A	ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150048	Period:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
		CAP	TAL RELATED C	OSTS		3/27/2015 9:5	1 am
	Cost Center Description		NEW CAP BLDG & FIXT - OFFSITE		EMPLOYEE BENEFI TS	NONPATI ENT TELEPHONES	
		(SQUARE FEET)		(SQUARE FEE		(PHONES)	
			(SQUARE FEET)		(GROSS		
		1.00	1.01	2.00	<u>SALARI ES)</u> 4. 00	5. 01	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	5.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 011, 397					1.00
1.01 2.00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP	0	275, 456		0		1.01 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 069	400		0 126, 484, 325	5	4.00
5.01	00540 NONPATI ENT TELEPHONES	3, 798			0 242, 156	2, 933	5. 01
5.02	00550 DATA PROCESSING	13, 613			0 3, 350, 573		
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	15,650 2,028			0 798, 271 0 310, 565		
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	8, 975			0 389, 781		
5.06	00590 OTHER ADMINISTRATIVE AND GENERAL	32, 143			0 5, 151, 497		
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	186, 326 12, 335			0 1, 834, 776 0 320, 189		
9.00	00900 HOUSEKEEPING	6, 776			0 1, 532, 082		•
10.00	01000 DI ETARY	12, 568			0 1, 402, 969		
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	9,873			0 934, 265 0 579, 767		
13.00	01400 CENTRAL SERVICES & SUPPLY	8, 411			0 605, 359		
15.00	01500 PHARMACY	7, 271	C		0 3, 580, 017		
16.00	01600 MEDI CAL RECORDS & LI BRARY	9, 390			0 447,679		
17.00 17.01	01700 SOCI AL SERVI CE 01701 I NSERVI CE EDUCATI ON	1, 241 10, 409			0 701, 151 0 786, 728		
23.00	02300 PARAMED ED PRGM	3, 741	2,680		0 201, 704		
	INPATIENT ROUTINE SERVICE COST CENTERS	I	-	1			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	109, 246 24, 552			0 13, 429, 581 0 3, 626, 044		
40.00	04000 SUBPROVI DER – I PF	22, 340			0 3, 642, 332		
41.00	04100 SUBPROVI DER – I RF	17, 898			0 1, 270, 182		
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 681	C		0 537, 390	0 0	43.00
50.00	05000 OPERATING ROOM	61, 557	13, 091		0 2,035,318	189	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 316			0 657, 686		
54.00		62, 380			0 5, 341, 593 0 1, 430, 115		•
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 579 13, 945			0 1, 430, 115 0 3, 452, 520		
65.00	06500 RESPIRATORY THERAPY	1,647	c		0 1, 490, 460		
66.00	06600 PHYSI CAL THERAPY	50, 400	42, 316		0 4, 644, 395		
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	7,011	3, 892		0 971, 950 0 198, 975		•
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0,072			0 0		
	07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	° .	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 490				0 0	•
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0 0	
76.01	03952 NEURODI AGNOSTI C	0	C		0 0	0	
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	4, 523	C	0	0 191, 742	2 12	76.97
91.00		22, 772	C		0 4, 600, 978	8 82	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS	9, 782	847		0 1, 573, 472	2 57	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	4, 646	2, 872	2	0 785, 831	25	96.00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 I NTEREST EXPENSE				0 075 4/4	10	113.00
116.00) 11600 HOSPI CE) SUBTOTALS (SUM OF LINES 1-117)	445 792, 674			0 975, 466 0 74, 025, 559		116. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	172,011	, , , , , , , , , , , , , , , , , , , ,		0 , 1, 020, 007	2,120	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0)	0 0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE	2, 705 19, 030			0 15		192. 00 194. 00
	07951 FOUNDATION	206			0 175, 677		194.00
194.02	07952 RETAIL SERVICES	2, 340			0 86, 158	3 0	194. 02
	07953 REID CONTRACTED SERVICES	175 257			0 411,899		194.03
	07954 REID PHYSICIAN ASSOC. 07955 OTHER NON REIMBURSABLE COST CENTERS	175, 357 532			0 49, 816, 988 0 27, 683		194. 04 194. 05
194.06	07956 VACANT SPACE	18, 553			0 0	0	194.06
	07957 LYNN RHC	0			0 627, 209		194.07
	307958 CAMBRIDGE RHC 07959 MAIN STREET FAMILY RHC	0			0 889, 750 0 392, 601		194. 08 194. 09
174.05	I STALL TAWELT AND THE AND	0		1	J J72, 001	U U	1174.07

Health Fina	ancial Systems REII	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014		
		CAP	ITAL RELATED CO	OSTS			
	Cost Center Description	FLXT	NEW CAP BLDG & FIXT - OFFSITE	EQUI P	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARI ES)	(PHONES)	
		1.00	1.01	2.00	4.00	5. 01	
194.100796	50 REID URGENT CARE OF EATON	0	0	(30, 786	0	194.10
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)	18, 579, 018	1, 793, 058	-2, 96	4 13, 220, 643	358, 202	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 369659	6. 509417	0.00000	0. 104524	122. 128196	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				83, 378	71, 775	204.00
205.00	Unit cost multiplier (Wkst. B, Part)				0. 000659	24. 471531	205.00

Health Financial Systems REID COST ALLOCATION - STATISTICAL BASIS	HUSPITAL & HEF	ALTH CARE SERVIO Provider	CCN: 150048 P	eri od:	of Form CMS-2 Worksheet B-1	2002-11
			FI To	rom 01/01/2014 o 12/31/2014	Date/Time Pre	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC R	3/27/2015 9:5 econciliation	1 am
	PROCESSI NG (TERMI NALS)	RECEI VI NG AND STORES	(TOTAL REVENUE)	OUNTS RECEI VABLE		
	(TERMINALS)	(SUPPLY	KEVENUE)	(TOTAL		
	5.02	EXPENSE) 5.03	5.04	REVENUE) 5. 05	5A. 06	
GENERAL SERVICE COST CENTERS	5.02	5.03	5.04	5.05	5A. 00	
. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
01 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.0 ¹ 2.00
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
. 01 00540 NONPATI ENT TELEPHONES						5.0
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES	2, 283					5.02 5.03
04 00570 ADMI TTI NG	35		659, 424, 656			5.04
. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	15		0	659, 424, 656		5.0
. 06 00590 OTHER ADMINI STRATI VE AND GENERAL . 00 00700 OPERATI ON OF PLANT	28		0	0	-19, 113, 136 0	5.0 7.0
. 00 00800 LAUNDRY & LINEN SERVICE	2		0	0	0	8.0
. 00 00900 HOUSEKEEPI NG	3		0	0	0	9.0
0. 00 01000 DI ETARY 1. 00 01100 CAFETERIA	34		0	0	0	10.0
1. 00 01100 CAFETERI A 3. 00 01300 NURSI NG ADMI NI STRATI ON	14	-	0	0	0	11.0 13.0
4.00 01400 CENTRAL SERVICES & SUPPLY	12		0	0	0	14.0
	40		0	0	0	15.0
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	84		0	0	0	16.00 17.00
17. 01 01701 I NSERVI CE EDUCATI ON	148		0	0	0	17.0
23.00 02300 PARAMED ED PRGM	10	3, 280	0	0	0	23.0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	238	674, 447	39, 904, 014	39, 904, 014	0	30.00
1. 00 03100 I NTENSI VE CARE UNI T	35		10, 487, 397	10, 487, 397	0	31.0
IO. 00 04000 SUBPROVI DER – I PF	15		12, 314, 444	12, 314, 444	0	40.0
11. 00 04100 SUBPROVIDER - IRF 13. 00 04300 NURSERY	28		2, 966, 381 1, 918, 280	2, 966, 381 1, 918, 280	0	41.0 43.0
ANCI LLARY SERVICE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	1, 710, 200	1, 710, 200	0	+5.00
50.00 05000 OPERATING ROOM	87		116, 337, 791	116, 337, 791	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	32		5, 936, 353 104, 322, 539	5, 936, 353 104, 322, 539	0	52.0 54.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	102		54, 845, 480	54, 845, 480	0	59.00
0. 00 06000 LABORATORY	58		82, 029, 174	82, 029, 174	0	60.0
55. 00 06500 RESPI RATORY THERAPY 56. 00 06600 PHYSI CAL THERAPY	12		8, 906, 792 16, 229, 687	8, 906, 792 16, 229, 687	0	65. 0 66. 0
9. 00 06900 ELECTROCARDI OLOGY	49		23, 032, 573	23, 032, 573	0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	8	4, 849	2, 873, 626	2, 873, 626	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		-	12, 284, 550		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS			25, 298, 988 88, 375, 657	25, 298, 988 88, 375, 657	0	72.0 73.0
74.00 07400 RENAL DIALYSIS	2	14, 373	721, 849	721, 849	0	74.0
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	C	0	0	0	0	
76. 01 03952 NEURODI AGNOSTI C 76. 97 07697 CARDI AC REHABI LI TATI ON	2	6, 594	0 973, 310	973, 310	0	76.0 76.9
OUTPATIENT SERVICE COST CENTERS						
1.00 09100 EMERGENCY	75	344, 646	38, 926, 930	38, 926, 930	0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 23.00 04040 PATIENT CARE CENTER - OCC	39	52, 544	2, 554, 256	2, 554, 256	0	92.0 93.0
OTHER REIMBURSABLE COST CENTERS		02,011	2,001,200	2,001,200	0	70.0
26. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	12	304, 854	5, 743, 948	5, 743, 948	0	96. 0
SPECIAL PURPOSE COST CENTERS 13.00 11300 INTEREST EXPENSE		1				113. 0
16. 00 11600 HOSPI CE	3	274, 667	2, 440, 637	2, 440, 637		116.0
18.00 SUBTOTALS (SUM OF LINES 1-117)	1, 652		659, 424, 656		-19, 113, 136	118. 0
NONREI MBURSABLE COST CENTERS 90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			0	0	0	190. 0
92. 00 19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1	12, 957	0	0		190.0
94.0007950 RENTAL SPACE	C	73, 283	0	0	0	194.0
94. 01 07951 FOUNDATI ON	6	5, 270	0	0		194.0
94. 02 07952 RETAIL SERVI CES 94. 03 07953 REID CONTRACTED SERVI CES	36	8, 213	0	0		194. 0 194. 0
94. 04 07954 REID PHYSICIAN ASSOC.	588	778, 403	0	0		194. 0 194. 0
94.0507955 OTHER NON REIMBURSABLE COST CENTERS	C	0	0	О		194. 0
194. 06 07956 VACANT_SPACE 194. 07 07957 LYNN_RHC	0		0	0		194. 0 194. 0
194. 07 07957 LYNN RHC 194. 08 07958 CAMBRI DGE RHC		25, 015 25, 829	0	0		194.0
94.09 07959 MAIN STREET FAMILY RHC		12, 208	0	0	0	194. 09
94. 10 07960 REID URGENT CARE OF EATON	C	2, 801	0	0		194.1
200.00 Cross Foot Adjustments						200. 0

Heal th Fi	nancial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	
		PROCESSI NG	RECEIVING AND	(TOTAL	OUNTS		
		(TERMI NALS)	STORES	REVENUE)	RECEI VABLE		
			(SUPPLY		(TOTAL		
			EXPENSE)		REVENUE)		
		5.02	5.03	5.04	5.05	5A. 06	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	19, 654, 120	3, 647, 904	2, 549, 14	5 5, 308, 081		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8, 608. 900569	0. 376709	0.00386	6 0. 008050		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	3, 729, 767	691, 931	118, 47	9 271, 453		204.00
205.00	Unit cost multiplier (Wkst. B, Part)	1, 633. 713097	0. 071454	0. 00018	0 0. 000412		205.00

OST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2014		
		1		1	o 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		(ACCUM. COST) 5.06	7.00	LAUNDRY) 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
00 01 00 01 02 03 04 05 06 00 00 00 00 00 00 00 00 00 00 00 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	313, 057, 224 8, 492, 901 1, 030, 263 2, 461, 020 2, 085, 709 577, 513 1, 114, 106 3, 532, 320 27, 099, 420 4, 751, 847	620, 267 12, 335 6, 490 11, 035 9, 873 1, 955 8, 411	738, 878 C C C C C C C C C C C C) 16, 382 282 0 0 805 0 10 0 0	53, 613 0 0 0 0	11. 0 13. 0 14. 0 15. 0
. 00	01700 SOCIAL SERVICE	2, 670, 495					
7.01	01701 I NSERVI CE EDUCATI ON	2, 590, 205					17.0
3. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	378, 920	2, 807		0	0	23.0
D. 00	03000 ADULTS & PEDI ATRI CS	22, 287, 941	108, 140	216, 917	4, 564	30, 627	30.0
1.00	03100 I NTENSI VE CARE UNI T	6, 096, 644					
). 00 . 00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	5, 211, 802 2, 229, 462					
. 00	04300 NURSERY	787, 672					
	ANCI LLARY SERVICE COST CENTERS					-	
0. 00 1. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	28, 296, 396 1, 458, 011	40, 624 8, 316				50. C
. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 209, 766					54.0
9.00	05900 CARDI AC CATHETERI ZATI ON	6, 780, 444	4, 593	34, 191	152		59. C
0.00		11, 780, 971					60.0
. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 450, 765 8, 229, 826		-			65. C
. 00	06900 ELECTROCARDI OLOGY	2, 530, 405				-	
0.00	07000 ELECTROENCEPHALOGRAPHY	504, 897	5, 400				
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	146, 383 13, 270, 550		-			
	07300 DRUGS CHARGED TO PATIENTS	1, 053, 084			193		
. 00	07400 RENAL DIALYSIS	739, 032		C			74. C
0.00	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0		
	03952 NEURODI AGNOSTI C 07697 CARDI AC REHABI LI TATI ON	377, 727	0				
	OUTPATIENT SERVICE COST CENTERS		-				
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 018, 183	22, 772	104, 004	1, 301	0	91. C 92. C
	04040 PATIENT CARE CENTER - OCC	2, 532, 581	405	2, 311	601	0	
	OTHER REIMBURSABLE COST CENTERS					1	1
. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	2,005,823	3, 752		10	0	96. C
3.00	SPECIAL PURPOSE COST CENTERS						113.0
6.00	11600 HOSPI CE	1, 911, 646		C			116. C
8.00		201, 694, 730	440, 497	738, 761	15, 357	53, 613	118. C
0 00	NONREIMBURSABLE COST CENTERS	0	0	0) 0	0	190. C
	19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 218, 755	-	-			192.0
	07950 RENTAL SPACE	2, 498, 848					194. C
	07951 FOUNDATION 07952 RETAIL SERVICES	476, 551 470, 766	206 684				194. C 194. C
	07953 REID CONTRACTED SERVICES	526, 440					194. C
4.04	07954 REID PHYSICIAN ASSOC.	101, 721, 129	129, 804			0	194. C
	07955 OTHER NON REIMBURSABLE COST CENTERS	46, 310			0		194. C
	07956 VACANT SPACE 07957 LYNN RHC	452, 566 915, 259					194. C 194. C
	07958 CAMBRI DGE RHC	1, 434, 995			0		194. C
4.09	07959 MAIN STREET FAMILY RHC	551, 983		C	0	0	194.0
	07960 REID URGENT CARE OF EATON	48, 892	0	0	0	0	194.1
0.00 1.00							200. 0 201. 0

Heal th	Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	OTHER	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		ADMI NI STRATI VE	PLANT	LINEN SERVICE	E (HOURS OF	(MEALS SERVED)	
		AND GENERAL	(SQUARE FEET)	(POUNDS OF	SERVICE)		
		(ACCUM. COST)		LAUNDRY)			
		5.06	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per Wkst. B,	19, 113, 136	9, 011, 418	1, 272, 37	0 2, 705, 562	2, 419, 942	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0.061053	14. 528289	1. 72203	0 165. 154560	45. 137224	203.00
204.00	Cost to be allocated (per Wkst. B,	845, 804	3, 580, 490	409, 93	2 197, 781	567, 766	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0.002702	5. 772498	0. 55480	3 12.073068	10. 590081	205.00
	11)						

Health Financial	Systems	
MOLTADOLIA T200		1

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-
COST ALLOCATION - STATISTICAL BASIS			CCN: 150048 Pe	eriod:	Worksheet B-1	
			Fi To	rom 01/01/2014 0 12/31/2014	Date/Time Pre	naroo
				0 12/31/2014	3/27/2015 9:5	1 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(MANHOURS)	ADMI NI STRATI ON		(DRUGS)	RECORDS &	
		(DI RECT	SUPPLY (MED_SUPPLIES)		LI BRARY (TOTAL	
		NURSING HRS)	(MED SUPPLIES)		REVENUE)	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS		1				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1. (
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE						1. (
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.0
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG						5. (5. (
5. 03 00560 PURCHASING RECEIVING AND STORES						5.0
5. 04 00570 ADMI TTI NG						5.0
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.0
5. 06 00590 OTHER ADMINISTRATIVE AND GENERAL						5.0
7.00 00700 OPERATION OF PLANT						7.0
3. 00 00800 LAUNDRY & LINEN SERVICE						8. (
9. 00 00900 HOUSEKEEPI NG						9. (
10. 00 01000 DI ETARY	0 504 700					10.0
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	3, 531, 703					11. (
14. 00 01400 CENTRAL SERVICES & SUPPLY	8, 188 42, 184					14. (
15. 00 01500 PHARMACY	120, 386			26, 308, 751		15. (
16.00 01600 MEDICAL RECORDS & LIBRARY	0			20,000,701	659, 424, 656	
17.00 01700 SOCIAL SERVICE	0		-	0	0	
17.01 01701 INSERVICE EDUCATION	30, 583	0	780	0	0	17. (
23. 00 02300 PARAMED ED PRGM	5, 594	0	110	0	0	23. (
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS	499, 928			8, 431	39, 904, 014	
31. 00 03100 I NTENSI VE CARE UNI T	127, 701	127, 701		2, 307	10, 487, 397	
0.00 04000 SUBPROVIDER - IPF	155, 537			1, 249	12, 314, 444	
I 1. 00 04100 SUBPROVI DER – I RF I 3. 00 04300 NURSERY	42, 642 17, 668			429 0	2, 966, 381 1, 918, 280	
ANCI LLARY SERVICE COST CENTERS	17,000	17,000		<u> </u>	1, 710, 200	45.0
50. 00 05000 OPERATING ROOM	204, 653	204, 653	8, 433, 103	186, 871	116, 337, 791	50. (
52.00 05200 DELIVERY ROOM & LABOR ROOM	22, 591			1, 701	5, 936, 353	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	192, 441	192, 441	15, 768	486, 511	104, 322, 539	54.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	50, 314	50, 314	7, 004, 174	2, 970	54, 845, 480	59. (
50. 00 06000 LABORATORY	155, 266		., .==, =	42	82, 029, 174	
55. 00 06500 RESPI RATORY THERAPY	53, 863			20, 626	8, 906, 792	
66. 00 06600 PHYSI CAL THERAPY	163, 414		.,	309	16, 229, 687	
59. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	35, 422 7, 046		0	210, 121	23, 032, 573 2, 873, 626	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				0	12, 284, 550	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0		-	0	25, 298, 988	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	21, 474, 229	88, 375, 657	
74.00 07400 RENAL DI ALYSI S	0	C	0	438	721, 849	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTER	RS O	0	0	0	0	76.
6. 01 03952 NEURODI AGNOSTI C	0	-	0 0	0	0	
6. 97 07697 CARDI AC REHABI LI TATI ON	7,403	7,403	0	0	973, 310	76. 9
OUTPATIENT SERVICE COST CENTERS	100 740	100.740		74 740		
21.00 09100 EMERGENCY	188, 710	188, 710	842	74, 712	38, 926, 930	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR 23.00 04040 PATIENT CARE CENTER - OCC	65, 569	C	0	998	2, 554, 256	92.
OTHER REIMBURSABLE COST CENTERS	00, 309	. 0	¹ 0	778	2, 334, 230	73.1
26. 00 09600 DURABLE MEDICAL EQUIP-RENTED	43, 906	C	857, 851	0	5, 743, 948	96.
SPECIAL PURPOSE COST CENTERS	,				2, 1.0, 710	1
113.0011300 INTEREST EXPENSE						113.
16. 00 11600 HOSPI CE	34, 943			144, 379	2, 440, 637	
18.00 SUBTOTALS (SUM OF LINES 1-117)	2, 275, 952	1, 563, 451	17, 762, 298	22, 616, 328	659, 424, 656	118.
NONREI MBURSABLE COST CENTERS						1100
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE 92. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	N 0			0		190. 192.
94. 00 07950 RENTAL SPACE			-	0		192.
94. 01 07951 FOUNDATI ON	8, 862	-		0		194.
94. 02 07952 RETAIL SERVICES	5, 571		0	0		194.
94. 03 07953 REI D CONTRACTED SERVICES	22, 543		o o	o		194.
94. 04 07954 REID PHYSICIAN ASSOC.	1, 156, 058		786, 512	3, 613, 792		194.
94.05 07955 OTHER NON REIMBURSABLE COST CENTER		0		0	0	194.
94.06 07956 VACANT SPACE	0	0	0	0		194.
94.0707957 LYNN RHC	25, 171		1, 050	15, 790		194.
194. 08 07958 CAMBRI DGE RHC	25, 849		900	43, 614		194.
194. 09 07959 MAIN STREET FAMILY RHC	10, 677		-	16, 820		194.
194.10 07960 RELD URGENT CARE OF EATON 200.00 Cross Foot Adjustments	1, 019	C	0	2, 407	0	194. ⁻ 200. (
AND AND THROSE FOOT ANTIETMONTS	1	1	1			12000

Health Fi	nancial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provi der	CCN: 150048	Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MANHOURS)	ADMI NI STRATI ON	SERVICES &	(DRUGS)	RECORDS &	
				SUPPLY		LI BRARY	
			(DI RECT	(MED_SUPPLIES	5)	(TOTAL	
			NURSING HRS)			REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	756, 210	1, 345, 231	3, 880, 86	28, 882, 774	5, 069, 909	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 214120	0. 860424	0. 20920	1. 097839	0. 007688	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	240, 532	89, 529	455, 97	73 459, 192	402, 574	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 068107	0. 057264	0. 02458	0. 017454	0.000610	205.00

ST ALLOCATION - STATISTICAL		D HOSPI TAL & HEAL		CCN: 150048	Peri od:	eu of Form CMS-255 Worksheet B-1
					From 01/01/2014 To 12/31/2014	Date/Time Prepar
Cost Center Descri	ption	SOCI AL SERVI CE	I NSERVI CE	PARAMED ED		<u>3/27/2015 9:51 a</u>
	•		EDUCATI ON	PRGM		
		(TIME SPENT) 17.00	(IN HOUSE ED) 17.01	(TIME SPENT) 23.00	_	
GENERAL SERVICE COST CEN	ITERS	17.00	17.01	20.00		
00 00100 NEW CAP REL COSTS-						
01 00101 NEW CAP BLDG & FLX						
00 00200 NEW CAP REL COSTS- 00 00400 EMPLOYEE BENEFITS						
01 00540 NONPATIENT TELEPHO						
02 00550 DATA PROCESSI NG						
03 00560 PURCHASING RECEIVI	NG AND STORES					
00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNT	S RECEIVARIE					
00590 OTHER ADMINI STRATI						
00700 OPERATION OF PLANT						
DO 00800 LAUNDRY & LINEN SE	RVI CE					
00 00900 HOUSEKEEPI NG						
. 00 01000 DI ETARY . 00 01100 CAFETERI A						1
. 00 01300 NURSI NG ADMI NI STRA	TION					1
.00 01400 CENTRAL SERVICES &	SUPPLY					1
00 01500 PHARMACY						1
. 00 01600 MEDICAL RECORDS & . 00 01700 SOCIAL SERVICE	LI BRARY	6, 040				1
01 01701 INSERVICE EDUCATIO	N	0, 040	49, 583			1
00 02300 PARAMED ED PRGM		0	174	1	0	2
INPATIENT ROUTINE SERVIC		11		1	-1	
. 00 03000 ADULTS & PEDIATRIC		3, 272 777	13, 540		0	3
. 00 03100 I NTENSI VE CARE UNI . 00 04000 SUBPROVI DER - I PF	I	0	3, 343 3, 533		0	3
00 04100 SUBPROVIDER - IRF		0	950		0	4
00 04300 NURSERY		0	477		0	4
ANCI LLARY SERVICE COST C	ENTERS					
. 00 05000 0PERATING ROOM . 00 05200 DELIVERY ROOM & LA		0 32	862 644		0	5
. 00 05400 RADI OLOGY-DI AGNOST		0	2, 389		-	5
00 05900 CARDI AC CATHETERI Z		0	822		0	5
00 06000 LABORATORY	.,	0	1, 314		0	6
. 00 06500 RESPI RATORY THERAP . 00 06600 PHYSI CAL THERAPY	Y	0	1, 170 1, 668		0	6
. 00 06900 ELECTROCARDI OLOGY		0	514	1	0	6
00 07000 ELECTROENCEPHALOGR	APHY	0	59		0	7
00 07100 MEDICAL SUPPLIES C		0	0		0	7
00 07200 I MPL. DEV. CHARGED 00 07300 DRUGS CHARGED TO P		0	0		0	7
00 07400 RENAL DIALYSIS	ATTENTS	0	148		0	7
00 03950 OTHER ANCILLARY SE	RVICE COST CENTERS	0	0	1	0	7
. 01 03952 NEURODI AGNOSTI C		0	0		0	7
. 97 07697 CARDI AC REHABI LI TA		0	153		0	7
. 00 09100 EMERGENCY	CENTERS	1, 959	3, 364		0	9
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 707	0,001			9.
00 04040 PATIENT CARE CENTE		0	737		0	9
OTHER REIMBURSABLE COST			200	1		
. 00 09600 DURABLE MEDICAL EQ SPECIAL PURPOSE COST CEN		0	298	i	0	9
3. 00 11300 I NTEREST EXPENSE	ITERS					11
6. 00 11600 HOSPI CE		0	543		0	11
8.00 SUBTOTALS (SUM OF		6, 040	36, 702	10	0	11
NONREI MBURSABLE COST CEN			~	1	ol	10
D. 00 19000 GLFT, FLOWER, COFF 2. 00 19200 PHYSI CLANS' PRI VAT		0	0		0	19 19
4. 00 07950 RENTAL SPACE		0	0		0	19
4. 01 07951 FOUNDATI ON		0	86	1	0	19
1. 02 07952 RETAIL SERVICES		0	29		0	19
4.03 07953 REID_CONTRACTED_SE 4.04 07954 REID_PHYSICIAN_ASS		0	0 7, 955		0	19 19
4. 05 07955 OTHER NON REIMBURS		0	4, 176		ŏ	19
4. 06 07956 VACANT SPACE		0	0	1	0	19
4. 07 07957 LYNN RHC		0	225		0	19
4.0807958 CAMBRIDGE RHC		0	373		0	19
4.0907959 MAIN STREET FAMILY 4.1007960 REID URGENT CARE 0		0	0 37		0	19 19
0.00 Cross Foot Adjustm			57		~	20
1.00 Negative Cost Cent		1		1		20

Health Fina	ncial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
						Date/Time Pre	epared: 51 am
	Cost Center Description	SOCI AL SERVI CE	I NSERVI CE	PARAMED ED			
			EDUCATI ON	PRGM			
		(TIME SPENT)	(IN HOUSE ED)	(TIME SPENT))		
		17.00	17.01	23.00			
202.00	Cost to be allocated (per Wkst. B,	2, 847, 827	2, 914, 767	454, 28	35		202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	471. 494536	58. 785612	4, 542. 85000	00		203.00
204.00	Cost to be allocated (per Wkst. B,	89, 249	524, 574	128, 13	39		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	14. 776325	10. 579715	1, 281. 39000	00		205.00
	11)						

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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared:
		Titl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	i	1	_		
30. 00 03000 ADULTS & PEDIATRICS	30, 921, 840		30, 921, 84		30, 921, 840	
31.00 03100 INTENSIVE CARE UNIT	8, 118, 028		8, 118, 02		8, 118, 028	
40. 00 04000 SUBPROVIDER - IPF	7, 119, 870		7, 119, 87	0 0	7, 119, 870	
41. 00 04100 SUBPROVIDER – IRF	3, 016, 010		3, 016, 01	0 0	3, 016, 010	41.00
43. 00 04300 NURSERY	1, 094, 274		1, 094, 27	74 0	1, 094, 274	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	34, 242, 544		34, 242, 54	4 0	34, 242, 544	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 850, 097		1, 850, 09	97 0	1, 850, 097	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 224, 799		20, 224, 79	09 0	20, 224, 799	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 337, 705		9, 337, 70	05 0	9, 337, 705	59.00
60. 00 06000 LABORATORY	13, 801, 126		13, 801, 12	26 0	13, 801, 126	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 850, 455	0	2, 850, 45	55 0	2, 850, 455	65.00
66. 00 06600 PHYSI CAL THERAPY	9, 831, 913		9, 831, 9		9, 831, 913	
69. 00 06900 ELECTROCARDI OLOGY	3, 173, 553		3, 173, 55		3, 173, 553	
70.00 07000 ELECTROENCEPHALOGRAPHY	645, 246		645, 24		645, 246	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	270, 243		270, 24		270, 243	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 275, 256		14, 275, 25		14, 275, 256	
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 403, 932		25, 403, 93		25, 403, 932	
74. 00 07400 RENAL DIALYSIS	860, 497		860, 49		860, 497	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	000,177		000, 1	0 0	000, 177	
76. 01 03952 NEURODI AGNOSTI C				0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	435, 129		435, 12		435, 129	
OUTPATIENT SERVICE COST CENTERS	433, 127		433, 12	- 7	433, 127	/0. //
91. 00 09100 EMERGENCY	10, 938, 178		10, 938, 17	78 0	10, 938, 178	91 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 152, 074		2, 152, 07		2, 152, 074	
93. 00 04040 PATIENT CARE CENTER - OCC	2, 132, 074		2, 132, 01		2, 132, 074	
OTHER REIMBURSABLE COST CENTERS	2,074,423		2,074,42	.5	2,074,423	75.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2, 434, 989		2, 434, 98	39 0	2, 434, 989	96 00
SPECIAL PURPOSE COST CENTERS	2,434,707	1	2,434,70	,, 0	2,434,707	70.00
113. 00 11300 I NTEREST EXPENSE						1113.00
116. 00 11600 HOSPI CE	2, 262, 722		2, 262, 72	22	2, 262, 722	
200.00 Subtotal (see instructions)	208, 134, 903					
201.00 Less Observation Beds	2, 152, 074		2, 152, 07		2, 152, 074	
202.00 Total (see instructions)	205, 982, 829					
	203, 702, 027	1 0	203, 702, 02	-/ 0	205, 702, 029	202.00

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared: 1 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 1					
30. 00 03000 ADULTS & PEDI ATRI CS	37, 287, 937		37, 287, 93	57		30.00
31. 00 03100 I NTENSI VE CARE UNI T	10, 487, 397		10, 487, 39			31.00
40. 00 04000 SUBPROVIDER - IPF	12, 314, 444		12, 314, 44			40.00
41. 00 04100 SUBPROVIDER - IRF	2, 966, 381		2, 966, 38			41.00
43. 00 04300 NURSERY	1, 918, 280		1, 918, 28			43.00
ANCI LLARY SERVI CE COST CENTERS	.,,		.,,	· - 1		1
50. 00 05000 OPERATI NG ROOM	43, 347, 096	72, 990, 695	116, 337, 79	0. 294337	0. 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 997, 147	1, 939, 206			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 244, 856	86,077,683			0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 271, 985	38, 573, 495			0. 000000	
60. 00 06000 LABORATORY	33, 285, 122	48, 744, 052			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	7, 624, 256	1, 282, 536			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	5, 384, 801	10, 844, 886			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	4, 126, 968	18, 905, 605			0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 120, 900	2, 868, 942			0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 339, 329	5, 945, 221			0.000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 312, 695	10, 986, 293			0. 000000	
73. 00 07200 DRUGS CHARGED TO PATIENTS	38, 832, 646	49, 543, 011			0. 000000	
74. 00 07400 RENAL DIALYSIS	654, 335	49, 543, 011 67, 514			0. 000000	
			/21,04	0 0.000000	0. 000000	
76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 76. 01 03952 NEURODI AGNOSTI C	0	0		0 0.000000	0. 000000	
	-	0	072.21			
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 288	972, 022	973, 31	0 0. 447061	0. 000000	76.97
	(001 150	22 025 772	20.02/.02		0,000000	01 00
91.00 09100 EMERGENCY	6, 891, 158				0.00000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	404, 840	2, 211, 237			0.00000	
93. 00 04040 PATIENT CARE CENTER - OCC	0	2, 554, 256	2, 554, 25	6 1.125346	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	5, 743, 948	5, 743, 94	8 0. 423923	0.00000	96.00
SPECIAL PURPOSE COST CENTERS	1 1					
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	671, 615	1, 769, 022				116.00
200.00 Subtotal (see instructions)	265, 369, 260	394, 055, 396	659, 424, 65	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	265, 369, 260	394,055,396	659, 424, 65	6		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Peri od: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared 3/27/2015 9:51 am	ed:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·		
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					. 00
31.00 03100 INTENSIVE CARE UNIT				31.	
40. 00 04000 SUBPROVIDER – IPF				40.	. 00
41.00 04100 SUBPROVIDER – IRF				41.	. 00
43. 00 04300 NURSERY				43.	. 00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 294337			50.	. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 311655			52.	. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 193868			54.	. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 170255			59.	. 00
60. 00 06000 LABORATORY	0. 168247			60.	. 00
65. 00 06500 RESPI RATORY THERAPY	0. 320032			65.	. 00
66. 00 06600 PHYSI CAL THERAPY	0. 605798			66.	. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 137785			69.	. 00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 224541			70.	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.021999			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.564262			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 287454			73.	. 00
74.00 07400 RENAL DIALYSIS	1. 192073			74.	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000			76.	. 00
76. 01 03952 NEURODI AGNOSTI C	0.000000			76.	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 447061			76.	
OUTPATIENT SERVICE COST CENTERS	I				
91. 00 09100 EMERGENCY	0. 280993			91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.822634			92.	. 00
93.00 04040 PATIENT CARE CENTER - OCC	1. 125346			93.	. 00
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 423923			96.	. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE				113.	. 00
116.00 11600 HOSPI CE				116.	
200.00 Subtotal (see instructions)				200.	
201.00 Less Observation Beds				201.	. 00
202.00 Total (see instructions)				202.	. 00

		HUSPITAL & HEF				U OI FOI III CIVIS-	2002-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
					From 01/01/2014	Part I	
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared:
			т: 4		11		or am
				le XIX	Hospi tal	Cost	
		T 1 1 0 1		T 1 1 0 1	Costs	T 0	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)				-	
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS	-1	i				
	00 ADULTS & PEDIATRICS	30, 921, 840		30, 921, 84	0 0	30, 921, 840	
	DO INTENSIVE CARE UNIT	8, 118, 028		8, 118, 02	.8 0	8, 118, 028	31.00
40.00 0400	00 SUBPROVIDER - IPF	7, 119, 870		7, 119, 87	0 0	7, 119, 870	40.00
41.00 0410	00 SUBPROVIDER - IRF	3, 016, 010		3, 016, 01	0 0	3, 016, 010	
43.00 0430	00 NURSERY	1, 094, 274		1, 094, 27	4 0	1, 094, 274	43.00
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	34, 242, 544		34, 242, 54	4 0	34, 242, 544	50.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	1, 850, 097		1, 850, 09	0 0	1, 850, 097	52.00
	DO RADI OLOGY-DI AGNOSTI C	20, 224, 799		20, 224, 79		20, 224, 799	
	O CARDI AC CATHETERI ZATI ON	9, 337, 705		9, 337, 70		9, 337, 705	
	DO LABORATORY	13, 801, 126		13, 801, 12		13, 801, 126	
	O RESPIRATORY THERAPY	2, 850, 455				2, 850, 455	
	O PHYSI CAL THERAPY	9, 831, 913				9, 831, 913	
	DO ELECTROCARDI OLOGY	3, 173, 553		3, 173, 55		3, 173, 553	
	00 ELECTROENCEPHALOGRAPHY	645, 246		645, 24		645, 246	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	270, 243		270, 24		270, 243	
	00 IMPL. DEV. CHARGED TO PATIENT	14, 275, 256		14, 275, 25		14, 275, 256	
	DO DRUGS CHARGED TO PATIENTS	25, 403, 932		25, 403, 93		25, 403, 932	
	00 RENAL DI ALYSI S	860, 497		860, 49		860, 497	
	O OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
	2 NEURODI AGNOSTI C	0			0 0	0	
	27 CARDI AC REHABI LI TATI ON	435, 129		435, 12	9 0	435, 129	76.97
	ATIENT SERVICE COST CENTERS	-					
	DO EMERGENCY	10, 938, 178		10, 938, 17			
92.00 0920	00 OBSERVATION BEDS (NON-DISTINCT PART)	2, 152, 074		2, 152, 07	4	2, 152, 074	92.00
93.00 0404	O PATIENT CARE CENTER - OCC	2, 874, 423		2, 874, 42	3 0	2, 874, 423	93.00
OTHE	R REIMBURSABLE COST CENTERS						
96.00 0960	O DURABLE MEDICAL EQUIP-RENTED	2, 434, 989		2, 434, 98	9 0	2, 434, 989	96.00
SPEC	I AL PURPOSE COST CENTERS		·	·			
113.00 1130	00 INTEREST EXPENSE						113.00
116.001160		2, 262, 722		2, 262, 72	2	2, 262, 722	
200.00	Subtotal (see instructions)	208, 134, 903					
201.00	Less Observation Beds	2, 152, 074		2, 152, 07		2, 152, 074	
202.00	Total (see instructions)	205, 982, 829					
202.00		200, 702, 027		1 200, 702, 02	0	200, 702, 027	1-02.00

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Health Financial Systems REID	HOSPITAL & HEAL	_TH CARE SERVIO	CES	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			CCN: 150048	Period: From 01/01/2014 To 12/31/2014		pared: 1 am
			le XIX	Hospi tal	Cost	
Cost Center Description	Inpati ent	Charges Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	37, 287, 937		37, 287, 93	7		30.00
31.00 03100 INTENSIVE CARE UNIT	10, 487, 397		10, 487, 39	7		31.00
40. 00 04000 SUBPROVIDER - IPF	12, 314, 444		12, 314, 44	4		40.00
41.00 04100 SUBPROVIDER - IRF	2, 966, 381		2, 966, 38	1		41.00
43. 00 04300 NURSERY	1, 918, 280		1, 918, 28	0		43.00
ANCI LLARY SERVI CE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	43, 347, 096	72, 990, 695	116, 337, 79	0. 294337	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 997, 147	1, 939, 206	5, 936, 35	0. 311655	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 244, 856	86,077,683		9 0. 193868	0, 000000	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 271, 985	38, 573, 495	54, 845, 48	0. 170255	0, 000000	59.00
60. 00 06000 LABORATORY	33, 285, 122	48, 744, 052			0,000000	60.00
65. 00 06500 RESPI RATORY THERAPY	7, 624, 256	1, 282, 536			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 384, 801	10, 844, 886			0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	4, 126, 968	18, 905, 605				
70.00 07000 ELECTROENCEPHALOGRAPHY	4, 684	2, 868, 942			0.000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 339, 329	5, 945, 221				
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	14, 312, 695	10, 986, 293			0, 000000	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	38, 832, 646	49, 543, 011				
74. 00 07400 RENAL DIALYSIS	654, 335	67, 514				
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0//0/1	, 21, 0	0 0.000000		
76. 01 03952 NEURODI AGNOSTI C	0	0		0 0.000000	0.000000	•
76. 97 07697 CARDI AC REHABI LI TATI ON	1,288	972, 022	973, 31	0,000000	0. 000000	
OUTPATIENT SERVICE COST CENTERS	1,200	772,022	773, 31	0 0.447001	0.000000	/0. //
91. 00 09100 EMERGENCY	6, 891, 158	32,035,772	38, 926, 93	0. 280993	0.000000	91 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	404, 840	2, 211, 237				
93. 00 04040 PATIENT CARE CENTER - OCC	0,040	2, 554, 256				
OTHER REIMBURSABLE COST CENTERS	0	2, 334, 230	2, 334, 23	1. 123340	0.000000	75.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	5, 743, 948	5, 743, 94	.8 0. 423923	0.000000	96.00
SPECIAL PURPOSE COST CENTERS	U U	5, 743, 740	5, 745, 94	0.423723	0.000000	70.00
113. 00 11300 I NTEREST EXPENSE	1					113.00
116. 00 11600 HOSPI CE	671, 615	1, 769, 022	2, 440, 63	7		116.00
200.00 Subtotal (see instructions)	265, 369, 260	394, 055, 396				200.00
201.00 Less Observation Beds	203, 307, 200	374,033,370	0.007, 424, 00	0		200.00
201.00 Total (see instructions)	265, 369, 260	394, 055, 396	659, 424, 65	6		201.00

Health Financial Systems REI	D HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150048	Peri od:	Worksheet C	
			From 01/01/2014	Part I	
			To 12/31/2014	Date/Time Pre	
		Title XIX	Hospi tal	3/27/2015 9:5 Cost	
Cost Center Description	PPS Inpatient	пцеліх		0031	
cost center bescription	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41. 00 04100 SUBPROVIDER - IRF					41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
59.00 05900 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 PATIENTS	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76.00
76. 01 03952 NEURODI AGNOSTI C	0. 000000				76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
93.00 04040 PATIENT CARE CENTER - OCC	0. 000000				93.00
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				96.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems REII) HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	pared: 1 am
	-		e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 340, 789	0	4, 340, 78	9 32, 918	131.87	30.00
31.00 INTENSIVE CARE UNIT	1, 077, 173		1, 077, 17	3 5, 569	193. 42	31.00
40. 00 SUBPROVIDER - IPF	865, 332	0	865, 33	2 12, 618	68.58	40.00
41.00 SUBPROVIDER - IRF	601, 202	0	601, 20	2 2, 900	207.31	41.00
43.00 NURSERY	127, 698		127, 69	8 1, 899	67.24	43.00
200.00 Total (lines 30-199)	7, 012, 194		7, 012, 19	4 55, 904		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	17, 828					30.00
31.00 INTENSIVE CARE UNIT	2, 338	452, 216	,			31.00
40. 00 SUBPROVIDER - IPF	8, 312	570, 037				40.00
41.00 SUBPROVIDER - IRF	1, 981	410, 681				41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30-199)	30, 459	3, 783, 912				200. 00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5		
	_	Ti tl	e XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs		
	Related Cost	(from Wkst. C,		Program	(column 3 x		
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)		
	Part II, col.	8)	2)				
	26)						
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS	1	1	1	1	-		
50.00 05000 OPERATI NG ROOM	3, 198, 810					1	
52.00 05200 DELIVERY ROOM & LABOR ROOM	324, 052						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 213, 438					54.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,071,210						
60. 00 06000 LABORATORY	982, 708						
65. 00 06500 RESPI RATORY THERAPY	157, 514					65.00	
66. 00 06600 PHYSI CAL THERAPY	1, 836, 685				207, 950		
69. 00 06900 ELECTROCARDI OLOGY	399, 361	23, 032, 573			47, 555	69.00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	192, 839	2, 873, 626	0.06710)7 4, 470	300	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 659	12, 284, 550	0. 00135	56 1, 874, 411	2, 542	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	66, 266	25, 298, 988	0. 00261	9 8, 396, 396	21, 990	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	486, 213	88, 375, 657	0.00550	18, 663, 220	102, 685	73.00	
74.00 07400 RENAL DIALYSIS	51, 251	721, 849	0.07100	453, 077	32, 168	74.00	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000	0 0	0	76.00	
76. 01 03952 NEURODI AGNOSTI C	0	0	0.00000	0 0	0	76.01	
76. 97 07697 CARDI AC REHABI LI TATI ON	117, 560	973, 310	0. 12078	34 1, 288	156	76.97	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	1, 153, 621	38, 926, 930	0. 02963	5, 965, 329	176, 788	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	302, 106	2, 616, 077	0. 11548	404, 840	46, 751	92.00	
93.00 04040 PATIENT CARE CENTER - OCC	317, 849	2, 554, 256	0. 12443	39 0	0	93.00	
OTHER REI MBURSABLE COST CENTERS							
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	241, 709				-		
200.00 Total (lines 50-199)	14, 129, 851	592, 009, 580	1	115, 028, 828	2, 340, 795	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS Cost Center Description	SS THROUGH COS ⁻ Nursing School 1.00	Ti tl	e XVIII AII Other Medical Education Cos	Peri od: From 01/01/2014 To 12/31/2014 Hospi tal Swi ng-Bed Adj ustment t Amount (see i nstructi ons)		pared: <u>1 am</u>
INPATIENT ROUTINE SERVICE COST CENTERS	-	Allied Health Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols.	
INPATIENT ROUTINE SERVICE COST CENTERS	-	Cost	Medical Education Cos	Adjustment t Amount (see	(sum of cols.	
	1.00		Education Cos	t Amount (see		
	1.00	2.00			1 through 3	
	1.00	2.00		instructions)		
	1.00	2.00		,	minus col. 4)	
			3.00	4.00	5.00	
30 00 03000 ADULTS & PEDLATRICS						
	0	C		0 0	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	C		0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	C)	0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	C)	0 0	0	41.00
43.00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
·	Days	5 ÷ col. 6)	Program Days	Program		
	-			Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	32, 918	0.00	17, 82	8 0		30.00
31.00 03100 INTENSIVE CARE UNIT	5, 569	0.00	2, 33	8 0		31.00
40. 00 04000 SUBPROVIDER - IPF	12, 618	0.00	8, 31	2 0		40.00
41.00 04100 SUBPROVIDER - IRF	2, 900	0.00	1, 98	1 0		41.00
43.00 04300 NURSERY	1, 899			0 0		43.00
200.00 Total (lines 30-199)	55, 904		30, 45	9 0		200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	5 Provi der		Period: From 01/01/2014 To 12/31/2014				
		Ti tl	e XVIII	Hospi tal	PPS			
Cost Center Description	Non Physician	Nursing School	Allied Healt	n All Other	Total Cost			
	Anesthetist	0		Medi cal	(sum of col 1			
	Cost			Education Cost	through col.			
					3 4)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATI NG 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	454, 28	5 0	454, 285	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	0	65.00		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00		
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	74.00		
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.00		
76. 01 03952 NEURODI AGNOSTI C	0	0		0 0	0	76.01		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97		
OUTPATIENT SERVICE COST CENTERS	· · · ·			·				
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00		
93. 00 04040 PATIENT CARE CENTER - OCC	0	0		0 0	0	93.00		
OTHER REIMBURSABLE COST CENTERS			1	· · · · ·				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00		
200.00 Total (lines 50-199)	0	0						
				,		•		

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-1								
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provi der		Peri od:	Worksheet D			
THROUG	GH COSTS				From 01/01/2014				
					To 12/31/2014	Date/Time Pre 3/27/2015 9:5	pared: 1 am		
				e XVIII	Hospi tal	PPS			
	Cost Center Description	Total	Total Charges			Inpati ent			
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program			
		Cost (sum of		(col. 5 ÷ col	5	Charges			
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.				
		4)			7)				
		6.00	7.00	8.00	9.00	10.00			
	ANCI LLARY SERVICE COST CENTERS		444 007 704			00 7/4 004			
50.00	05000 OPERATING ROOM	0	116, 337, 791						
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	-,						
54.00	05400 RADI OLOGY-DI AGNOSTI C	454, 285					54.00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	54, 845, 480						
60.00	06000 LABORATORY	0	82, 029, 174						
65.00	06500 RESPI RATORY THERAPY	0	8, 906, 792				65.00		
66.00	06600 PHYSI CAL THERAPY	0	16, 229, 687				66.00		
69.00	06900 ELECTROCARDI OLOGY	0	23, 032, 573						
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 873, 626						
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 284, 550				71.00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	25, 298, 988						
73.00	07300 DRUGS CHARGED TO PATIENTS	0	88, 375, 657						
74.00		0	721, 849				74.00		
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000			76.00		
76.01	03952 NEURODI AGNOSTI C	0	0	0.00000			76.01		
76.97	07697 CARDI AC REHABI LI TATI ON	0	973, 310	0.00000	0 0.00000	1, 288	76.97		
	OUTPATIENT SERVICE COST CENTERS				-1				
	09100 EMERGENCY	0							
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 616, 077						
93.00	04040 PATIENT CARE CENTER - OCC	0	2, 554, 256	0.00000	0 0.00000	0	93.00		
	OTHER REIMBURSABLE COST CENTERS			1					
96.00		0			0 0. 000000		96.00		
200.00	Total (lines 50-199)	454, 285	592,009,580			115, 028, 828	200. 00		

Heal th Financial Systems REID HOSPI APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE THROUGH COSTS				Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS				1		
50.00 O5000 OPERATING ROOM	0	30, 008, 662		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	105, 073		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	64, 957	36, 318, 582		67		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	17, 362, 226		0		59.00
60. 00 06000 LABORATORY	0	8, 205, 062		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	416, 103		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 131		0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	9, 696, 561		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 256, 750		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	75, 830		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 680, 815		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	15, 204, 525		0		73.00
74.00 07400 RENAL DIALYSIS	0	7, 297		0		74.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0		76.00
76. 01 03952 NEURODI AGNOSTI C	0	0		0		76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	415, 631		0		76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	7, 920, 402		0		7 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	932, 371		0		92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	298, 185		0		93.00
OTHER REIMBURSABLE COST CENTERS	1	.,				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
200.00 Total (lines 50-199)	64, 957	133, 905, 206	158, 16			200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-								
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 3/27/2015 9:5			
		Ti tl	e XVIII	Hospi tal	PPS			
			Charges		Costs			
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services			
		Services (see	Reimbursed	Reimbursed	(see inst.)			
	Worksheet C,	inst.)	Servi ces	Services Not				
	Part I, col. 9		Subject To	Subject To				
			Ded. & Coins					
			(see inst.)	(see inst.)				
	1.00	2.00	3.00	4.00	5.00			
ANCI LLARY SERVI CE COST CENTERS								
50.00 OPERATING ROOM	0. 294337			0 0	8, 832, 660	•		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 311655			0 0	32, 747			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 193868			0 0	7, 041, 011	•		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 170255			0 0	2, 956, 006			
60. 00 06000 LABORATORY	0. 168247	8, 205, 062	1, 19	0 8	1, 380, 477	60.00		
65. 00 06500 RESPI RATORY THERAPY	0. 320032	416, 103		0 0	133, 166	65.00		
66. 00 06600 PHYSI CAL THERAPY	0. 605798	1, 131		0 0	685	66.00		
69. 00 06900 ELECTROCARDI OLOGY	0. 137785	9, 696, 561		0 0	1, 336, 041	69.00		
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 224541	1, 256, 750		0 0	282, 192	70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 021999	75, 830		0 0	1, 668	71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 564262	5, 680, 815		0 0	3, 205, 468	72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 287454	15, 204, 525	110, 81	1 0	4, 370, 602	73.00		
74.00 07400 RENAL DIALYSIS	1. 192073	7, 297		0 0	8, 699	74.00		
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.00		
76. 01 03952 NEURODI AGNOSTI C	0. 000000	0		0 0	0	76.01		
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 447061	415, 631		0 0	185, 812	76.97		
OUTPATIENT SERVICE COST CENTERS		•	•			1		
91.00 09100 EMERGENCY	0. 280993	7, 920, 402		0 0	2, 225, 578	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 822634	932, 371		0 0	767,000	92.00		
93.00 04040 PATIENT CARE CENTER - OCC	1. 125346	298, 185		0 0	335, 561	93.00		
OTHER REIMBURSABLE COST CENTERS						1		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 423923	0		0 0	0	96.00		
200.00 Subtotal (see instructions)		133, 905, 206	112, 00)9 0	33, 095, 373	200.00		
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00		
Only Charges								
202.00 Net Charges (line 200 +/- line 201)		133, 905, 206	112, 00	09 0	33, 095, 373	202.00		

Health Financial Systems REID	HOSPI TAL & HEAL	LTH CARE SERVICES	S	In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	N: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pro 3/27/2015 9:1	epared: 51 am
		Title >	XVIII	Hospi tal	PPS	
	Cos	ts		· · · · · · · · · · · · · · · · · · ·		
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				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	202	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69.00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	31, 853	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.00
76. 01 03952 NEURODI AGNOSTI C	0	0				76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	I I	I				_
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93. 00 04040 PATIENT CARE CENTER - OCC	0	0				93.00
OTHER REI MBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	32, 055	0				200. 00 201. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 +/- line 201)	32, 055	0				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 150048 Period: Worksheet D	
Component CCN: 15S048 From 01/01/2014 Part II To 12/31/2014 Date/Time Prepa 3/27/2015 9:51	
Title XVIII Subprovider - PPS	
Cost Center Description Capital Total Charges Ratio of Cost Inpatient Capital Costs	
Related Cost (from Wkst. C, to Charges Program (column 3 x	
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4)	
Part II, col. 8) 2)	
26)	
<u>1.00</u> <u>2.00</u> <u>3.00</u> <u>4.00</u> <u>5.00</u>	
ANCI LLARY SERVI CE COST CENTERS	
	50.00
	52.00
	54.00
	59.00
	50.00
	65.00
	66.00
	59.00
	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 16, 659 12, 284, 550 0. 001356 234, 005 317	71.00
	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 486, 213 88, 375, 657 0. 005502 1, 751, 710 9, 638	73.00
74. 00 07400 RENAL DIALYSIS 51, 251 721, 849 0. 071000 48, 991 3, 478	74.00
	76.00
76. 01 03952 NEURODI AGNOSTI C 0 0 0 0 0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON 117, 560 973, 310 0. 120784 0 0 0	76. 97
OUTPATIENT SERVICE COST CENTERS	
	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0. 000000 0 0	92.00
93. 00 04040 PATI ENT_CARE_CENTER - OCC 317, 849 2, 554, 256 0. 124439 0 0	93.00
OTHER REIMBURSABLE COST CENTERS	
	96.00
200. 00 Total (Lines 50-199) 13, 827, 745 592, 009, 580 6, 332, 024 130, 730	00.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150048	Peri od:	Worksheet D	
THROUG	SH COSTS				From 01/01/2014		
			Component	CCN: 15SO48	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
			Ti tl	e XVIII	Subprovider -	PPS	
					I PF		
	Cost Center Description	Non Physician	lursing School	Allied Healt		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	5	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS					-	
	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	454, 2	35 0	454, 285	
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	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
76.01	03952 NEURODI AGNOSTI C	0	0		0 0	0	76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	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 50-199)	0	0	454, 2	35 0	454, 285	200. 00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod
		component	L CCN. 155046	10 12/31/2014	3/27/2015 9:5	
		Ti tl	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	10.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		444 007 704	0.0000		(45.040	50.00
50. 00 05000 OPERATING ROOM	0					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-,				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	454, 285					
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY	0	82, 029, 174			1, 417, 770	
65. 00 06500 RESPIRATORY THERAPY	0	8, 906, 792			239, 042	65.00
66.00 06600 PHYSI CAL THERAPY	0	16, 229, 687				
69. 00 06900 ELECTROCARDI OLOGY	0	23, 032, 573				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2, 873, 626				70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	12, 284, 550				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	25, 298, 988				•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	88, 375, 657			1, 751, 710	•
74.00 07400 RENAL DIALYSIS	0	721, 849			48, 991	74.00
76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0.0000		0	76.00
76. 01 03952 NEURODI AGNOSTI C	0	070.010	0.0000			76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	973, 310	0.0000	0.00000	0	76.97
OUTPATIENT SERVICE COST CENTERS		00.00/.000	0.0000	0 00000	500 707	01 00
91.00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	2/010/077				92.00
93. 00 04040 PATIENT CARE CENTER - OCC	0	2, 554, 256	0.00000	0.00000	0	93.00
		E 742 040	0.0000	0 000000	0	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0. 00000		
200.00 Total (lines 50-199)	454, 285	592, 009, 580	1	l	6, 332, 024	200.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	_TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150048	Period:	Worksheet D	
THROUC	COSTS		Component	CCN: 15S048	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod.
			Component	. CON. 155046	10 12/31/2014	3/27/2015 9:5	
-			Ti tl	e XVIII	Subprovider -	PPS	
					I PF		
	Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCI LLARY SERVICE COST CENTERS	-1			-		
50.00	05000 OPERATING ROOM	0	0		0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 490	0		0		54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60.00	06000 LABORATORY	0	0		0		60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0		66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 505		0		73.00
	07400 RENAL DIALYSIS	0	0		0		74.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0		76.00
	03952 NEURODI AGNOSTI C	0	0		0		76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
	OUTPATIENT SERVICE COST CENTERS	1		1			
	09100 EMERGENCY	0	0		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	0		0		93.00
	OTHER REIMBURSABLE COST CENTERS	1		1	-		
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0		96.00
200.00	Total (lines 50-199)	3, 490	4, 505		0		200.00

		HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
			Component	CON. 155040	From 01/01/2014 To 12/31/2014	Part V	norod.
			component	CCN: 15S048	10 12/31/2014	Date/Time Pre 3/27/2015 9:5	pareu: 1 am
			Ti tl	e XVIII	Subprovider -	PPS	
					IPF		
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS		-		-	-	
	05000 OPERATING ROOM	0. 294337	0		0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 311655	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 193868	0		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0. 170255	0		0 0	0	
	06000 LABORATORY	0. 168247	0		0 0	0	
	06500 RESPI RATORY THERAPY	0. 320032	0		0 0	0	
	06600 PHYSI CAL THERAPY	0. 605798	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0. 137785	0		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	0. 224541	0		0 0	0	1 1 0 . 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 021999	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 564262	0		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0. 287454	4, 505	9, 31	2 0	1, 295	
	07400 RENAL DI ALYSI S	1. 192073	0		0 0	0	
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	
	03952 NEURODI AGNOSTI C	0. 000000	0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	0. 447061	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 280993			0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 822634	0		0 0	0	
	04040 PATIENT CARE CENTER - OCC	1. 125346	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 423923			0 0	0	
200.00	Subtotal (see instructions)		4, 505	9, 31	2 0	1, 295	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges				-		
202.00	Net Charges (line 200 +/- line 201)		4, 505	9, 31	2 0	1, 295	202.00

Health Financial Systems REID	HOSPI TAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150048	Peri od:	Worksheet D	
			001 450040	From 01/01/2014	Part V	
		Component	CCN: 15S048	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared: 51 am
		Ti tl	e XVIII	Subprovider -	PPS	
			-	I PF		
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
59. 00 105900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2,677	0				73.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76.00
76. 01 03952 NEURODI AGNOSTI C	0	0				76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	0				93.00
OTHER REIMBURSABLE COST CENTERS	·					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	2,677	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 677	0				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15048 Period: From 01/01/2014 Porvider CD: 12/31/2014 Dirac CD: Date/Time Prepared: 01/2015 9:51 am Image: Cost Center Description Capital Related Cost (from Wkst. 6, Part 11, col. 26) Total Charges Ratio of Cost (Col. 1 + col. 8) Total Charges (Col. 1 + col. 2) Copital Program (Col. 1 + col. 2) Copital Program (Col. 1 + col. 2) Copital Program (Col. 1 + col. 2) Copital Costs (Col. 1 + col. 2)	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-1							
Cost Center Description Capital Related Cost (From Wkst. C. 26) Total Charges (autor) Ratio of Cost (col umn 4) Inpatient Program (Charges) Capital Costs (col umn 4) 50.00 05000 OPERATING ROOM 3.198,810 116,337,791 0.027496 5.034 138 50.00 50.00 05000 OPERATING ROOM 3.198,810 116,337,791 0.027496 5.034 138 50.00 50.00 05000 OPERATING ROOM 3.213,438 104,322,539 0.030803 86,291 2.658 54.00 0.027496 5,034 138 50.00 50.00 05500 OPERATING ROOM 3.213,438 104,322,539 0.030803 86,291 2.658 54.00 0.019531 0 0 59.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 66.00 0.979,744 11.489 650,720 0.017865 650,216 11.499 65.00 66.00 06500 RESPI RATORY 182,629,7174 0.017385 650,216 11.499 65.00 70.00 000000 LABORATORY 3.92,633	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS			From 01/01/2014	Part II Date/Time Pre		
ANCI LLARY SERVICE COST CENTERS (From Wkst. B, Part I, col. 26) (From Wkst. C, 26) (to Charges 20) Program Charges (col umn 3 x col umn 4) 50.00 05000 0PERATI NG ROOM 3,198,810 116,337,791 0.027496 5,034 138 50.00 52.00 05200 DELI VEY ROOM & LABOR ROOM 3,24,052 5,946,353 0.05458 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,213,438 104,322,539 0.030803 86,291 2,658 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1,071,210 54,845,480 0.019531 0 0 59.00 60.00 06000 ABORATORY 982,708 82,029,174 0.011880 799,767 90,508 66.00 60.00 66.00 06600 LECTROCARDI OLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 66.00 06600 DECTROCARDI OLOGY 399,361 23,032,573 0.017356 111 071.00 71.00 <td< td=""><td></td><td></td><td>Ti tl</td><td>e XVIII</td><td></td><td></td><td></td></td<>			Ti tl	e XVIII				
ANCI LLARY SERVICE COST CENTERS Col um 4) Col um 4) 50.00 05000 OPERATING ROOM 3, 198, 810 116, 337, 791 0. 027496 5, 034 138 52.00 05000 OPERATING ROOM 3, 198, 810 116, 337, 791 0. 027496 5, 034 138 52.00 05000 OPERATING ROOM 3, 24, 052 5, 936, 353 0. 054588 0 0 52. 00 54.00 05400 RADI LOCGY-DI AGNOSTI C 3, 213, 438 104, 322, 539 0. 03803 86, 291 2, 655 59.00 60.00 06500 RADI AC CATHETERI ZATI ON 1, 071, 210 54, 845, 480 0. 017685 650, 216 11, 499 65.00 66.00 06500 RESPI RATORY THERAPY 157, 514 8, 906, 792 0. 017685 650, 216 11, 499 65.00 66.00 06500 RESPI RATORY THERAPY 1, 836, 685 16, 229, 687 0. 113168 799, 767 90.508 66.00 67.00 07000 ELECTROCARDI OLOGY 399, 861 23, 325, 573 0. 017365 111 0 71.00 71.00 07100 MEDI CA	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs		
Part II, col. 26) 8) 2) 3 4 ANCILLARY SERVICE COST CENTERS		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x		
26) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)		
I. 00 2. 00 3. 00 4. 00 5. 00 ANCI LLARY SERVICE COST CENTERS		Part II, col.	8)	2)	-			
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 0PERATI NG ROOM 3, 198, 810 116, 337, 791 0. 027496 5, 034 138 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 324, 052 5, 936, 353 0. 054588 0 0 52. 00 54. 00 05400 RADI OLOGY -DI AGNOSTI C 3, 213, 438 104, 322, 539 0. 030803 86, 291 2, 658 54. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 1, 071, 210 54, 845, 480 0.019531 0 0 59. 00 60. 00 06500 RESPI RATORY 982, 708 82, 029, 174 0.011780 221, 304 2, 651 60. 00 66. 00 06600 PHYSI CAL THERAPY 1, 836, 685 16, 229, 687 0.113168 799, 767 90, 508 66. 00 69. 00 ELECTROCARDI OLOGY 399, 361 23, 032, 573 0.017339 14, 718 255 69. 00 71. 00 07200 ELECTROENCEPHALOGRAPHY 192, 839 2, 873, 626 0.001356 111 0 71. 00 73. 00 07200 DURUS CHARGED TO PATI ENTS								
50.00 05000 OPERATI NG ROOM 3, 198, 810 116, 337, 791 0.027496 5, 034 138 50.00 52.00 05200 DELI VERY ROM & LABOR ROOM 3,224, 052 5, 936, 353 0.054588 0 0 52.00 54.00 O5400 RADI 0LOGY-DI AGNOSTI C 3, 213, 438 104, 322, 539 0.030803 86, 291 2, 658 54.00 59.00 O5900 CARDI AC CATHETERI ZATI ON 1, 071, 210 54, 845, 480 0.019531 0 0 59.00 60.00 066000 RESPI RATORY THERAPY 157, 514 8, 906, 792 0.017685 650, 216 11, 499 66.00 64.00 06600 PHSI CAL THERAPY 1, 836, 685 16, 229, 687 0.117348 799, 767 90, 508 66.00 67.00 07000 ELECTROCARDI OLOGY 399, 361 23, 032, 573 0.017339 14, 718 255 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16, 659 12, 284, 550 0.001356 111 0 71.00 72.00 07400 REVARGED TO PATI ENTS 486, 213 <t< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></t<>		1.00	2.00	3.00	4.00	5.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM 324,052 5,936,353 0.054588 0 0 52.00 54.00 05400 RADIOLOCY-DIAGNOSTIC 3,213,438 104,322,539 0.030803 86,291 2,685 54.00 59.00 06000 CARDIAC CATHETERIZATION 1,017,210 54,845,480 0.019531 0 0 59.00 60.00 06500 RESPI RATORY 982,708 82,029,174 0.011980 221,304 2,651 60.00 65.00 06500 RESPI RATORY THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 69.00 06900 ELECTROCARDIOLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192,839 2,873,626 0.067107 214 14 70.00 71.00 07100 MPLD EV. CHARGED TO PATI ENTS 16,659 12,284,550 0.001356 111 0 71.00 72.00 07200 I MPL DEV. CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614								
54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 213, 438 104, 322, 539 0.030803 86, 291 2, 658 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 1, 071, 210 54, 845, 480 0.019531 0 0 59.00 60.00 06000 LABORATORY 982, 708 82, 029, 174 0.011980 221, 304 2, 651 60.00 65.00 06500 RESPI RATORY THERAPY 157, 514 8, 906, 792 0.017685 65.0216 11, 499 65.00 66.00 06600 PHYSI CAL THERAPY 1, 836, 685 16, 229, 687 0.113168 799, 767 90, 508 66.00 69.00 06900 ELECTROCARDI OLOGY 399, 361 23, 032, 573 0.017339 14, 718 255 69.00 70.00 O7000 ELECTROCARD PHALOGRAPHY 192, 839 2, 873, 626 0.067107 214 14 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16, 659 12, 284, 550 0.0005502 55, 614 306 73.00 72.00 07400 RENANCI LLASY SERVICE COST CENTERS 0		3, 198, 810	116, 337, 791			138	50.00	
59.00 05900 CARDI AC CATHETERI ZATI ON 1,071,210 54,845,480 0.019531 0 0 59.00 60.00 06000 LABORATORY 982,708 82,029,174 0.011980 221,304 2,651 60.00 65.00 06500 RESPI RATORY THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 66.00 06600 PHYSI CAL THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 69.00 04900 ELECTROCARDI OLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192,839 2,873,626 0.067107 214 14 70.00 71.00 07100 MEDL CAL SUPPLI ES CHARGED TO PATI ENTS 16,626 25,989,888 0.002619 6,466 17 72.00 73.00 07300 RUGS CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614 306 73.00 74.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 <td>52.00 05200 DELIVERY ROOM & LABOR ROOM</td> <td>324,052</td> <td>5, 936, 353</td> <td>0. 05458</td> <td>38 0</td> <td>0</td> <td>52.00</td>	52.00 05200 DELIVERY ROOM & LABOR ROOM	324,052	5, 936, 353	0. 05458	38 0	0	52.00	
60.00 06000 LABORATORY 982,708 82,029,174 0.011980 221,304 2,651 60.00 65.00 06500 RESPI RATORY THERAPY 157,514 8,906,792 0.017685 650,216 11,499 65.00 66.00 06600 PHYSI CAL THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 69.00 06900 ELECTROCARDIOLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192,839 2,873,626 0.067107 214 14 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 16,659 12,284,550 0.001356 111 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614 306 73.00 74.00 0400 RENAL DI ALYSI S 51,251 721,849 0.071000 9,902 703 74.00 76.00 76.00 76.00 76.00 76.01 76.01 76.01 76.01 76.01 <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>3, 213, 438</td> <td>104, 322, 539</td> <td>0. 03080</td> <td>03 86, 291</td> <td>2, 658</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 213, 438	104, 322, 539	0. 03080	03 86, 291	2, 658	54.00	
65.00 06500 RESPI RATORY THERAPY 157,514 8,906,792 0.017685 650,216 11,499 65.00 66.00 06600 PHYSI CAL THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 69.00 06900 ELECTROCARDI OLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192,839 2,873,626 0.067107 214 11 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 16,659 12,284,550 0.001356 111 0 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614 306 73.00 74.00 07400 RENAL DI ALYSI S 51,251 721,849 0.071000 9,902 703 74.00 76.01 03952 NERODI AGNOSTI C 0 0 0 0.000000 0 76.01 76.01 09100 EMERGENCY 1,153,621 38,926,930 0.029636 461 <	59. 00 05900 CARDI AC CATHETERI ZATI ON	1,071,210	54, 845, 480	0. 01953	31 0	0	59.00	
66.00 06600 PHYSI CAL THERAPY 1,836,685 16,229,687 0.113168 799,767 90,508 66.00 69.00 06900 ELECTROCARDI OLOGY 399,361 23,032,573 0.017339 14,718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192,839 2,873,626 0.067107 214 14 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 16,659 12,284,550 0.001356 111 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614 306 73.00 74.00 07400 RENAL DI ALYSI S 51,251 721,849 0.071000 9,902 703 74.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 0 09100 EMEGENCY 1,153, 621 38,926,930 0.029636 461 14 91.00 92.00	60. 00 06000 LABORATORY	982, 708			30 221, 304	2, 651	60.00	
69.00 06900 ELECTROCARDI OLOGY 399, 361 23, 032, 573 0.017339 14, 718 255 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 192, 839 2, 873, 626 0.067107 214 14 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 16, 659 12, 284, 550 0.001356 111 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 66, 266 25, 298, 988 0.002619 6, 466 17 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 486, 213 88, 375, 657 0.005502 55, 614 306 73.00 74.00 07400 RENAL DI ALYSI S 51, 251 721, 849 0.071000 9, 902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 0 76.00 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 79.00 09100 EMERENCY 1, 153, 621 38, 926, 930	65. 00 06500 RESPI RATORY THERAPY	157, 514	8, 906, 792	0. 01768	650, 216	11, 499	65.00	
70.00 07000 ELECTROENCEPHALOGRAPHY 192, 839 2, 873, 626 0.067107 214 14 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 16, 659 12, 284, 550 0.001356 111 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 66, 266 25, 298, 988 0.002619 6, 466 17 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 486, 213 88, 375, 657 0.005502 55, 614 306 73.00 74.00 07400 RENAL DI ALYSI S 51, 251 721, 849 0.071000 9, 902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 76.00 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 76.00 07697 CARDI AC REHABILI TATI ON 117, 560 973, 310 0.120784 0 0 76.97 0100 DEMERGENCY 1, 153, 621 38, 926, 930 0.029636 461 14 91.00 91.00 <	66. 00 06600 PHYSI CAL THERAPY	1, 836, 685	16, 229, 687	0. 11316	58 799, 767	90, 508	66.00	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 16,659 12,284,550 0.001356 111 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 66,266 25,298,988 0.002619 6,466 17 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 486,213 88,375,657 0.005502 55,614 306 73.00 74.00 07400 RENAL DI ALYSI S 51,251 721,849 0.071000 9,902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 76.00 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.00 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.00 76.01 07697 CARDI AC REHABI LI TATI ON 117,560 973,310 0.120784 0 0 76.97 0 09100 EMERGENCY 1,153,621 38,926,930 0.029636 461 14 91.00 92.00 092200 OBSERVATI ON BEDS (NON-DI STI NCT PA	69. 00 06900 ELECTROCARDI OLOGY	399, 361	23, 032, 573	0. 01733	39 14, 718	255	69.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 66, 266 25, 298, 988 0.002619 6, 466 17 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 486, 213 88, 375, 657 0.005502 55, 614 306 73.00 74.00 07400 RENAL DI ALYSI S 51, 251 721, 849 0.071000 9, 902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 76.00 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 76.97 CARDI AC REHABILI TATI ON 117, 560 973, 310 0.120784 0 0 76.97 0 09100 EMERGENCY 1, 153, 621 38, 926, 930 0.029636 461 14 91.00 92.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0.000000 0 92.00 93.00 91.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0.000000 0 92.00 93.00 <	70.00 07000 ELECTROENCEPHALOGRAPHY	192, 839	2, 873, 626	0.06710	07 214	14	70.00	
73.00 07300 DRUGS CHARGED TO PATIENTS 486, 213 88, 375, 657 0.005502 55, 614 306 73.00 74.00 07400 RENAL DI ALYSI S 51, 251 721, 849 0.071000 9, 902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 0 76.00 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 76.97 OZAPOT CARDI AC REHABILITATION 117, 560 973, 310 0.120784 0 0 76.97 0 09100 EMERGENCY 1, 153, 621 38, 926, 930 0.029636 461 14 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0.000000 0 92.00 93.00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0.124439 0 0 93.00 0 0 09600 DURABLE MEDI CAL EQUI P-RENTED 241, 709 5, 743, 948 0.042081 0 0 96.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 659	12, 284, 550	0.00135	56 111	0	71.00	
74.00 07400 RENAL DI ALYSI S 51, 251 721, 849 0.071000 9, 902 703 74.00 76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 0 76.00 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 76.97 07697 CARDI AC REHABI LI TATI ON 117, 560 973, 310 0.120784 0 0 76.97 00 09100 EMERGENCY 1, 153, 621 38, 926, 930 0.029636 461 14 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 2, 616, 077 0.000000 0 92.00 93.00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0.124439 0 0 93.00 0THER REI MBURSABLE COST CENTERS 0 0 241, 709 5, 743, 948 0.042081 0 0 96.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	66, 266	25, 298, 988	0. 0026	6, 466	17	72.00	
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0.000000 0 76.00 76.01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 0 76.01 76.07 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76.01 76.97 07697 CARDI AC REHABI LI TATI ON 117,560 973,310 0.120784 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 1,153,621 38,926,930 0.029636 461 14 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 2,616,077 0.000000 0 92.00 93.00 04040 PATI ENT CARE CENTER - OCC 317,849 2,554,256 0.124439 0 0 93.00 0THER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 241,709 5,743,948 0.042081 0 0 96.00	73.00 07300 DRUGS CHARGED TO PATIENTS	486, 213	88, 375, 657	0.00550	55, 614	306	73.00	
76. 01 03952 NEURODI AGNOSTI C 0 0 0.000000 0 76. 01 76. 01 7697 CARDI AC REHABI LI TATI ON 117, 560 973, 310 0.120784 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 01, 125, 621 38, 926, 930 0.029636 461 14 91. 00 91. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0.000000 0 92. 00 93. 00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0.124439 0 0 93. 00 0THER REI MBURSABLE COST CENTERS 0 0 241, 709 5, 743, 948 0.042081 0 0 96. 00	74.00 07400 RENAL DIALYSIS	51, 251	721, 849	0.07100	9, 902	703	74.00	
76. 97 07697 CARDI AC REHABI LI TATI ON 117, 560 973, 310 0. 120784 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0117, 560 973, 310 0. 120784 0 0 76. 97 91. 00 09100 EMERGENCY 1, 153, 621 38, 926, 930 0. 029636 461 14 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 2, 616, 077 0. 000000 0 92. 00 93. 00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0. 124439 0 0 93. 00 0THER REI MBURSABLE COST CENTERS 0 0 94.00 96.00 DURABLE MEDI CAL EQUI P-RENTED 241, 709 5, 743, 948 0. 042081 0 0 96. 00	76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 0	0	76.00	
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1, 153, 621 38, 926, 930 0.029636 461 14 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 2, 616, 077 0.000000 0 0 92.00 93.00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0.124439 0 0 93.00 0THER REI MBURSABLE COST CENTERS 0 0 241, 709 5, 743, 948 0.042081 0 0 96.00	76. 01 03952 NEURODI AGNOSTI C	0	0	0.0000	0 0	0	76.01	
91. 00 09100 EMERGENCY 1, 153, 621 38, 926, 930 0. 029636 461 14 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0. 000000 0 0 92. 00 93. 00 04040 PATI ENT CARE CENTER - OCC 317, 849 2, 554, 256 0. 124439 0 0 93. 00 0THER REI MBURSABLE COST CENTERS 241, 709 5, 743, 948 0. 042081 0 0 96. 00	76. 97 07697 CARDI AC REHABI LI TATI ON	117, 560	973, 310	0. 12078	34 0	0	76.97	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 2, 616, 077 0.000000 0 92. 00 93. 00 04040 PATI ENT_CARE_CENTER - OCC 317, 849 2, 554, 256 0.124439 0 0 93. 00 0THER_REI_MBURSABLE_COST_CENTERS 0 0 241, 709 5, 743, 948 0.042081 0 0 96. 00	OUTPATIENT SERVICE COST CENTERS							
93. 00 04040 PATI ENT_CARE_CENTER - OCC 317, 849 2, 554, 256 0. 124439 0 0 93. 00 0THER_REI_MBURSABLE_COST_CENTERS 0 0 0 96. 00 09600 DURABLE_MEDI CAL_EQUI P-RENTED 241, 709 5, 743, 948 0. 042081 0 0 96. 00		1, 153, 621	38, 926, 930	0. 02963	36 461	14	91.00	
OTHER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 241, 709 5, 743, 948 0. 042081 0 0 96. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 616, 077	0.0000	0 0	0	92.00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 241, 709 5, 743, 948 0. 042081 0 0 96. 00	93.00 04040 PATIENT CARE CENTER - OCC	317, 849	2, 554, 256	0. 12443	39 0	0	93.00	
200.00 Total (lines 50-199) 13, 827, 745 592, 009, 580 1, 850, 098 108, 763 200.00						-		
	200.00 Total (lines 50-199)	13, 827, 745	592, 009, 580		1, 850, 098	108, 763	200. 00	

Heal th	Financial Systems REID	HOSPI TAL & HEAL	_TH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150048	Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2014		
			Component	CCN: 15T048	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
			Ti tl	e XVIII	Subprovider -	PPS	
					I RF		
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	5	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	1		1			
	05000 OPERATING ROOM	0	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	454, 2	35 0	454, 285	1
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	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76.00
76.01	03952 NEURODI AGNOSTI C	0	0		0 0	0	76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0		96.00
200.00	Total (lines 50-199)	0	0	454, 2	35 0	454, 285	200.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod
		component	CCN. 151040	10 12/31/2014	3/27/2015 9:5	
		Ti tl	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	40.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	11/ 227 701	0,00000		E 024	50.00
	0					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-,				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	454, 285					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	59.00
	0	82, 029, 174				60.00
65. 00 06500 RESPI RATORY THERAPY	0	8, 906, 792				1
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	16, 229, 687				66.00
	0	23, 032, 573				1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2,873,626				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	12, 284, 550			111	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	25, 298, 988				
73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS	0	88, 375, 657 721, 849				73.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	/21,849	0.00000		9,902	74.00
76. 00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76. 01 03952 NEURODI AGNOSTI C	0				-	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		, °				76.97
OUTPATIENT SERVICE COST CENTERS	0	973, 310	0.0000	0.00000	0	/0.9/
91. 00 09100 EMERGENCY	0	38, 926, 930	0.0000	0. 000000	461	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93. 00 04040 PATIENT CARE CENTER - OCC	0	2, 554, 256				93.00
OTHER REIMBURSABLE COST CENTERS	0	2, 334, 230	0.00000	0.000000	0	, , 5. 00
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED	0	5, 743, 948	0.00000	0.00000	0	96.00
200.00 Total (lines 50-199)	454, 285			0.00000	1, 850, 098	
	101,200	1 0,2,00,,000	1	1	.,000,070	1200.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150048	Peri od:	Worksheet D	
THROUG	GH COSTS		Component	CCN: 15T048	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narodi
			component	CON. 151046	10 12/31/2014	3/27/2015 9:5	
			Ti tl	e XVIII	Subprovider -	PPS	
		r			I RF		
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.	9		
		x col. 10)	10.00	x col. 12)			
		11.00	12.00	13.00			
F0 00	ANCI LLARY SERVICE COST CENTERS				0		50.00
50.00	05000 OPERATING ROOM	0	0		0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	376	641		3		54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60.00	06000 LABORATORY	0	465		0		60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0		65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0		66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	674		0		73.00
74.00	07400 RENAL DI ALYSI S	0	0		0		74.00
	03950 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0		76.00
	03952 NEURODI AGNOSTI C	0	0		0		76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
01 00	OUTPATIENT SERVICE COST CENTERS				0		01.00
	09100 EMERGENCY	0	0		0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
93.00	04040 PATIENT CARE CENTER - OCC	0	0		0		93.00
04 00	OTHER REIMBURSABLE COST CENTERS				0		04 00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0		96.00
200.00	Total (lines 50-199)	376	1, 780		3		200. 00

		HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150048	Peri od:	Worksheet D	
			Component	CCN: 15T048	From 01/01/2014 To 12/31/2014	Part V	norod.
			Component	CCN: 151048	10 12/31/2014	Date/Time Pre 3/27/2015 9:5	pared: 1 am
			Ti tl	e XVIII	Subprovider -	PPS	i uni
					IRF		
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	0.004007					
	05000 OPERATING ROOM	0. 294337			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 311655			0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 193868			0 0	124	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 170255			0 0	0	59.00
60.00	06000 LABORATORY	0. 168247	465		0 0	78	60.00
65.00	06500 RESPI RATORY THERAPY	0. 320032			0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 605798			0 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 137785	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 224541	0		0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 021999	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 564262	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 287454	674	1, 52		194	73.00
	07400 RENAL DIALYSIS	1. 192073	0		0 0	0	74.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	76.00
	03952 NEURODI AGNOSTI C	0. 000000			0 0	0	76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0. 447061	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 280993			0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 822634			0 0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	1. 125346	0	l	0 0	0	93.00
96.00	OTHER REIMBURSABLE COST CENTERS	0 400000			0	0	04 00
		0. 423923			0 0	0	
200.00			1, 780	1, 52		396	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00			1, 780	1, 52	21 0	206	202.00
202.00	I met ondryes (The 200 +/ - The 201)	1	I I, 760	I, J∡	0	390	1202. UU

Health Financial Systems REI	D HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provi der	CCN: 150048	Peri od:	Worksheet D	
		0	- CON 157040	From 01/01/2014	Part V	
		Component	CCN: 15T048	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared: 51 am
		Titl	e XVIII	Subprovider -	PPS	
				I RF		
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00		<u> </u>		
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM						52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON						59.00
60. 00 06000 LABORATORY		0				60.00
65. 00 06500 RESPI RATORY THERAPY		0				65.00
66. 00 06600 PHYSI CAL THERAPY		0				66.00
69. 00 06900 ELECTROCARDI OLOGY		0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	437	0				73.00
74.00 07400 RENAL DIALYSIS	C	0 0				74.00
76.00 03950 OTHER ANCI LLARY SERVICE COST CENTERS	C	0 0				76.00
76. 01 03952 NEURODI AGNOSTI C	C	0 0				76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	C	0 0				76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	C	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0				92.00
93.00 04040 PATIENT CARE CENTER - OCC	C	0				93.00
OTHER REIMBURSABLE COST CENTERS	-					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	C	-				96.00
200.00 Subtotal (see instructions)	437	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	C					201.00
Only Charges		_				
202.00 Net Charges (line 200 +/- line 201)	437	' O	1			202.00

Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150048	Period: From 01/01/2014	Worksheet D Part V	
				To 12/31/2014		pared:
					3/27/2015 9:5	<u>1 am</u>
		l lit	le XIX	Hospi tal	Cost	
			Charges	0.1	Costs	
Cost Center Description	Lost to Charge	PPS Reimbursed Services (see	Cost Reimbursed	Cost Reimbursed	PPS Services	
	Ratio From Worksheet C,	inst.)	Servi ces	Services Not	(see inst.)	
	Part I, col. 9		Subject To	Subject To		
	raiti, cui. 🤊		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2100	0100		0100	
50. 00 05000 OPERATI NG ROOM	0. 294337	0	5, 686, 53	35 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 311655	0	198, 05	64 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 193868	0	6, 588, 70	0 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 170255	0	1, 763, 90	07 0	0	59.00
60. 00 06000 LABORATORY	0. 168247	0	3, 679, 57	/2 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 320032	0	116, 79	95 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 605798	0	2, 274, 89	0 8	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 137785	0	1, 081, 33	39 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 224541	0	329, 24	6 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 021999	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 564262	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 287454	0	3, 161, 76	07 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	1. 192073			0 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	76.00
76. 01 03952 NEURODI AGNOSTI C	0. 000000			0 0	0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 447061	0	61, 42	28 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1	1	1			
91.00 09100 EMERGENCY	0. 280993		-,,		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 822634				0	92.00
93. 00 04040 PATIENT CARE CENTER - OCC	1. 125346	0	482, 99	04 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		-	1	-	-	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 423923			0 0	-	
200.00 Subtotal (see instructions)		0	28, 988, 08	0		200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges			20 000 00		_	202 00
202.00 Net Charges (line 200 +/- line 201)	I	0	28, 988, 08	32 0	0	202.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		CCN: 150048	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 3/27/2015 9:5	epared: 51 am
		Ti t	le XIX	Hospi tal	Cost	_
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 673, 758		•			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	61, 725	C				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 277, 338	C				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	300, 314	C				59.00
60. 00 06000 LABORATORY	619, 077	C				60.00
65. 00 06500 RESPI RATORY THERAPY	37, 378	C				65.00
66. 00 06600 PHYSI CAL THERAPY	1, 378, 129	C				66.00
69. 00 06900 ELECTROCARDI OLOGY	148, 992	C C				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	73, 929	l c				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c c				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	c c				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	908, 863	l c				73.00
74.00 07400 RENAL DIALYSIS	0	l c				74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	l c				76.00
76. 01 03952 NEURODI AGNOSTI C	0	C C				76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	27, 462		•			76.97
OUTPATIENT SERVICE COST CENTERS	,	-				-
91. 00 09100 EMERGENCY	942, 437	C				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	171, 843		•			92.00
93. 00 04040 PATIENT CARE CENTER - OCC	543, 535		•			93.00
OTHER REIMBURSABLE COST CENTERS	0.0,000					
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED	0	C				96.00
200.00 Subtotal (see instructions)	8, 164, 780	-	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 104, 700					201.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	8, 164, 780	c				202.00
	0,104,700		1			1202.00

REID HOSPITAL	& HEALTH CARE SERVICES	

In Lieu of Form CMS-2552-10

'OMDITI,	Financial Systems REID HOSPITAL & HEALTH			u of Form CMS-2	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 150048	Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre	pare
				3/27/2015 9:5	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed days			32, 918	
00	Inpatient days (including private room days, excluding swing-			32, 918	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation be	ed days)		30, 627	4.
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	00,027	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	21 of the cost	0	7
00	reporting period	il days) thi odgit becember	ST OF THE COST	0	· ·
00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	-			
. 00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	17, 828	9.
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	ave)	0	10
. 00	through December 31 of the cost reporting period (see instruc-		oom days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	room days) after	0	11
	December 31 of the cost reporting period (if calendar year, en			_	
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
3. 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 ye			0	
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	1 17
	reporting period	es through becomber of e		0.00	
3. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period			0.00	10
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
0. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions			30, 921, 840	
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23
5.00	x line 18)			0	20
4.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
	7 x line 19)				
	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		30, 921, 840	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · ·			
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	
				0	
. 00	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges)	÷line 28)		0 00000	21
. 00 . 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ·	÷line 28)		0. 000000 0. 00	
. 00 . 00 . 00 . 00	Semi-private room charges (excluding swing-bed charges)	÷line 28)			32
. 00 . 00 . 00 . 00 . 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00 0.00 0.00	32 33 34
0.00 0.00 .00 2.00 3.00 4.00 5.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	nus line 33)(see instruc	tions)	0.00 0.00 0.00 0.00	32 33 34 35
9.00 0.00 1.00 2.00 3.00 4.00 5.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	nus line 33)(see instruc ne 31)		0.00 0.00 0.00 0.00 0.00	32 33 34 35 36
9.00 0.00 1.00 2.00 3.00 4.00 5.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nus line 33)(see instruc ne 31)		0.00 0.00 0.00 0.00	32 33 34 35 36
2. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nus line 33)(see instruc ne 31)		0.00 0.00 0.00 0.00 0.00	32 33 34 35 36
2.00 .00 .00 2.00 3.00 3.00 5.00 5.00 7.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nus line 33)(see instruc ne 31) and private room cost di		0.00 0.00 0.00 0.00 0.00	32 33 34 35 36 37
0.00 0.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	nus line 33)(see instruc ne 31) and private room cost di JSTMENTS instructions)		0.00 0.00 0.00 30,921,840 939.36	32 33 34 35 36 37 37
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	nus line 33)(see instruc ne 31) and private room cost di <u>JSTMENTS</u> instructions) 38)		0.00 0.00 0.00 0.00 0 30,921,840	32 33 34 35 36 37 38 38 39

Heal th	Financial Systems REID H	IOSPI TAL & HEALT	H CARE SERVIC	ES	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (eri od:	Worksheet D-1	
					rom 01/01/2014 0 12/31/2014	Date/Time Pre	pared:
						3/27/2015 9: 5	1 am
	Cost Costos Description	Tatal		XVIII	Hospi tal	PPS	
	Cost Center Description	Total npatient CostIn	Total patient DavsD	Average Per)iem (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
10.00		1.00	2.00	3.00	4.00	5.00	10.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	8, 118, 028	5, 569	1, 457. 72	2, 338	3, 408, 149	43.00
44.00	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.00
47.00	Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wks					31, 414, 966	
49.00	Total Program inpatient costs (sum of lines 4	1 through 48)(se	e instruction	is)		51, 570, 025	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine se	rvices (from	Wkst D sum	of Parts L and	2, 803, 194	50.00
00.00				intot. D, Sum		2,000,171	00.00
51.00	Pass through costs applicable to Program inpa-	tient ancillary	services (fro	om Wkst. D, su	m of Parts II	2, 405, 752	51.00
52.00	and IV) Total Program excludable cost (sum of lines 50) and 51)				5, 208, 946	52.00
	Total Program inpatient operating cost excludi		ited. non-phys	ician anesthe	tist. and	46, 361, 079	
	medical education costs (line 49 minus line 52	5 1				,,	
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge						54.00 55.00
	Target amount (line 54 x line 55)					0.00	56.00
	Difference between adjusted inpatient operation	ng cost and targ	jet amount (li	ne 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost repo market basket	orting period en	idi ng 1996, up	dated and com	pounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year of	ost report, upda	ited by the ma	irket basket		0.00	60.00
	If line 53/54 is less than the lower of lines				he amount by	0	61.00
	which operating costs (line 53) are less than		(lines 54 x 6	0), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see in Relief payment (see instructions)	istructions)				0	62.00
	Allowable Inpatient cost plus incentive payment	nt (see instruct	ions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	s through Decemb	er 31 of the	cost reportin	g period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs	s after December	31 of the co	st reporting	period (See	0	65.00
	instructions)(title XVIII only)			. 0			
66.00	Total Medicare swing-bed SNF inpatient routine	e costs (line 64	plus line 65	5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through D	ecember 31 of	the cost ren	orting period	0	67.00
	(line 12 x line 19)	0			0.1	, j	07100
68.00	Title V or XIX swing-bed NF inpatient routine	costs after Dec	ember 31 of t	he cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient ro	outine costs (li	ne 67 ± line	68)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NUF					0	07.00
	Skilled nursing facility/other nursing facili	2		• •			70.00
71.00	Adjusted general inpatient routine service cos		ne 70 ÷ line 2	!)			71.00
72.00 73.00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applical		line 14 x lin	ie 35)			72.00 73.00
	Total Program general inpatient routine service						74.00
75.00	Capital-related cost allocated to inpatient re	outine service c	costs (from Wo	orksheet B, Pa	rt II, column		75.00
74 00	26, line 45)	2)					74 00
76.00 77.00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76.00 77.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess						79.00
80. 00 81. 00	Total Program routine service costs for companing Inpatient routine service cost per diem limita		st limitation	(line 78 minu	s line 79)		80. 00 81. 00
	Inpatient routine service cost per drem frim a						81.00
83.00	Reasonable inpatient routine service costs (se	· · · · · · · · · · · · · · · · · · ·					83.00
	Program inpatient ancillary services (see ins	,	`				84.00
	Utilization review - physician compensation (Total Program inpatient operating costs (sum o						85.00 86.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		agn 00)				55.00
	Total observation bed days (see instructions)					2, 291	87.00
	Adjusted general inpatient routine cost per di	•	ine 2)			939.36	
89.00	Observation bed cost (line 87 x line 88) (see	Instructions)				2, 152, 074	89.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 340, 789	30, 921, 840	0. 14037	2, 152, 074	302, 106	90.00
91.00 Nursing School cost	0	30, 921, 840	0.00000	2, 152, 074	0	91.00
92.00 Allied health cost	0	30, 921, 840	0.00000	2, 152, 074	0	92.00
93.00 All other Medical Education	0	30, 921, 840	0.00000	2, 152, 074	0	93.00

MPUT	ATI ON OF I NPATI ENT OPERATI NG COST	Provider CCN: 150048 Component CCN: 15S048		Worksheet D-1 Date/Time Pre 3/27/2015 9:5	pare
		Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS I NPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		12, 618	1 1.
	Inpatient days (including private room days, excluding swing-			12, 618	2
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be			12, 618	4
00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	12,010	4 5
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7
00	reporting period	i days) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			0.010	9
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	8, 312	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct			_	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12
	through December 31 of the cost reporting period	5	5 ,	-	
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX			0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	an (exer during swring bed i	uays)	0	
. 00	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT	- thursen December 21 -	6 + +	0.00	1 1 7
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions	·		7, 119, 870	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost report	ng period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reportion	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
	x line 20)	1 3			
	Total swing-bed cost (see instructions)			0	
1	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		7, 119, 870	27
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		-	0	29
	Semi-private room charges (excluding swing-bed charges)	line 20)		0	30
	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- 1118 20)		0.000000	
	Average semi-private room per diem charge (line 20 ÷ line 3)			0.00	
. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	34
-	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 7, 119, 870	
	27 minus line 36)				³⁷
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			E(4 0)	200
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			564.26 4,690,129	
	Medically necessary private room cost applicable to the Progra			4,070,127	
	Total Program general inpatient routine service cost (line 39			4, 690, 129	

OMPUT	Financial Systems REID ATION OF INPATIENT OPERATING COST		LTH CARE SERVI Provi der	CCN: 150048	Peri od:	u of Form CMS- Worksheet D-1	
			Componen	t CCN: 15SO48	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	3/27/2015 9:5 PPS	
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		•	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00 C) 42.
. 00	Intensive Care Type Inpatient Hospital Units	0		0.0			42.
8.00	INTENSIVE CARE UNIT	0	C	0. (0 00	C	
1.00 5.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
. 00	SURGI CAL I NTENSI VE CARE UNI T						45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	t. D-3, col. 3	3, line 200)			1, 681, 702	2 48
. 00	Total Program inpatient costs (sum of lines 4	1 through 48)(see instructio	ons)		6, 371, 831	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine	services (from	Wkst. D, sur	n of Parts I and	570, 037	7 50
. 00	Pass through costs applicable to Program inpa and IV)	tıent ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	134, 220) 51
. 00	Total Program excludable cost (sum of lines 5	0 and 51)				704, 257	52
8.00	Total Program inpatient operating cost exclud		elated, non-phy	sician anestr	netist, and	5, 667, 574	1 53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
. 00	Program di scharges					C	54
	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	arget amount (1	ino 56 minus	lino 52)		
. 00	Bonus payment (see instructions)	ng cost and ta	inger anount (i	The so minus	TTHE 53)		
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996, ι	pdated and co	ompounded by the	0.00	
~~~	market basket						
). 00 . 00	Lesser of lines 53/54 or 55 from prior year c If line 53/54 is less than the lower of lines				the amount by	0.00	
. 00	which operating costs (line 53) are less than						
~~	amount (line 56), otherwise enter zero (see i	nstructions)					
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (soo instru	uctions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						1 03
. 00	Medicare swing-bed SNF inpatient routine cost	s through Dece	ember 31 of the	e cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	per 31 of the c	ost reporting	period (See	l o	) 65
	instructions)(title XVIII only)					_	
. 00	Total Medicare swing-bed SNF inpatient routin	e costs (line	64 plus line 6	5)(title XVII	l only). For	0	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	n December 31 d	of the cost re	eporting period	l c	67
	(line 12 x line 19)	-				-	
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after D	ecember 31 of	the cost repo	orting period	0	68
9.00	Total title V or XIX swing-bed NF inpatient r	outine costs (	line 67 + line	e 68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER NU					I	_
0. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		• •			70
. 00	Program routine service cost (line 9 x line 7		ine io ÷ inte	-)			72
. 00	Medically necessary private room cost applica						73
. 00 . 00	Total Program general inpatient routine servi		,		ort II column		74
. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service		IOTKSNEEL B, F	art II, corumn		/5
. 00	Per diem capital-related costs (line 75 ÷ lin						76
	Program capital -related costs (line 9 x line	· ·					77
. 00 . 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		provider record	ls)			78
. 00	Total Program routine service costs for compa				nus line 79)		80
. 00	Inpatient routine service cost per diem limit						81
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .				82
. 00	Program inpatient ancillary services (see ins						84
. 00	Utilization review - physician compensation (	see instructio					85
. 00	Total Program inpatient operating costs (sum		nrough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	THROUGH CUST				C	87
	Adjusted general inpatient routine cost per d	iem (line 27 ÷	line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see					0	89

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
		Ti tl	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•	•			
90.00 Capital-related cost	865, 332	7, 119, 870	0. 12153	8 0	0	90.00
91.00 Nursing School cost	0	7, 119, 870	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	7, 119, 870	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 119, 870	0.00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150048 Component CCN: 15T048		Worksheet D-1 Date/Time Pre 3/27/2015 9:5	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2,900	1
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		2, 900	2
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		2, 900	4
00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	2, ,00	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roor	n davs) through December	31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 981	9
	newborn days)		g bou unu	1, 701	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, er		Join days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
00	through December 31 of the cost reporting period	( only (including privat	a room dave)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions	5)		3, 016, 010	21
. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ng period (line	0	22
00	5 x line 17) Swing had agat applicable to SNE type convises often December	21 of the east reporting	a posted (line (	0	1 22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (inte o	0	23
. 00	Swing-bed cost applicable to NF type services through December	- 31 of the cost reportio	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	1 of the east reporting	noried (line 0	0	25
. 00	x line 20)	si oi the cost reporting	period (inte o	0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 016, 010	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi - private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforontial (line	0 3, 016, 010	
. 00	27 minus line 36)	and private room cost all		3, 010, 010	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 040 00	
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 040. 00 2, 060, 240	
	Medically necessary private room cost applicable to the Progra			2,000,240	
	Total Program general inpatient routine service cost (line 39			2,060,240	

	Financial Systems REID TION OF INPATIENT OPERATING COST	HOSPI TAL & HEA		CCN: 150048	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15T048	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	3/27/2015 9:5 PPS	
	Cost Center Description	Total	Total	Average Pe	IRF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42.
	ntensive Care Type Inpatient Hospital Units	0		<u>, 0.</u>			42
	NTENSI VE CARE UNI T	0	C	0.	00 0	0 0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
	SURGI CAL I NTENSI VE CARE UNI T						46
	THER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00 F	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			781, 679	48
	Total Program inpatient costs (sum of lines 4	1 through 48)(	see instructio	ons)		2, 841, 919	49
	ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tient routine	services (from	n Wkst. D, su	m of Parts I and	410, 681	50
1	)						
	Pass through costs applicable to Program inpa and IV)	itient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	109, 139	51
. 00 T	Fotal Program excludable cost (sum of lines 5	,				519, 820	
	Total Program inpatient operating cost exclud nedical education costs (line 49 minus line 5		lated, non-phy	/sician anest	hetist, and	2, 322, 099	53
	ARGET AMOUNT AND LIMIT COMPUTATION	) 				1	1
. 00 F	Program di scharges					0	
	Farget amount per discharge					0.00	
	Farget amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and ta	raet amount (1	ing 56 minus	line 53)		
	Bonus payment (see instructions)	ng cost and ta	inger anount (i		TTHE 55)		
	esser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996, ι	updated and c	ompounded by the	0.00	
	narket basket						
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i			00), 01 18 0	i the target		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme ROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	) 63
	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	e cost report	ing period (See	0	64
	nstructions)(title XVIII only)						
	Medicare swing-bed SNF inpatient routine cost nstructions)(title XVIII only)	s after Decemb	er 31 of the c	cost reportin	g period (See	C	65
	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66
	CAH (see instructions)						
	Fitle V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	of the cost r	eporting period	C	67
1 1	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)			(0)			
	Fotal title V or XIX swing-bed NF inpatient r ART III - SKILLED NURSING FACILITY, OTHER NU					0	69
	Skilled nursing facility/other nursing facili						70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 7		(1:	25)			72
	Medically necessary private room cost applica Total Program general inpatient routine servi						73
	Capital -related cost allocated to inpatient r				Part II, column		75
1	26, line 45) Por diom capital related costs (line 75 , lin	2)					
	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line						76
. 00   I	npatient routine service cost (line 74 minus	· · ·					78
1	ggregate charges to beneficiaries for excess						79
	fotal Program routine service costs for compa		ost limitation	n (line 78 mi	nus line 79)		80
	npatient routine service cost per diem limit npatient routine service cost limitation (li		)				81
	Reasonable inpatient routine service cost film tation (in						83
	Program inpatient ancillary services (see ins						84
5. 00 L	Jtilization review - physician compensation (	see instructio					85
	Total Program inpatient operating costs (sum		rough 85)				86
	ART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					C	87
	Adjusted general inpatient routine cost per c		line 2)			0.00	
00 0	Deservation bed cost (line 87 x line 88) (see	instructions)					89

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•	•			
90.00 Capital-related cost	601, 202	3, 016, 010	0. 19933	67 0	0	90.00
91.00 Nursing School cost	0	3, 016, 010	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	3, 016, 010	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 016, 010	0.00000	0 0	0	93.00

REI D	HOSPI TAL	&	HEALTH	CARE	SERVI CES	

Heal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES	In Lie	eu of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 150048	Peri od:	Worksheet D-1		
			From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5		
		Title XIX	Hospi tal	Cost		
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS				1	
	Inpatient days (including private room days and swing-bed days,			32, 918		
2.00 3.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days do not complete this line.		ivate room days,	32, 918 0		
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	30, 627 0	4.00 5.00	
6.00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6.00	
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8.00	
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 829	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi	y (including private r ons)	oom days)	0	10.00	
	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	er 0 on this line)	5 /		11.00	
	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	3	3 /		12.00	
	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	0	13.00			
	Total nursery days (title V or XIX only)	excluding swing-bed	uays)		14.00	
	Nursery days (title V or XIX only)				16.00	
	SWING BED ADJUSTMENT					
	Medicare rate for swing-bed SNF services applicable to services reporting period		17.00			
	Medicare rate for swing-bed SNF services applicable to services reporting period		18.00			
	Medicaid rate for swing-bed NF services applicable to services reporting period Medicaid rate for swing-bed NF services applicable to services	0			19.00 20.00	
	reporting period Total general inpatient routine service cost (see instructions)		lie cost	30, 921, 840		
	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)		ing period (line	0		
23.00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 x line 20) $$	of the cost reporting	period (line 8	0	25.00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 30, 921, 840	26.00 27.00	
~~ ~~	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				00.00	
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0		
	Semi-private room charges (excluding swing-bed charges)			0	30.00	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000		
	Average private room per diem charge (line 29 ÷ line 3)			0.00		
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
	Average per diem private room charge differential (line 32 minu		tions)	0.00		
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line	0 30, 921, 840		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			1	
	Adjusted general inpatient routine service cost per diem (see i	nstructions)		939.36		
	Program general inpatient routine service cost (line 9 x line 3			1, 718, 089		
	Medically necessary private room cost applicable to the Program			0 1 719 090		
41.00	Total Program general inpatient routine service cost (line 39 +	11 ne 40)		1, 718, 089	41.00	

Heal th	Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lie	u of Form CMS-2	2552-10						
	ATION OF INPATIENT OPERATING COST Provider CCN: 150048 Period: From 01/01/2014	Worksheet D-1							
	To 12/31/2014	Date/Time Pre 3/27/2015 9:5							
	Title XIX         Hospital           Cost Center Description         Total         Average Per         Program Days	Cost Program Cost							
		(col. 3 x col. 4)							
	1.00 2.00 3.00 4.00	5.00							
42.00	NURSERY (title V & XIX only)         1,094,274         1,899         576.24         112           Intensive Care Type Inpatient Hospital Units         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1	64, 539	42.00						
43.00	INTENSIVE CARE UNIT 8, 118, 028 5, 569 1, 457. 72 328	478, 132	43.00						
44.00 45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44.00 45.00						
46.00	SURGICAL INTENSIVE CARE UNIT		46.00						
47.00	OTHER SPECIAL CARE (SPECIFY)		47.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1.00 2,957,377	48.00						
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	5, 218, 137							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00						
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00						
52.00	Total Program excludable cost (sum of lines 50 and 51)	0							
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00						
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges	0	54.00						
55.00	Target amount per discharge	0.00							
56.00 57.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56.00 57.00						
58.00	Bonus payment (see instructions)	0 0. 00	58.00 59.00						
59.00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket								
60.00 61.00									
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)									
62.00	0	62.00							
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST									
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00						
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00						
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66.00						
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00						
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68.00						
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00						
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00						
71.00 72.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) Program routine service cost (line 9 x line 71)		71.00 72.00						
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00						
74.00 75.00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74.00 75.00						
	26, line 45)								
76.00 77.00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76.00 77.00						
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00						
79.00 80.00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79.00 80.00						
81.00	Inpatient routine service cost per diem limitation		81.00						
82.00 83.00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82.00 83.00						
84.00	Program inpatient ancillary services (see instructions)		84.00						
85.00 86.00	Utilization review – physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		85.00 86.00						
Q7 00	PART I V - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	2, 291	87.00						
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	939.36	88.00						
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2, 152, 074	89.00						

Health Financial Systems RELE	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				Γο 12/31/2014		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 340, 789	30, 921, 840	0. 14037	2, 152, 074	302, 106	90.00
91.00 Nursing School cost	0	30, 921, 840	0.00000	2, 152, 074	0	91.00
92.00 Allied health cost	0	30, 921, 840	0.00000	2, 152, 074	0	92.00
93.00 All other Medical Education	0	30, 921, 840	0.00000			93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150048 Component CCN: 15S048	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prep 3/27/2015 9:5	pare
		Title XIX	Subprovider - IPF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		12, 618	1 1
00	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-b			12, 618	
00	Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	d days)		12, 618	4
00	Total swing-bed SNF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	dave) after December 2	1 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	uays) arter December s	I OI LINE COST	0	l °
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	0	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en	ter 0 on this line)			1.10
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	5. 01	<b>3</b> ,	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
	Medically necessary private room days applicable to the Progra			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 899 112	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through December 31 o	t the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions	)		7, 119, 870	21
. 00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	r 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
	x line 20)		,	0	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		0 7, 119, 870	
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and observation had			1 ~~
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	ai yes)	0	
. 00	Semi-private room charges (excluding swing bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 min		tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	0 7, 119, 870	
. 00	27 minus line 36)		•		
. 00					1
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU:	STMENTS			
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	instructions)		564.26	
. 00 . 00 . 00 . 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	instructions) 38)		564. 26 0 0	39

COMPUT	Financial Systems         REID           ATION OF INPATIENT OPERATING COST	HOSPITAL & HEA		CCN: 150048	Peri od:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15SO48	From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
			Ti t	le XIX	Subprovider -	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.
3. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43.
4.00	CORONARY CARE UNIT						44.
5.00 5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			179, 978	48.
. 00	Total Program inpatient costs (sum of lines 4	1 through 48)(	see instructio	ins)		179, 978	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.
. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.
2.00	Total Program excludable cost (sum of lines §					0	
3. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9		lated, non-phy	sician anesth	etist, and	0	53.
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and ta	ract amount (	ino 56 minus	Lipo 52)	0	
. 00	Bonus payment (see instructions)	ng cost and ta	nget anount (i	The 56 million	TTHE 55)	0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996, u	pdated and co	mpounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	ost report un	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
2.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructrons)				0	62.
3.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63.
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	cost reporti	na period (See	0	64.
	instructions)(title XVIII only)	0			0 1 1		
5. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s after Decemb	er 31 of the c	ost reporting	period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66
00	CAH (see instructions)	costs through	December 21	f the cost re	porting poriod	o	67
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	n the cost re	eporting period	0	07.
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68
9 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (	line 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY	, AND ICF/MR O	NLY			
0. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		• •			70.
. 00	Program routine service cost (line 9 x line 3		The 70 ÷ Trhe	2)			72
. 00	Medically necessary private room cost applica						73
. 00 . 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•	,		Part II. column		74
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess						79
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost limitation	ı (ııne /8 mir	ius line /9)		80
	Inpatient routine service cost per drem rim		)				82
. 00	Reasonable inpatient routine service costs (s		s)				83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ins)				84 85
5.00	Total Program inpatient operating costs (sum	of lines 83 th					86.
00	PART IV - COMPUTATION OF OBSERVATION BED PASS					0	07
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•	,				89.

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of						2552-10
COMPUTATION OF INPATIENT OPERATING COST				Period: From 01/01/2014	Worksheet D-1	
		Component	Component CCN: 15SO48		Date/Time Prep 3/27/2015 9:5	
		Tit	le XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST		•			
90.00 Capital-related cost	865, 332	7, 119, 870	0. 12153	8 0	0	90.00
91.00 Nursing School cost	0	7, 119, 870	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	7, 119, 870	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 119, 870			0	93.00

)MPU14	TION OF INPATIENT OPERATING COST	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prep 3/27/2015 9:5	pare
		Title XIX	Subprovider - IRF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	NPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		2, 900	1 1.
	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-b			2, 900	2.
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3
	do not complete this line. Semi-private room days (excluding swing-bed and observation be			2,000	
	Total swing-bed SNF type inpatient days (including private roc	5 7	r 31 of the cost	2, 900 0	45
	reporting period				
	Total swing-bed SNF type inpatient days (including private roc	m days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through December	21 of the cost	0	7
	reporting period	i days) till odgit becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
	Total inpatient days including private room days applicable to newborn days)	the program (excluding	swing-bed and	0	9
	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct			_	
	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period	3 . 0 .	<b>3</b> ,		
	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)			1, 899	
	Nursery days (title V or XIX only)			112	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	1 17
	reporting period			0.00	
	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	10
	reporting period	through becomen of or		0.00	
	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period Total general inpatient routine service cost (see instructions	.)		3, 016, 010	21
	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	3, 010, 010	
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24
	7 x line 19)		5 1 2 2 2		
	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		3, 016, 010	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	us ling 22) (coo inctrus	tions)	0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	,		0	36
	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	3, 016, 010	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
. 00 [	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 040. 00	
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			0	
. 00				0	40

	Financial         Systems         REID           ATION OF INPATIENT OPERATING COST	HOSPITAL & HEA		CCN: 150048	Peri od:	worksheet D-1	
			Component	CCN: 15T048	From 01/01/2014 To 12/31/2014		
			Ti t	le XIX	Subprovider -	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		IRF Program Days ÷	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	-
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.
3. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43.
1.00	CORONARY CARE UNIT						44.
5.00 5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wks			>		1, 293	
9. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48)(	see instructio	ins)		1, 293	49.
0. 00	Pass through costs applicable to Program inpa	ntient routine	services (from	Wkst. D, sum	of Parts I and	0	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	ntient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.
2.00	and IV)	0  and  E1				0	52.
3.00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5	ling capital re	lated, non-phy	sician anesth	etist, and	0	
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.
	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	0	0			0	58.
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	ending 1996, u	pdated and co	mpounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i				the target		
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	
. 00	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	period (See	0	65.
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir	o costs (lino	64 plus lipo 6			0	66.
	CAH (see instructions)			<i>,</i> , ,	57		
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	porting period	0	67.
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.
. 00	Skilled nursing facility/other nursing facili	ty/ICF/MR rout	ine service co	st (line 37)			70.
. 00 . 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ıne 70 ÷ line	2)			71.
. 00	Medically necessary private room cost applica	ble to Program					73.
. 00 . 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r		,		Part II, column		74 75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76
00	Program capital-related costs (line 9 x line						77
. 00 . 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	s)			78
. 00	Total Program routine service costs for compa	rison to the c			us line 79)		80
. 00 . 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				81
. 00	Reasonable inpatient routine service costs (s	ee instruction					83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (		uns)				84 85
. 00	Total Program inpatient operating costs (sum						85.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
7.00 3.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see		,				89.

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of						2552-10
COMPUTATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		
	_	Tit	le XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	601, 202	3, 016, 010	0. 19933	67 0	0	90.00
91.00 Nursing School cost	0	3, 016, 010	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 016, 010	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 016, 010	0. 00000	0 0	0	93.00

	ancial Systems REID HOSPITAL & HEALTH ANCILLARY SERVICE COST APPORTIONMENT	CARE SERVI	CCN: 150048	Peri		u of Form CMS-2 Worksheet D-3	
INPALLENT	ANCILLART SERVICE COST APPORTIONWENT	PLOVE	CCN. 150046		00. 1 01/01/2014	WULKSHEEL D-3	
				To	12/31/2014		pared:
						3/27/2015 9:5	1 am
		Ti tl	e XVIII		Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	Inpatient	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x col.	
			1.00		2.00	2) 3.00	
LNP	ATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
	00 ADULTS & PEDIATRICS				21, 775, 624		30. 0
	DO I NTENSI VE CARE UNI T				4, 834, 819		31.0
	00 SUBPROVIDER - IPF				888, 649		40.0
	00 SUBPROVIDER - IRF				000,017		41.0
	DO NURSERY				-		43.0
	ILLARY SERVICE COST CENTERS		1	Į			
50.00 050	DO OPERATING ROOM		0. 2943	37	28, 761, 894	8, 465, 690	50.0
52.00 052	DO DELIVERY ROOM & LABOR ROOM		0. 3116	55	37, 013	11, 535	52.0
54.00 054	DO RADI OLOGY-DI AGNOSTI C		0. 1938	68	14, 915, 471	2, 891, 633	54.0
	DO CARDI AC CATHETERI ZATI ON		0. 1702	55	7, 245, 670	1, 233, 612	59.0
	DO LABORATORY		0. 1682		19, 542, 560	3, 287, 977	
	00 RESPI RATORY THERAPY		0. 3200		4, 183, 020		
	00 PHYSI CAL THERAPY		0.6057		1, 837, 534		
	DO ELECTROCARDI OLOGY		0. 1377		2, 742, 635		
	00 ELECTROENCEPHALOGRAPHY		0. 2245		4, 470		
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0219		1, 874, 411		
	DO IMPL. DEV. CHARGED TO PATIENT		0. 5642		8, 396, 396		
	DO DRUGS CHARGED TO PATIENTS		0. 2874		18, 663, 220	5, 364, 817	
	DO RENAL DI ALYSI S		1. 1920		453, 077	540, 101	
	50 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	0	
	52 NEURODI AGNOSTI C		0.0000		0	0	76.0
	97 CARDIAC REHABILITATION		0. 4470	61	1, 288	576	76.9
	PATIENT SERVICE COST CENTERS		0. 2809	02	5, 965, 329	1, 676, 216	91.0
	00 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2809		5, 905, 329 404, 840	333, 035	
	40 PATIENT CARE CENTER - OCC		1. 1253		404, 840	0	
	ER REIMBURSABLE COST CENTERS		1. 1255	-0	0	0	, 75.0
	00 DURABLE MEDICAL EQUIP-RENTED		0. 4239	23	0	0	96.0
200.00	Total (sum of lines 50-94 and 96-98)		0. 1207		115, 028, 828	-	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0	0.,, ,00	201.0
202.00	Net Charges (line 200 minus line 201)	、···· -··	1		115, 028, 828		202.0

Health Financial Systems REID HOSPITAL & HEALTH	CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150048	Peri od:	Worksheet D-3	
			From 01/01/2014		
	Component	t CCN: 15SO48	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Title XVIII		Subprovider -	PPS	
			I PF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVIDER - IPF			8, 779, 391		40.00
41. 00 04100 SUBPROVIDER - IRF			0, 777, 371		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					101.00
50. 00 05000 OPERATI NG ROOM		0. 2943	37 615, 819	181, 258	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3116		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1938			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1702			1
60. 00 06000 LABORATORY		0. 1682		238, 536	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3200	32 239,042	76, 501	65.00
66. 00 06600 PHYSI CAL THERAPY		0.6057	98 304,008	184, 167	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1377	85 114, 277	15, 746	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2245	41 0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 0219	99 234,005	5, 148	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5642	62 172, 848	97, 532	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2874		503, 536	
74. 00 07400 RENAL DIALYSIS		1. 1920	73 48, 991	58, 401	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	76.00
76. 01 03952 NEURODI AGNOSTI C		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4470	61 0	0	76.97
OUTPATI ENT SERVI CE COST CENTERS		1			
91.00 09100 EMERGENCY		0. 2809		146, 883	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 8226		0	
93. 00 04040 PATIENT CARE CENTER - OCC		1. 1253	46 0	0	93.00
		0.4000	22		04.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 4239		0	
200.00 Total (sum of lines 50-94 and 96-98)	(1) 00 (1)		6, 332, 024	1, 681, 702	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(The 61)		6 222 024		201.00
202.00 Net Charges (line 200 minus line 201)		I	6, 332, 024	l	202.00

Health Financial Systems REID HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150048	Peri od:	Worksheet D-3	;
			From 01/01/2014		
	Component	t CCN: 15T048	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Titl	e XVIII	Subprovi der –	PPS	
			IRF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			2, 355, 133		41.00
43. 00 04300 NURSERY			2, 333, 133		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 2943	37 5, 034	1, 482	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3116		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1938		16, 729	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1702		0	
60. 00 06000 LABORATORY		0. 1682			
65. 00 06500 RESPI RATORY THERAPY		0. 3200			
66. 00 06600 PHYSI CAL THERAPY		0.6057			
69.00 06900 ELECTROCARDI OLOGY		0. 1377			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2245	41 214	48	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0219	99 111	2	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5642	62 6, 466	3, 649	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2874	54 55, 614	15, 986	73.00
74. 00 07400 RENAL DIALYSIS		1. 1920		11, 804	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	76.00
76. 01 03952 NEURODI AGNOSTI C		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4470	61 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		1			
91. 00 09100 EMERGENCY		0. 2809		130	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8226			
93. 00 04040 PATIENT CARE CENTER - OCC		1. 1253	46 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		0.4000	0.0		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 4239		-	
200.00 Total (sum of lines 50-94 and 96-98)	(1) (1)		1, 850, 098	781, 679	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		1 050 000		201.00
202.00 Net Charges (line 200 minus line 201)		I	1, 850, 098	l	202.00

Heal th	Financial Systems REID HOSPITAL & HEALTH C	ARE SERVI	CES		In Lie	u of Form CMS-	2552-10
I NPATI E	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150048		ri od:	Worksheet D-3	
					om 01/01/2014		
				То	12/31/2014	Date/Time Pre 3/27/2015 9:5	
		Ti t	le XIX		Hospi tal	Cost	i ani
	Cost Center Description		Ratio of Cos	t l	Inpatient	Inpati ent	
			To Charges		Program	Program Costs	
			j i i i i i i i i i i i i i i i i i i i			(col. 1 x col.	
					J a J	2)	
			1.00		2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	D3000 ADULTS & PEDI ATRI CS				2, 606, 399		30.00
31.00	D3100 I NTENSI VE CARE UNI T				869, 312		31.00
40.00	D4000 SUBPROVIDER - IPF				0		40.00
41.00	D4100 SUBPROVIDER - IRF				0		41.00
43.00	D4300 NURSERY				248, 478		43.00
7	ANCI LLARY SERVI CE COST CENTERS						1
50.00	D5000 OPERATING ROOM		0. 2943	37	2, 863, 859	842, 940	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM		0. 3116	55	270, 471	84, 294	52.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C		0. 1938	68	1, 268, 320	245, 887	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1702	55	1, 058, 761	180, 259	59.00
	D6000 LABORATORY		0. 1682	47	2, 279, 699	383, 553	60.00
65.00	06500 RESPI RATORY THERAPY		0. 3200	32	717, 321	229, 566	65.00
66.00	D6600 PHYSI CAL THERAPY		0.6057	98	141, 043	85, 444	66.00
69.00	D6900 ELECTROCARDI OLOGY		0. 1377	85	213, 340	29, 395	69.00
70.00	D7000 ELECTROENCEPHALOGRAPHY		0. 2245	41	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0219	99	9, 282	204	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 5642	62	0	0	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS		0. 2874	54	2, 612, 148	750, 872	73.00
74.00	07400 RENAL DIALYSI S		1. 1920		27, 623	32, 929	74.00
76.00	D3950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000	00	0	0	76.00
76.01	D3952 NEURODI AGNOSTI C		0.0000	00	0	0	76.01
76.97	D7697 CARDI AC REHABI LI TATI ON		0. 4470	61	0	0	76.97
(	DUTPATIENT SERVICE COST CENTERS						1
	D9100 EMERGENCY		0. 2809	93	327, 531	92, 034	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8226	34	0	0	92.00
	D4040 PATIENT CARE CENTER - OCC		1. 1253		0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						1
	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 4239	23	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)			1	11, 789, 398	2, 957, 377	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		1	0		201.00
202.00	Net Charges (line 200 minus line 201)	,		1	11, 789, 398		202.00

Health Financial Systems REID HOSPITAL & HEALTH	I CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150048	Peri od:	Worksheet D-3	
		000 450040	From 01/01/2014		
	Component	t CCN: 15SO48	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
	Ti t	le XIX	Subprovider -	Cost	
Cost Conton Description		Ratio of Cos	IPF st Inpatient	Innotiont	
Cost Center Description		To Charges		Inpatient Program Costs	
		10 charges	Charges	(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER – I PF			1, 621, 000		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2943	37 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3116	55 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1938	68 61, 628	11, 948	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1702	55 0	0	59.00
60. 00 06000 LABORATORY		0. 1682	47 237, 747	40, 000	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3200	32 36, 578	11, 706	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 6057	98 26, 921	16, 309	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1377	85 7, 687	1, 059	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2245	41 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0219	99 616	14	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5642	62 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2874		77, 837	
74. 00 07400 RENAL DI ALYSI S		1. 1920	73 0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	76.00
76. 01 03952 NEURODI AGNOSTI C		0.0000			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4470	61 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		-		1	
91. 00 09100 EMERGENCY		0. 2809			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8226			
93. 00 04040 PATIENT CARE CENTER - OCC		1. 1253	46 0	0	93.00
OTHER REIMBURSABLE COST CENTERS				1	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 4239		-	
200.00 Total (sum of lines 50-94 and 96-98)			717, 066	179, 978	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			717, 066	l	202.00

Health Financial Systems REID HOSPITAL & HEALTH	CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150048	Peri od:	Worksheet D-3	
	Component	CCN: 15T048	From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
	Component	L CCN: 151048	10 12/31/2014	3/27/2015 9:5	1 am
	Tit	le XIX	Subprovider -	Cost	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			2, 059		41.00
43. 00 04300 NURSERY			2,007		43.00
ANCI LLARY SERVI CE COST CENTERS					10100
50. 00 05000 OPERATI NG ROOM		0. 2943	37 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3116	55 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1938	68 2, 240	434	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1702		0	59.00
60. 00 06000 LABORATORY		0. 1682	47 701	118	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3200	32 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.6057	98 812	492	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1377	85 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2245		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0219	99 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5642		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2874		249	
74.00 07400 RENAL DIALYSIS		1. 1920		0	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	
76. 01 03952 NEURODI AGNOSTI C		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 4470	61 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY		0.2809		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.8226		0	
93. 00 04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS		1. 1253	46 0	0	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 4239	23 0	0	96.00
200.00 Total (sum of lines 50-94 and 96-98)		0. 4239	4, 618		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		4,018	1, 293	200.00
202.00 Net Charges (line 200 minus line 201)			4, 618		201.00
		I	1,010	I	1-02.00

CAL GUB ATLON OF RTHARDESHUT SETTLEMENT       Provider COX 10006       Print CX 100       Work hat the 222/2015       Work hat the 22/2015       Work	-	FINANCIAL SYSTEMS REID HUSPITAL & HEALTH C				U OT FORM CMS-	2552-10
Intervention         Intervention         PPS           0         1.00         2.00         1.00         2.00           1.01         D66 anounts other than buttler Payments To Determine the Instruct Most To Determine To Determine the Instruct Most To Determine To Determine Instruct Most To Determine To Determine To To Determine To Determine Instruct Most To Determine To Determine To Determine To Determine the Instruct Most To Determine To De	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	1		Date/Time Pre	
own A - IMPATENT High TAL SERVICE WRDE PDS         0         1.00         2.00           1.00         BC Amount's Other Than Outline Poyments for discharges occurring prior to October 1, 2013 (See Instructions)         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.01         1.00         1.02         1.00         1.02         1.00         1.02         1.00         1.02         1.00         1.02         1.00         1.02         1.00         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02         1.02			Ti tl	e XVIII	Hospi tal		1 am
Next A - TRATING TESPITAL SINGLES WORK PS         1.00           DB SG AmountS Other Then outliner payments for discharges occurring prior         42, 63, 62         1.01           1.01         DB Ge amountS other then outliner payments for discharges occurring on or after October 1, 2013 (see Instructions)         0         1.02           1.02         DB Ge amountS other then outliner payment for Model 4 PCI (see 0         0         1.02           2.00         Dettiner precedition amount         0         2.01           2.00         Dettiner precedition amount         0         2.01           2.00         Dettiner payment for Model 4 RPCI (see Instructions)         0         2.01           2.00         Dettiner precedition amount         0         2.03         0         2.01           2.00         Dettiner payment for Model 4 RPCI (see Instructions)         0         0         2.01           2.00         Dettiner payment for Model 4 RPCI (see Instructions)         0         0         0           3.00         TE count for allogathic and ostepasthic programs for the most recent         0         0.00         0           5.00         TE count for allogathic and ostepasthic programs shell moder 42         0.00         0         0           6.00         TE count for allogathic and ostepasthic programs is accordance with 42							
1.00       Bits Anoants other than Duff are Payments for discharges occurring prior to Actober 1. 2013 (see Instructions)       1.01         1.01       Bits Anoants other than outline payments for discharges occurring on or after other 1. 2013 (see Instructions)       0       1.02         1.02       Bits Anoants other than outline payments for discharges occurring on or after other 1. 2013 (see Instructions)       948.130       2.03         1.03       Bits Anoants other than outline payment for loaded 4 BPCI (see Instructions)       948.130       2.03         2.00       Duff ior payments for discharges of Weld 4 BPCI (see Instructions)       0       0       2.03         2.00       Managed Care Simulated Hammon And the by memories for Home of tays in the cost reporting period (see Instructions)       0.00       6.00         0.01       Feed Care Simulated Hammon And the discharges occurring provide cost reporting period ending on or before for231/1996, (see instructions)       0.00       6.00         0.02       Feed Care Simulated Bayment to the IME cap as specified under 42       0.00       7.00         0.03       Feed Care Simulated Bayment to the IME cap as specified under 42       0.00       7.00         0.04       Section 5503 reduction amount to the IME cap as specified under 42       0.00       7.00         0.04       Section 5503 reduction amount to the IME cap as specified under 42       0.00       7.00		PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		0	1.00	2.00	
1.01       BR amounts other than outline payments for discharges occurring prior       0       1.01         1.02       Detroit P. 2013 (see instructions)       0       1.02         1.02       Detroit P. 2013 (see instructions)       0       1.03         1.03       Detroit Indenia Specific operating payment for Model 4 IBCI (see instructions)       0       0         1.03       Detroit Indenia Specific operating payment for Model 4 IBCI (see instructions)       0       0         2.00       Dutline payments for discharges. (see instructions)       0       0       2.03         2.00       Dutline payments for discharges. (see instructions)       0       0       2.03         2.01       Detroit Indenia Subject Indenia	1.00				42, 663, 692		1.00
1.02       DBC amounts other than outliner payments for discharges occurring on ar after October 1, 2013 (see instructions)       0       1.03         1.03       DBC for Fodoral specific operating payment for Model 4 BPCI (see 0       0.01       1.03         0.00       DBC in or Fodoral specific operating payment for Model 4 BPCI (see 0       948, 130       2.00         0.01       Description payment for discharges for Model 4 BPCI (see instructions)       0       2.01         0.00       Description payment for discharges for Model 4 BPCI (see instructions)       0       0.02         0.01       Description for allopathic programs for the nost ocst reporting paried ending on or before 12/21/1996. (see instructions)       0.00       5.00         0.01       File count for all optathic and astepathic programs in accordance with 42 CFR 8412.105(7)(1)(iv)(8)(1)       0.00       7.01         0.02       CFR 8412.105(7)(1)(iv)(8)(1)       1.01       0.00       7.01         0.04       Description for all optation amount to the IME cap as specified under 42       0.00       7.01         0.04       Description for all optation amount to the IME cap as specified under 42       0.00       7.01         0.04       Description 503 of the AL of Fedoral Register, May 1, 2011.       0.00       8.01         0.04       Description 503 of the AL of Fedoral Register, May 1, 2011.       0.00		DRG amounts other than outlier payments for discharges occurring	g prior				
a Her Criber 1, 2013 (see instructions)       1.03         DB Corr Federal specific coparating payment for Model 4 BPCI (see instructions)       948, 130       2.00         D Dati for payment for discharges. (see instructions)       948, 130       2.01         D Dati for payment for discharges. (see instructions)       948, 130       2.01         D Dati for payment for discharges. (see instructions)       6.245, 6.25       3.00         D Dati for payment for discharges for Xoold 4 BPCI (see instructions)       6.245, 6.25       3.00         D Dati for payment for discharges for Xoold 4 BPCI (see instructions)       6.245, 6.25       3.00         D Dati for payment for discharges for Xoold 4 BPCI (see instructions)       0.00       6.025         D Dati for and do adding on or before 12/21/1076 (see instructions)       0.00       6.00         CER 413.76(0)       D The most recent       0.00       7.00         O MM A Section 422 (boc)(01(0)       0.00       7.00       7.01         CER 413.76(0), 421 (boc)(01(0)       1.01 (boc) (boc)(01(0)       0.00       7.00         O Adjustment (increase or decrease) to the Bris for Addel so July 1. 2011       0.00       7.01         CER 413.76(0), 411, 97(0) (2) (1) the the Bris store May 12. 1997, July 12. 1997, July 2. 1997, Ju							
1.03       DBC for Federal specific operating payment for Model 4 BPCI (see Instructions)       0       1.03         2.00       Outlier payments for discharges. (see instructions)       948,130       2.00         0.01       Dependence       0       2.00         0.01       Dependence       0       2.00         0.01       Dependence       0       2.00         0.00       Bod days available of wided by number of days in the cost reporting pariod (see instructions)       0.00       5.00         0.00       Effected Heal cal Education Adjustment       0.00       6.00       6.00         0.01       FFE count for all opathic and osleopathic programs for the most recent       0.00       6.00         0.02       CFR 4B7.21       0.00       6.00       6.00         0.03       CFR 4B7.21       0.00       7.01         0.04       CFR 4B7.21       0.00       7.01         0.05       CFR 4B7.21       0.00       7.01         1.05       MAN Section 450 reduction amount to the IME cap as specified under 42       0.00       7.01         1.04       MAN Section 450 reduction amount to the IME cap as specified under 42       0.00       7.01         1.05       MAN Section 550 reduction amount to the liME cap as splacified under 42       0.00	1.02		g on or		0		1.02
Instructions)         Outlier reconditiation amount         948,130         2.00           Outlier reconditiation amount         0         2.00         0.01         0         0         2.00           2011 or reconditiation amount         0         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.01         0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	1.03		e		0		1.03
2.01       Outlier resonant of alscharges for Model 4 JPCI (see Instructions)       0       2.01         2.02       Outlier payment for all scharges for Model 4 JPCI (see Instructions)       0       0.255, 25         3.00       Managed Care Simulated Payments       0.525, 25       3.00         4.00       Bod days avail able of ide by number of days in the cost reporting       158, 72       4.00         5.00       FIE count for allopabilic programs for the most recent       0.00       6.00       6.00         6.01       FIE count for allopabilic programs in accordance with 42       0.00       6.00       7.00         7.00       MR Section Aff (1)(iv)(8)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)							
2.02       Outlier payment for discharges for Model 4 PCI (see instructions)       0.0       2.02         3.00       Munaged Care Simulated Payments       6.256,625       3.00         4.00       Bed days available divided by number of days in the cost reporting period (see instructions).       0.00       5.00         5.00       Find rocal Modical Education Adjustment       0.00       5.00       5.00         6.00       FIL count for allopathic and osteopathic programs which meet the conter in for an adjustment in the file cap as specified under 42       0.00       6.00         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       7.01         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       7.01         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       7.01         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       7.01         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       7.01         CR 4412.105(7(1)(1)(4)(6)(1)       to the IME cap as specified under 42       0.00       8.00         All 510(5)(1.13.70(1)(2)(1)       to the FIE count for all opathic and 0.00       0.00       8.00         All 510(5)(1.13.70(1)(2)(1)       to the FIE count for allop							
3.00       Monaged Care Simulated Payments       6, 245, 625       3.00         4.00       Bed days avail able of wide by number of days in the cost reporting pariod (see instructions)       1.00       158, 72         5.00       FTE count for all opathic and osteopathic programs for the most recent       0.00       5.00         critteria for an addient to the cap for new programs in accordance with 42       0.00       7.00         CR 413, 79(e)       0.00       7.00       7.00       7.00         ACA Section 503 reduction amount to the IME cap as specified under 42       0.00       7.01         ACA Section 503 reduction amount to the IME cap as specified under 42       0.00       7.01         ACA Section 503 reduction mount to the IME cap as specified under 42       0.00       8.00         attrast 105(2), (10) (2) (1) (10) (2) If the cost report stradies July 1, 2011       0.00       8.00         attrast 105(2), (10) (2) (2) (1) vand Vol. 64 federal Register, May 12, 1998, page 2640 and Vol. 64 federal Register, May 12, 1998, page 2640 and Vol. 64 federal Register, May 12, 1998, page 2640 and Vol. 64 federal Register, May 2006, August 1, 2011, see       0.00       8.01         asction 503 of the ACA IF the cost report stradies July 1, 2011       0.00       8.01       0.00       8.02         0.00       The amount of increase if the hospital was avarded FE cap slots under scot show of the cost report stradies July 1.01       0.00			<b>ac</b> )		-		
4.00       Bed days available divided by number of days in the cost reporting indirect Medical Education Adjustment indirect Medical Education Adjustment is an ostempathic and ostempathic scale instructions)       0.00       5.00         5.00       FTE count For all quantic and ostempathic programs for the mest recent cost reporting period ending on or before 12/31/1996, (see instructions)       0.00       6.00         6.00       critical for an addenia on to the cap for new programs in accordance with 42 CR 413.79(e)       0.00       7.00         7.01       MA Section 452 reduction amount to the IWE cap as specified under 42       0.00       7.01         7.02       CR 4512.105(f)(1)(19)(8)(2) if the cost report stradiles July 1, 2011       0.00       7.01         8.00       Adjustment (increase or decrease) to the FTE count for all opathic and ostempathic and ostempathic and strand Register. May 12, 1998, page 2630 and Vol. 67 Federal Register. May 12, 1998, page 2630 of the A6A. If the cost report stradiles July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the cost report stradies July 1, 2011, see Section 503 of the A6A. If the programs in the current year 1 (see t			15)		-		
Indirect Medical Education Adjustment         Indirect Medical Education Adjustment         Indirect Medical Education Adjustment           0.0         CFE Count for allopathic and ostepathic programs for the most recent         0.00         5.00           0.0         CFE Terria Tor an add-on to the Cap for new programs in accordance with 42         0.00         6.00           0.00         CFE Section 503 reduction amount to the LBE Cap as specified under 42         0.00         7.00           0.00         CFE Section 503 reduction amount to the IME Cap as specified under 42         0.00         7.01           0.00         CFE Section 503 reduction amount to the IME Cap as specified under 42         0.00         7.01           0.01         CFE Section 503 reduction amount to the IME Cap as specified under 42         0.00         7.01           0.02         CFE Section 503 reduction amount to the IME Cap as specified under 42         0.00         8.01           0.03         Despe 2340 and vol. 61 Federal Register, May 12, 1998.         0.00         8.01           0.04         Despe 2340 and vol. 61 Federal Register, May 12, 1998.         0.00         8.01           0.05         Sam of Lineers of the Chap Section 5506 of AcA. (see instructions)         0.00         8.01           0.05         Sam of Lineers of the Social Section 5506 of AcA. (see instructions)         0.00         11.00		5	ng				
5.00       FTE count for allopathic and ostopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see Instructions)       0.00       5.00         6.00       FTE count for allopathic and ostopathic programs in accordance with 42 CFR 413.79(e)       0.00       7.00         7.01       MMA Section 422 reduction amount to the IME cap as specified under 42       0.00       7.01         7.02       CFR 5412.105(f)(1)(v)(50)(1)       The to cost report straddles July 1, 2011       0.00       7.01         7.03       CFR 5412.105(f)(1)(v)(50)(2) If the cost report straddles July 1, 2011       0.00       7.01         7.04       CFR 5412.105(f)(1)(v)(50)(2) If the cost report straddles July 1, 2011       0.00       8.00         8.00       Adjustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR       0.00       8.00         8.01       D.00       Estimated FTE cap slots under section 550 of the ACA. If the cost report straddle July 1, 2011, see instructions       0.00       8.01         8.02       D.00       Famaunt of increase if the hexpetial awas awarded FTE cap slots under section 550 of the ACA. Use instructions)       0.00       8.02         9.00       Sum of lines 5 plus of and stopathic regrams.       0.00       10.00       10.00         9.00       Sum of lines 5 plus of and stopathic and stopathic progr			-				
cost reporting period ending on or before 12/31/1996. (see instructions)         6.00         6.00           6.00         Fit count for all opathic and ostopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 (FR 413.70(c))         6.00         7.00           7.00         MMA Section 422 reduction amount to the IME cap as specified under 42         0.00         7.00           7.01         CAS 4312.05(f) (1) (1) (2) (1 the cop as specified under 42         0.00         7.01           7.02         MA Section 520 (2) (1) (1) (2) (2) (1 the cop as specified under 42         0.00         7.01           8.00         Adjustment (increase or decrease) to the FTE count for allopathic and ostepathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c) (2) (1) and Vol. 64 Federal Register, May 12, 1998.         0.00         8.01           8.01         The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under sectors 500 FAA. (see instructions)         0.00         8.02           9.02         Sati ant VCI and 7.01) plus/minus lines (8.8.01 and 0.00 and 8.02         0.00         10.00           9.03         Sum of lines 51 us 6 minus lines (7 and 7.01) plus/minus lines (8.8.01 and 0.00 and 8.02         0.00         10.00           9.00         Sum of lines 12 through 14 divided by 3.         0.00         10.00         10.00           10.00         Tere	F 00			T	0.00		E OO
6.00       FTE count for all opathic and osteopathic programs in accordance with 42 CFR 413.79(e)       6.00       6.00         7.01       MAS Section 422 reduction amount to the IME cap as specified under 42 CFR 413.79(e)       0.00       7.00         7.02       MAS Section 422 reduction amount to the IME cap as specified under 42 CFR 413.79(e)       0.00       7.01         7.03       ACA Section 420 reduction amount to the IME cap as specified under 42 CFR 412.705(f)(1)(1x)(8)(2) if the cost report straddles July 1, 2011       0.00       7.01         8.00       Adjustment (increase) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1x) and V01. d4 Federal Register, May 12, 1998, page 26340 and V01. 67 Federal Register, page 50059, August 1, 2002.       8.01         8.02       The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.02         9.00       ot see teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots from a closed teaching hospital was awarded FTE cap slots was awarded FTE cap slots from a closed teaching hospi	5.00				0.00		5.00
criteria for an add-on to the cap for new prögrams in accordance with 42         7.00         7.00           7.00         MMA Section 422 reduction amount to the IME cap as specified under 42         0.00         7.00           7.01         ACA Section 5503 reductions         0.00         7.01           8.00         ACA Section 5503 reductions         0.00         7.01           8.01         ACA Section 5503 reductions         0.00         7.01           8.02         Add statent (Increase in the cost report straddles July 1. 2011         0.00         8.00           8.01         Add statent (Increase in the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1. 2011. see instructions.         0.00         8.01           8.01         The amount of increase if the hospital was awarded FTE cap slots under section 5500 of the ACA. (see instructions)         0.00         8.02           0.01         The amount of increase if the hospital was awarded FTE cap slots from a discount for allopathic and osteopathic programs in the current year         0.00         0.00           10.01         Trea mount of increase if the hospital was awarded FTE cap slots from a discount for reslotts in dental and podiatric programs.         0.00         10.00           11.00         Trea secients in dental and podiatric programs.         0.00         12.00           11.00         Trea secints in i	6.00				0.00		6.00
7.00       MMA Section 422 reduction amount to the IME cap as specified under 42       0.00       7.00         7.01       ACA Section 5503 reduction amount to the IME cap as specified under 42       0.00       7.01         CFR 5412.105C/(1)(1)(0)(0)(1)(1)(1)(0)(1)(1)(1)(1)(0)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)			e with 42				
CFR 5412.103(fr)(1)(1)(0)(1)       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1       1 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>7</td></td<>							7
7.01       ACA Section 5503 reduction amount to the IME cap as specified under 42       0.00       7.01         CFR 5412-105C(f)(1)(0)(0)(2) If the cost perport straddles July 1, 2011       0.00       8.00         0.03       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1) valued Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 64 Federal Register, May 12, 1998, and the constructions of the ACA. If the cost report straddles July 1, 2011, see linstructions.       0.00       8.01         8.02       The amount of increase if the hospital was awarded FTE cap slots under cost electric to slots of the ACA. If the cost report straddles July 1, 2011, see linstructions.       0.00       8.02         9.00       Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01       0.00       9.00         10.00       FTE count for all apathic and osteopathic programs.       0.00       11.00         10.00       FTE count for the prior year.       0.00       13.00         10.00       Total allowable FTE count for the program or hospital closure       0.00       13.00         11.00       GTE selents 10.1 ded vided by 3       0.00       13.00       0.00       14.00         11.00       GTE selents 10.1 ded vided by 3       0.000       13.00       0.00       10.00       10.00       10.00       10.00	7.00		der 42		0.00		7.00
CFR 5412 105(f) (1i) (b) (2) IF the cost report straddles July 1, 2011       8.00       8.00         Adjustment (increase or decrease) to the FTE count for allopathic and costepathic programs for affiliated programs in accordance with 42 CFR       0.00       8.00         A13.75(b), 413.79(c) (2) (iv) and Vol. 64 Federal Register, May 12, 1998, page 25069, August 1, 2002.       0.00       8.01         8.01       The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.02         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)       0.00       8.02         0.05       Sine of lines 5 21 bits 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01       0.00       9.00         1.00       FTE count for the prory gear.       0.00       10.00         1.00       Current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       13.00         1.00       Gaument for residents in the dot atlo (see instructions)       0.00       16.00       18.00         1.00       Gruent year residents in the of year or hospital closure       0.00       16.00       10.00         1.00       Gruent year residents in dental and podiatric program       0.00       16.00	7.01		nder 42		0.00		7.01
6.00       Adjustment (Increase or decrease) to the FTE count for allopathic and osteppathic programs for affiliated programs in accordance with 42 CFR d13.75(b). 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 2508, August 1, 2002.       8.01         8.01       The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.01         8.02       The amount of increase if the hospital was awarded FTE cap slots under cost of lines 503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.02         8.01       Status of lines 510 is of minus lines (7 and 7.01) plus/minus lines (8, 8, 01 on 0.00       0.00       0.00         9.00       Sum of lines 52 plus de minus lines (7 and 7.01) plus/minus lines (8, 8, 01 on 0.00       0.00       11.00         10.00       TFE count for the programs in the current year from your records       0.00       11.00         11.00       Current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       14.00         15.00       Sum of Lines 12 through 14 divided by 3.       0.00       16.00       18.00         10.00       Adjusment for residents in lital years of the program       0.00       16.00       18.00         10.00       Current year resident divided by Jine 4).       0.000       16.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, Jappe 2540 and Vol. 67 Federal Register, page 5069, August 1, 2002.       0.00       8.01         8.01       The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.01         8.02       The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)       0.00       8.02         9.00       Sum of lines 5.0 bus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)       0.00       10.00         9.00       Sum of lines 5.0 bus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see instructions)       0.00       11.00         10.00       FTE court for allopathic and osteopathic programs.       0.00       11.00         11.00       TTE court for allowable FTE (see instructions)       0.00       12.00         12.00       Current year allowable FTE court for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.       0.00       13.00         15.00       May listed for this list aced by program or hospital closure       0.00       16.00         16.00       Adjustent for residents in initial years of the program sin 40.000       18.00       18.00         10.00       Drior year resident distaced by program or hospital cl	8.00				0.00		8.00
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20.00Prior year resident to bed ratio (see instructions)0.00000020.0021.00Enter the lesser of lines 19 or 20 (see instructions)020.0022.00IME payment adjustment (see instructions)022.00Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA022.0023.00INMeber of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).023.0024.00IME FTE Resident Count Over Cap (see instructions)0.0024.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)0.00000026.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0028.0027.00IME payments adjustment factor. (see instructions)029.0028.0029.00Total IME payment (sum of lines 22 and 28)029.0020.00Disproportionate Share Adjustment30.0022.0931.00Percentage of SSI recipient patient days (see instructions)17.2931.0032.00Sum of lines 30 and 3122.0932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00							
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Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).0.0023.0024.00IME FTE Resident Count Over Cap (see instructions)0.0024.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)0.0025.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.00Disproportionate Share Adjustment029.0031.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5.70 17.2931.0032.00Sum of lines 30 and 31 33.0022.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00							
23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).23.0024.00IME FTE Resident Count Over Cap (see instructions)0.0024.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)0.0025.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000026.0028.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment ( sum of lines 22 and 28)029.00Disproportionate Share Adjustment30.005.7030.0031.00Percentage of SSI recipient patient days (see instructions)17.2931.0032.00Sum of lines 30 and 3122.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00	22.00		400 - 5 +	MAA	0		22.00
slots under 42 Sec. 412. 105 (f) (1) (iv) (C).24.0024.0024.00IME FTE Resident Count Over Cap (see instructions)0.0024.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)0.0025.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment ( sum of lines 22 and 28)029.00Disproportionate Share Adjustment30.005.7030.0031.00Percentage of SSI recipient patient days (see instructions)17.2931.0032.00Sum of lines 30 and 3122.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00	23 00			ne mma	0.00		23.00
24.00IME FTE Resident Count Over Cap (see instructions)0.0024.0025.00If the amount on Line 24 is greater than -0-, then enter the Lower of Line 23 or Line 24 (see instructions)0.0025.0026.00Resident to bed ratio (divide Line 25 by Line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)00.00000029.00Total IME payment ( sum of Lines 22 and 28)029.00Di sproportionate Share Adjustment029.0029.0031.00Percentage of SSI recipient patient days (see instructions)17.2931.0032.00Sum of Lines 30 and 3122.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00	23.00		cup		0.00		20.00
Line 23 or line 24 (see instructions)26.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment (sum of lines 22 and 28)029.00Disproportionate Share Adjustment029.0030.00Percentage of SSI recipient patient days to Medicare Part A patient days5.7031.00Percentage of Medicaid patient days (see instructions)17.2932.00Sum of lines 30 and 3122.9933.00Allowable disproportionate share percentage (see instructions)8.18	24.00	IME FTE Resident Count Over Cap (see instructions)			0.00		24.00
26.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment (sum of lines 22 and 28)029.00Disproportionate Share Adjustment029.0030.00Percentage of SSI recipient patient days to Medicare Part A patient days5.7031.00Percentage of Medicaid patient days (see instructions)17.2931.00Sum of lines 30 and 3122.9933.00Allowable disproportionate share percentage (see instructions)8.18	25.00		ver of		0.00		25.00
27.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment (sum of lines 22 and 28)029.00Disproportionate Share Adjustment029.000.000000030.0030.00Percentage of SSI recipient patient days to Medicare Part A patient days5.7031.00Percentage of Medicaid patient days (see instructions)17.2932.00Sum of lines 30 and 3122.9933.00Allowable disproportionate share percentage (see instructions)8.18	26 00				0,00000		26.00
28.00IME add-on adjustment amount (see instructions)028.0029.00Total IME payment (sum of lines 22 and 28)029.00Disproportionate Share Adjustment029.0030.00Percentage of SSI recipient patient days to Medicare Part A patient days5.70(see instructions)31.00Percentage of Medicaid patient days (see instructions)31.00Percentage of Medicaid patient days (see instructions)17.2932.00Sum of lines 30 and 3122.9933.00Allowable disproportionate share percentage (see instructions)8.18							
Disproportionate Share Adjustment30. 00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5. 7030. 0031. 00Percentage of Medicaid patient days (see instructions)17. 2931. 0032. 00Sum of lines 30 and 3122. 9932. 0033. 00Allowable disproportionate share percentage (see instructions)8. 1833. 00	28.00				0		28.00
30. 00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)5. 7030. 0031. 00Percentage of Medicaid patient days (see instructions)17. 2931. 0032. 00Sum of lines 30 and 3122. 9932. 0033. 00Allowable disproportionate share percentage (see instructions)8. 1833. 00	29.00				0		29.00
(see instructions)17.2931.0031.00Percentage of Medicaid patient days (see instructions)17.2931.0032.00Sum of lines 30 and 3122.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00	20.00		ont days	T	E TO		20.00
31.00Percentage of Medicaid patient days (see instructions)17.2931.0032.00Sum of lines 30 and 3122.9932.0033.00Allowable disproportionate share percentage (see instructions)8.1833.00	30.00		ent uays		5.70		30.00
32.00         Sum of Lines 30 and 31         22.99         32.00           33.00         Allowable disproportionate share percentage (see instructions)         8.18         33.00	31.00				17.29		31.00
		Sum of Lines 30 and 31					
54. 00 prisproportronate snare aujustment (see instructions)               872, 473               34. 00							
	34.00	or sproportronate snare aujustment (see instructions)		I	8/2, 4/3		34.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048	Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
		Title XVIII	Hospi tal	PPS	
			Prior to October 1	On/After October 1	
	-	0	1.00	2.00	
	Uncompensated Care Adjustment				1.05
5. 00 5. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		9, 046, 380, 143 0. 000219436	7, 647, 644, 885 0. 000230453	
	Hospital uncompensated care payment (If line 34 is zero,		1, 985, 101	1, 762, 425	
	enter zero on this line) (see instructions)				
5. 03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1, 484, 746	444, 228	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line		1, 928, 974		36.
	35.03)				
00	Additional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I	li scharges	0		1 40
. 00	excluding discharges for MS-DRGs 652, 682, 683, 684 and		0		40.
	685 (see instructions)				
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.
. 01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		-		
. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42
. 00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43
	682, 683, 684 an 685. (see instructions)		-		
. 00	Ratio of average length of stay to one week (line 43		0. 000000		44
. 00	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45
	instructions)		0100		
. 00	Total additional payment (line 45 times line 44 times line		0		46
. 00	41.01) Subtotal (see instructions)		46, 413, 269		47
. 00	Hospital specific payments (to be completed by SCH and		55, 568, 910		48
	MDH, small rural hospitals only. (see instructions)		55 540 010		
. 00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		55, 568, 910		49
. 00	Payment for inpatient program capital (from Worksheet L,		3, 706, 796		50
~~	Parts I, II, as applicable)				
. 00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51
. 00	Direct graduate medical education payment (from Worksheet		0		52
00	E-4, line 49 see instructions).		17.054		6
. 00 . 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		17, 254 9, 003		53 54
. 00	Net organ acquisition cost (Worksheet D-4 Part III, col.		0		55
00	1, line 69)				
. 00	Cost of physicians' services in a teaching hospital (see intructions)		0		56
. 00	Routine service other pass through costs (from Wkst D,		0		57
~~	Part III, column 9, lines 30 through 35).		( 1 057		-
. 00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		64, 957		58
. 00	Total (sum of amounts on lines 49 through 58)		59, 366, 920		59
. 00	Primary payer payments		4, 902		60
. 00	Total amount payable for program beneficiaries (line 59 minus line 60)		59, 362, 018		61
. 00	Deductibles billed to program beneficiaries		4, 433, 760		62
	Coinsurance billed to program beneficiaries		132, 208		63
. 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		818, 380 531, 947		64 65
. 00	Allowable bad debts for dual eligible beneficiaries (see		531, 947		66
	instructions)				
. 00 . 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		55, 327, 997 440		67
. 00	applicable to MS-DRG (see instructions)		440		
00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69
. 00	96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		_		70
. 00	RURAL DEMONSTRATION PROJECT		0		70
92	Bundled Model 1 discount amount		0		70
	HVBP incentive payment (see instructions)		51, 391		70
. 94	Hospital readmissions reduction adjustment (see instructions)		-100, 406		70
. 95	Recovery of accel erated depreciation		0		70
. 96	Low volume adjustment for federal fiscal year (yyyy)		0 0		70
	(Enter in column 0 the corresponding federal year for the period prior to 10/1)				

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 3/27/2015 9:5	epared: 51 am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1.00	2.00	
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		70.9
0. 98	Low Volume Payment-3		0		70.9
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		55, 278, 542		71.0
1.01	Sequestration adjustment (see instructions)		1, 105, 571		71.0
2.00	Interim payments		54, 683, 081		72.
3.00	Tentative settlement (for contractor use only)		0		73.
4.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-510, 110		74.0
5.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		88, 527		75. (
	TO BE COMPLETED BY CONTRACTOR		-		
	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90. (
	Capital outlier from Worksheet L, Part I, line 2		0		91.
	Operating outlier reconciliation adjustment amount (see instructions)		0		92.
3.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.
4.00	The rate used to calculate the time value of money (see instructions)		0.00		94.
5.00	Time value of money for operating expenses (see instructions)		0		95.
6. 00	Time value of money for capital related expenses (see instructions)		0		96.

	Financial Systems REID HOSPITAL & HEAL TION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150048	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet E Part B Date/Time Pre 3/27/2015 9:5	pared
		Title XVIII	Hospi tal	PPS	
				1.00	
F	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions)			32, 055	1. C
	Medical and other services reimbursed under OPPS (see instru	ctions)		32, 937, 206	2.0
	PPS payments			37, 867, 008	
	Outlier payment (see instructions)	ustions)		211, 149	
	Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	uctions)		0. 948 31, 224, 471	
	Sum of line 3 plus line 4 divided by line 6			0.00	
	Transitional corridor payment (see instructions)			0.00	
	Ancillary service other pass through costs from Worksheet D,	Part IV, column 13, line	200	158, 167	
. 00	Organ acquisitions			0	10. (
	Total cost (sum of lines 1 and 10) (see instructions)			32, 055	11. (
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			110.000	1 4 0 /
	Ancillary service charges Organ acquisition charges (from Workshoot D.4. Dart III, lin			112, 009	
	Organ acquisition charges (from Worksheet D-4, Part III, lin Total reasonable charges (sum of lines 12 and 13)	E 07, CUL. 4)		0 112, 009	
	Customary charges			112,007	1
	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. (
. 00	Amounts that would have been realized from patients liable f	or payment for services o	on a chargebasis	0	16. (
	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)			0.00000	
	Total customary charges (see instructions)	nly if line 10 evende li	no. 11) (coo	112,009	
	Excess of customary charges over reasonable cost (complete o instructions)	niy if line is exceeds if	ne II) (see	79, 954	19. (
1	Excess of reasonable cost over customary charges (complete o	nlvifline 11 exceeds li	ne 18) (see	0	20. (
	instructions)		10 10) (300	0	20.
. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH s	ee instructions)		32, 055	21. (
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
	Total prospective payment (sum of lines 3, 4, 8 and 9)			38, 236, 324	24. (
	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.0
	Deductibles and Coinsurance relating to amount on line 24 (fi	or CAH see instructions)		7, 522, 785	
	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plu			30, 745, 594	
	see instructions)				
	Direct graduate medical education payments (from Worksheet E			0	-
	ESRD direct medical education costs (from Worksheet E-4, lin	e 36)		0	
1	Subtotal (sum of lines 27 through 29)			30, 745, 594	
	Primary payer payments			7, 935	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		30, 737, 659	32.0
	Composite rate ESRD (from Worksheet I-5, line 11)	1623)		0	33. (
	Allowable bad debts (see instructions)			274, 225	
	Adjusted reimbursable bad debts (see instructions)			178, 246	
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		96, 771	
	Subtotal (see instructions)			30, 915, 905	
	MSP-LCC reconciliation amount from PS&R			103	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Partial or full credits received from manufacturers for repl	acad davi cas (see i petrus	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	acea devices (See Thistiat		0	
	Subtotal (see instructions)			30, 915, 802	
	Sequestration adjustment (see instructions)			618, 316	
	Interim payments			30, 895, 533	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)			-598, 047	
	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	44.0
	§115.2				
_	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. (
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94. (

	Component CCN: 15SO48	From 01/01/2014 To 12/31/2014	Part B Date/Time Pre 3/27/2015 9:5	pared: 1 am
	Title XVIII	Subprovider - IPF	PPS	<u> </u>
			1.00	
B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
cal and other services (see instructions)	ati ana)		2,677	1
cal and other services reimbursed under OPPS (see instru payments	ctrons)		1, 295 2, 499	
ier payment (see instructions)			0	•
er the hospital specific payment to cost ratio (see instr	uctions)		0.000	•
e 2 times line 5 of line 3 plus line 4 divided by line 6			0 0.00	
nsitional corridor payment (see instructions)			0	
llary service other pass through costs from Worksheet D,	Part IV, column 13, line	200	0	
an acquisitions al cost (sum of lines 1 and 10) (see instructions)			0 2, 677	
UTATION OF LESSER OF COST OR CHARGES			2,011	111.00
onable charges			0.010	1 10 00
llary service charges an acquisition charges (from Worksheet D-4, Part III, lin	e 69 col 4)		9, 312 0	
al reasonable charges (sum of lines 12 and 13)			9, 312	•
omary charges		· · · ·		
regate amount actually collected from patients liable for unts that would have been realized from patients liable f	1 5	5	0	
such payment been made in accordance with 42 CFR 413.13(			0	10.00
o of line 15 to line 16 (not to exceed 1.000000)			0.000000	
al customary charges (see instructions) ess of customary charges over reasonable cost (complete o	nly if line 19 exceeds lin	0 11) (600	9, 312 6, 635	•
tructions)	in y i i i i e ceceeus i i	le 11) (see	0,035	19.00
ess of reasonable cost over customary charges (complete o	nly if line 11 exceeds lir	ne 18) (see	0	20.00
tructions) ser of cost or charges (line 11 minus line 20) (for CAH s	ee instructions)		2, 677	21.00
erns and residents (see instructions)			2,077	
of physicians' services in a teaching hospital (see ins	tructions)		0	
al prospective payment (sum of lines 3, 4, 8 and 9) UTATION OF REIMBURSEMENT SETTLEMENT			2, 499	24.00
uctibles and coinsurance (for CAH, see instructions)			0	25.00
uctibles and Coinsurance relating to amount on line 24 (f			0	
total {(lines 21 and 24 - the sum of lines 25 and 26) plu instructions)	s the sum of lines 22 and	23} (for CAH,	5, 176	27.00
ect graduate medical education payments (from Worksheet E	-4, line 50)		0	28.00
) direct medical education costs (from Worksheet E-4, lin	e 36)		0	
total (sum of lines 27 through 29) nary payer payments			5, 176 0	
total (line 30 minus line 31)			-	32.00
WABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	I CES)		-	
posite rate ESRD (from Worksheet I-5, line 11) pwable bad debts (see instructions)			0	33.00 34.00
usted reimbursable bad debts (see instructions)			0	•
wable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
total (see instructions) -LCC reconciliation amount from PS&R			5, 176 0	1
ER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
tial or full credits received from manufacturers for repl	aced devices (see instruct	i ons)	0	39. 98
OVERY OF ACCELERATED DEPRECIATION			0	•
total (see instructions) Jestration adjustment (see instructions)			5, 176 104	
erim payments			4, 549	41.00
tative settlement (for contractors use only)			0	•
	ance with CMS Pub. 15-2 o	chapter 1.		1
5. 2			0	
E COMPLETED BY CONTRACTOR				00.00
				90.00 91.00
rate used to calculate the Time Value of Money				92.00
e Value of Money (see instructions)			0	93.00
ance test <u>5.2</u> <u>EC</u> gina ier rat eVa	e due provider/program (see instructions) ed amounts (nonallowable cost report items) in accord OMPLETED BY CONTRACTOR I outlier amount (see instructions) reconciliation adjustment amount (see instructions) e used to calculate the Time Value of Money	e due provider/program (see instructions) ed amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, co OMPLETED BY CONTRACTOR I outlier amount (see instructions) reconciliation adjustment amount (see instructions) e used to calculate the Time Value of Money lue of Money (see instructions)	e due provider/program (see instructions) ed amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, OMPLETED BY CONTRACTOR I outlier amount (see instructions) reconciliation adjustment amount (see instructions) e used to calculate the Time Value of Money lue of Money (see instructions)	e due provider/program (see instructions)       523         ed amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0         OMPLETED BY CONTRACTOR       0         I outlier amount (see instructions)       0         • reconciliation adjustment amount (see instructions)       0         e used to calculate the Time Value of Money       0.00         Iue of Money (see instructions)       0

CALCUL		ovider CCN: 150048	Period: From 01/01/2014	Worksheet E Part B Date/Time Pre 3/27/2015 9:5	pared:
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			437	•
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) PPS payments			393 603	•
4.00	Outlier payment (see instructions)			0	•
5.00	Enter the hospital specific payment to cost ratio (see instructions	5)		0.000	•
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
8.00	Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Worksheet D, Part I	V, column 13, line	200	3	
10.00	Organ acqui si ti ons			0	•
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			437	11.00
	Reasonable charges				1
12.00	Ancillary service charges			1, 521	
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, c	col. 4)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			1, 521	14.00
15.00	Aggregate amount actually collected from patients liable for paymer	nt for services on a	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for paym	nent for services o	n 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)			1, 521	
19.00	Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	1, 084	•
20.00	instructions)	Line 11 evenede Li	na 10) (ana	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only if instructions)	Time II exceeds III	ne 18) (See	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see inst	tructions)		437	21.00
22.00	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruction Total prospective payment (sum of lines 3, 4, 8 and 9)	ons)		0 606	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			000	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			31	
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH,			0	
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the s see instructions)	sum of times 22 and	23} (TOF CAH,	1, 012	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, lir	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			1, 012 0	1
32.00	Subtotal (line 30 minus line 31)			1, 012	•
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	•
36.00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		0	
37.00	Subtotal (see instructions)			1, 012	•
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39.00 39.98	Partial or full credits received from manufacturers for replaced de	evices (see instruc	tions)	0	•
39.99	RECOVERY OF ACCELERATED DEPRECIATION	,	,	0	39.99
40.00	Subtotal (see instructions)			1,012	
40. 01 41. 00	Sequestration adjustment (see instructions) Interim payments			20 927	
42.00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			65	
44.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)				90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	•
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				92.00 93.00
					93.00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150048	Period: From 01/01/2014 To 12/31/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		54, 510, 6	81 0	30, 711, 833 0	1.00 2.00 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	07/30/2014	172, 4	00 07/30/2014	183, 700	3.01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	
3. 52				0	0	3.5
3.53				0	0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		172, 4	-	183, 700	3.54 3.99
5. 77	3. 50-3. 98)		172,4	00	103, 700	0.7
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		54, 683, 0	81	30, 895, 533	4.00
	TO BE COMPLETED BY CONTRACTOR	1	1			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5. 01	TENTATI VE TO PROVIDER		1	0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program		1	0		/
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.52
5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
5.01	SETTLEMENT TO PROVIDER		540.4	0	0	6.0
5.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		510, 1 54, 172, 9		598, 047 30, 297, 486	6.02 7.00
7.00	Tiotar mearcare program frability (see fistructions)		<u> </u>	Contractor	NPR Date	7.00
			0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor		5	1.00	2.00	8.00

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150048 CCN: 15S048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prep 3/27/2015 9:51	
		Ti tl	e XVIII	Subprovider - IPF	PPS	
		Inpatien	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		7, 348, 2	64 0	4, 549 0	1. ( 2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	3. (
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		7, 348, 2	64	4, 549	4.
	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER		[	0	0	-
01 02	ILIVIATIVE TO PROVIDER			0	0	5. 5.
)2 )3				0	0	5
55	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)		_			6
D1	SETTLEMENT TO PROVIDER		3, 4	78	523	6
)2	SETTLEMENT TO PROGRAM		7 054 7	0	0	6
00	Total Medicare program liability (see instructions)		7, 351, 7		5,072 NPR Date	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	

	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150048 CCN: 15T048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prep 3/27/2015 9:51	
		Titl	e XVIII	Subprovider - IRF	PPS	- cill
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 881, 0	65 0	927 0	1. 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3
)5				0	0	3
	Provider to Program					~
0	ADJUSTMENTS TO PROGRAM			0	0	3
51 52				0 0	0	3
52 53				0	0	3
53 54				0	0	3
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		2, 881, 00	E	927	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 881, 00	55	921	4
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
)3	Dravidan ta Dragnam			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
50 51				0	0	5
52				0	o	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		21, 20	)7	65	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		2, 902, 2		992	7
				Contractor	NPR Date	
				Number 1.00	(Mo/Day/Yr)	

Heal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES	In Lie	u of Form CMS-2	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150048	Peri od:	Worksheet E-1		
			From 01/01/2014			
			To 12/31/2014		pared:	
				3/27/2015 9:5	i am	
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS			1.00		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00						
2.00	2.00 Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12					
3.00	3.00 Medicare HMO days from Wkst S-3, Part I, column 6. line 2					
4.00	4.00 Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12					
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			659, 424, 656	5.00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 li	ne 20		24, 937, 530	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Worksheet S-2,	0	7.00	
	Part I line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			1, 870, 504	8.00	
9.00	Sequestration adjustment amount (see instructions)			37, 410	9.00	
10.00	Calculation of the HIT incentive payment after sequestration (s	ee instructions)		1, 833, 094	10.00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 861, 915		
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	is)	-28, 821	32.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Pre 3/27/2015 9:5	parec
		Title XVIII	Hospi tal	PPS	
				4.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medi	cal education payments)		0	1 1.0
. 00	Net IPF PPS Outlier Payments	cur cudeutren paymentes)		0	2.0
. 00	Net IPF PPS ECT Payments			0	
. 00	Unweighted intern and resident FTE count in the most recent co	ost report filed on or b	efore November	0.00	4. (
	15, 2004. (see instructions)	·			
. 01	Cap increases for the unweighted intern and resident FTE count			0.00	4.0
	program or hospital closure, that would not be counted without	t a temporary cap adjust	ment under		
	§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	
. 00	Current year's unweighted FTE count of I&R excluding FTEs in t	the new program growth p	eriod of a "new	0.00	6.
00	teaching program". (see inst.)			0.00	-
. 00	Current year's unweighted I&R FTE count for residents within t teaching program". (see inst.)	the new program growth p	eriod of a new	0.00	7.
. 00	Intern and resident count for IPF PPS medical education adjust	tment (see instructions)		0.00	8.
. 00	Average Daily Census (see instructions)			83. 909589	
0.00		the power of $5150 - 1$		0. 000000	
1.00	Teaching Adjustment (line 1 multiplied by line 10).			0.000000	11.
2.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0	
3.00	Nursing and Allied Health Managed Care payment (see instruction	on)		0	
	Organ acquisition (DO NOT USE THIS LINE)	,			14.
5.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	15.
6.00	Subtotal (see instructions)			0	16.
7.00	Primary payer payments			0	17.
8.00	Subtotal (line 16 less line 17).			0	18
9.00	Deducti bl es			0	
0.00	Subtotal (line 18 minus line 19)			0	20
	Coinsurance			0	
2.00	Subtotal (line 20 minus line 21)			0	22
3.00	Allowable bad debts (exclude bad debts for professional servic	ces) (see instructions)		0	
4.00	Adjusted reimbursable bad debts (see instructions)			0	24
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
6.00	Subtotal (sum of lines 22 and 24)	1 1:22 10)		0	26
	Direct graduate medical education payments (from Worksheet E-4	t, TThe 49)		0 64, 957	1
8.00	Other pass through costs (see instructions) Outlier payments reconciliation			04,957	
9.00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
0.99	Recovery of Accel erated Depreciation			0	
1.00	Total amount payable to the provider (see instructions)			64, 957	
1.01				1, 299	
2.00	Interim payments			54, 683, 081	32.
3.00	1 5			0 1/ 000/ 001	33.
4.00	Balance due provider/program line 31 minus lines 31.01, 32 and	33		-54, 619, 423	
5.00	Protested amounts (nonallowable cost report items) in accordar		chapter 1,	0 1/ 0 1 / 120	35.
	§115. 2	· · · · · · · · · · · · · · · · · · ·			
	TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Worksheet E-3, Part II, line 2			0	50.
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				52

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prep 3/27/2015 9:5	pared
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			0	1.0
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000	2. (
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0	3.
I. 00	Outlier Payments			0	4.
5.00	Unweighted intern and resident FTE count in the most recent c	ost reporting period en	ding on or prior	0.00	5.
	to November 15, 2004 (see instructions)		- ·		
5. 01	Cap increases for the unweighted intern and resident FTE coun			0.00	5.0
	program or hospital closure, that would not be counted withou	t a temporary cap adjust	ment under		
	§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
o. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program". (see inst.)	***		0.00	
8.00	Current year's unweighted I&R FTE count for residents within teaching program". (see inst.)	the new program growth p	errod of a new	0.00	8.
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions)		0.00	9.
	Average Daily Census (see instructions)	there (see this full to those)		83. 909589	10.
1.00				0.000000	11.
2.00				0.000000	12.
3.00	Total PPS Payment (see instructions)			0	13.
4.00		i on)		0	14.
	Organ acqui si ti on (DO NOT USE THIS LINE)			0	15.
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16.
	Subtotal (see instructions)	dotronoy		Ő	17
	Primary payer payments			0	18.
	Subtotal (line 17 less line 18).			0	19
	Deducti bl es			0	20.
1.00	Subtotal (line 19 minus line 20)			0	21.
	Coinsurance			0	22
3.00	Subtotal (line 21 minus line 22)			0	23.
4.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	24.
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
6.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	26
7.00	Subtotal (sum of lines 23 and 25)			0	27
	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	28.
	Other pass through costs (see instructions)			64, 957	29.
	Outlier payments reconciliation			0	30.
1.00				0	31.
1.99				0	31.
	Total amount payable to the provider (see instructions)			64, 957	
2.01	Sequestration adjustment (see instructions)			1, 299	32.
	Interim payments			54, 683, 081	33.
	Tentative settlement (for contractor use only)	d 24		0 54 610 422	34.
	Balance due provider/program line 32 minus lines 32.01, 33 an Protested amounts (nonallowable cost report items) in accorda		chantor 1	-54, 619, 423 0	35. 36.
0.00	§115. 2	HEE WITH CWS PUD. 15-2,	chapter I,	0	30.
	TO BE COMPLETED BY CONTRACTOR				
0 00	Original outlier amount from Worksheet E-3, Part III, line 4			0	50.
	Outlier reconciliation adjustment amount (see instructions)			0	51.
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	53

	Financial Systems REID HOSPITAL & HEALTH ATION OF REIMBURSEMENT SETTLEMENT	CARE SERVICES Provider CCN: 150048	Period:	u of Form CMS-2 Worksheet E-3	
ALCOL			From 01/01/2014	Part II	
		Component CCN: 15SO48	To 12/31/2014	Date/Time Prep 3/27/2015 9:5	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medi	cal education payments)		7, 847, 482	1.
00	Net IPF PPS Outlier Payments			331, 218	2
00	Net IPF PPS ECT Payments			1, 647	3
00	Unweighted intern and resident FTE count in the most recent cc 15, 2004. (see instructions)	st report filed on or be	efore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE count	for residents that were	e displaced by	0.00	4
01	program or hospital closure, that would not be counted without			0.00	
00	§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
00 00	New Teaching program adjustment. (see instructions) Current year's unweighted FTE count of I&R excluding FTEs in t	bo now program growth	oriod of a "now	0.00 0.00	5
00	teaching program". (see inst.)	he new program growth pe	errou or a new	0.00	C
00	Current year's unweighted I&R FTE count for residents within t	he new program growth pe	eriod of a "new	0.00	7
	teaching program". (see inst.)				
00	Intern and resident count for IPF PPS medical education adjust	ment (see instructions)		0.00	8
00	Average Daily Census (see instructions)			34.569863	9
). 00 I. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to t	ne power of .5150 -1}.		0.00000	10 11
	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 8, 180, 347	12
	Nursing and Allied Health Managed Care payment (see instruction	n)		0, 180, 347	13
	Organ acquisition (DO NOT USE THIS LINE)			0	14
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
	Subtotal (see instructions)			8, 180, 347	16
	Primary payer payments			0	
3. 00	Subtotal (line 16 less line 17).			8, 180, 347	18
	Deducti bl es			438, 339	19
0. 00	Subtotal (line 18 minus line 19)			7, 742, 008	
	Coinsurance			243, 720	
	Subtotal (line 20 minus line 21)			7, 498, 288	
	Allowable bad debts (exclude bad debts for professional servic	es) (see instructions)		0	23
	Adjusted reimbursable bad debts (see instructions)			0	24
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	25
	Subtotal (sum of lines 22 and 24)	Line (0)		7, 498, 288	26 27
	Direct graduate medical education payments (from Worksheet E-4 Other pass through costs (see instructions)	, ITTHE 49)		0 3, 490	
	Outlier payments reconciliation			3, 490	29
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Recovery of Accel erated Depreciation			0	30
	Total amount payable to the provider (see instructions)			7, 501, 778	
	Sequestration adjustment (see instructions)			150, 036	
	Interim payments			7, 348, 264	32
	Tentative settlement (for contractor use only)			0	33
	Balance due provider/program line 31 minus lines 31.01, 32 and			3, 478	
5.00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with CMS Pub. 15-2, (	chapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Worksheet E-3, Part II, line 2			331, 218	50
	Outlier reconciliation adjustment amount (see instructions)			0	51
1 (1()	The rate used to calculate the Time Value of Money			0.00	52

ALCUI	ATION OF REIMBURSEMENT SETTLEMENT	CARE SERVICES Provider CCN: 150048	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15T048	From 01/01/2014	Part III Date/Time Pre	pare
		Title XVIII	Subprovider - IRF	3/27/2015 9:5 PPS	1 80
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			2, 761, 679	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0431	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			59, 376	3.
00	Outlier Payments			195, 031	4
00	Unweighted intern and resident FTE count in the most recent cost	st reporting period en	ding on or prior	0.00	5
	to November 15, 2004 (see instructions)				
01	Cap increases for the unweighted intern and resident FTE count			0.00	5
	program or hospital closure, that would not be counted without	a temporary cap adjust	ment under		
~ ~	§412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs in the	he new program growth p	eriod of a "new	0.00	7
00	teaching program". (see inst.)	be now program growth n	oried of a "now	0.00	8
00	Current year's unweighted I&R FTE count for residents within the teaching program". (see inst.)	he new program growth p		0.00	0
00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions)		0.00	9
. 00	Average Daily Census (see instructions)			7.945205	
. 00				0.000000	
. 00	Teaching Adjustment (see instructions)			0.000000	
. 00	Total PPS Payment (see instructions)			3, 016, 086	
. 00	Nursing and Allied Health Managed Care payments (see instruction	on)		0,010,000	
. 00	Organ acquisition (DO NOT USE THIS LINE)			-	15
. 00		uctions)		0	16
. 00	Subtotal (see instructions)			3, 016, 086	
3. 00	, , ,			0	18
. 00				3, 016, 086	19
. 00	Deducti bl es			35, 200	20
. 00	Subtotal (line 19 minus line 20)			2, 980, 886	21
2. 00	Coinsurance			19, 760	22
. 00	Subtotal (line 21 minus line 22)			2, 961, 126	23
. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		0	24
. 00	Adjusted reimbursable bad debts (see instructions)			0	25
. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	26
. 00	Subtotal (sum of lines 23 and 25)			2, 961, 126	27
. 00	Direct graduate medical education payments (from Worksheet E-4,	, line 49)		0	
. 00				376	
. 00	1 5			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 99	5			0	
. 00				2, 961, 502	
. 01				59, 230	
	Interim payments			2, 881, 065	
	Tentative settlement (for contractor use only)	24			34
6.00	Balance due provider/program line 32 minus lines 32.01, 33 and		phonton 1	21, 207	
o. 00	Protested amounts (nonallowable cost report items) in accordance §115.2	Ce with UMS PUD. 15-2,	unapter I,	0	36
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Worksheet E-3, Part III, line 4			195, 031	50
. 00	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00	The rate used to calculate the Time Value of Money			0.00	52
00	Time Value of Money (see instructions)			0	53

ALCUL/	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prep	
			10 12/31/2014	3/27/2015 9:5	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	<u> </u>
			1.00	2.00	<u> </u>
1	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X	IX SERVICES		+
00	COMPUTATION OF NET COST OF COVERED SERVICES		5, 218, 137		1.00
00	Medical and other services		5, 210, 137	8, 164, 780	
00	Organ acquisition (certified transplant centers only)		0	0, 104, 700	3.00
00	Subtotal (sum of lines 1, 2 and 3)		5, 218, 137	8, 164, 780	
00	patient primary payer payments		0		5.00
00	Outpatient primary payer payments		0	6.00	
00	Subtotal (line 4 less sum of lines 5 and 6)	5, 218, 137	8, 164, 780	7.00	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
00	Routine service charges		11 700 000	20,000,000	8.00
	Ancillary service charges	11, 789, 398	28, 988, 082		
	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.00
	Total reasonable charges (sum of lines 8 through 11)		11, 789, 398	28, 988, 082	
	CUSTOMARY CHARGES		11,707,370	20, 700, 002	12.00
3. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s	Ũ			
4.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42	n 0	0	14.00	
5. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15.00	
	Total customary charges (see instructions)	11, 789, 398			
	Excess of customary charges over reasonable cost (complete only	6, 571, 261	20, 823, 302		
	line 4) (see instructions)		-, ,	,,	
3. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e 0	0	18.00
I	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instru		0	0	20.00
	Cost of covered services (enter the lesser of line 4 or line 16		5, 218, 137	8, 164, 780	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provi	ders. 0		22.00
	Other than outlier payments Outlier payments		0	0	22.00
	Program capital payments		0	0	23.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	26.00
	Subtotal (sum of lines 22 through 26)		0	0	27.00
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
9.00	Titles V or XIX (sum of lines 21 and 27)		5, 218, 137	8, 164, 780	29.00
ſ	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
	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)		5, 218, 137	8, 164, 780	
	Deductibles		0	0	32.00
1	Coinsurance		0	0	
	Allowable bad debts (see instructions) Utilization review		0	0	34.00 35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	5, 218, 137	8, 164, 780	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	5, 210, 137	0, 104, 780	37.00
	Subtotal (line 36 ± line 37)		5, 218, 137	8, 164, 780	
	Direct graduate medical education payments (from Wkst. E-4)		0	2, 101, 100	39.0
	Total amount payable to the provider (sum of lines 38 and 39)		5, 218, 137	8, 164, 780	
	Interim payments		5, 218, 137	8, 164, 780	
	Balance due provider/program (line 40 minus line 41)		0	0	
		e with CMS Pub 15-2,			43.00

CULA		Provider CCN: 150048	Period: From 01/01/2014	Worksheet E-3 Part VII	
		Component CCN: 15SO48	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
P	ART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XI		2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES				1
	npatient hospital/SNF/NF services		179, 978		1
0 0	Nedical and other services			0	
0 0	Drgan acquisition (certified transplant centers only)		0		
0 3	Subtotal (sum of lines 1, 2 and 3)		179, 978	0	
	npatient primary payer payments		0		
	Dutpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		179, 978	0	
_	OMPUTATION OF LESSER OF COST OR CHARGES				4
	leasonabl e Charges				4
	Routine service charges		717 0//		
	Ancillary service charges		717, 066	0	
	Organ acquisition charges, net of revenue ncentive from target amount computation		0		1
	Fotal reasonable charges (sum of lines 8 through 11)		717, 066	0	
	USTOMARY CHARGES		/17,000	0	1'
	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	1
	basi s			-	
00 4	Amounts that would have been realized from patients liable for pa	ayment for services or	0 ו	0	1
a	a charge basis had such payment been made in accordance with 42 (	ČFR §413.13(e)			
00 F	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	1
00	Fotal customary charges (see instructions)		717, 066	0	1
	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	537, 088	0	1
	ine 4) (see instructions)				
	Excess of reasonable cost over customary charges (complete only i	t line 4 exceeds line	e 0	0	1
	16) (see instructions) nterns and Residents (see instructions)		0	0	1
	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16)		179, 978	0	
	ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	pleted for PPS provid			1 -
	Other than outlier payments		0	0	2
	Dutlier payments		0	0	2
00 F	Program capital payments		0		2
00 0	Capital exception payments (see instructions)		0		2
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Fitles V or XIX (sum of lines 21 and 27)		179, 978	0	2
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1_
	Excess of reasonable cost (from line 18)		0 179, 978	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		1/9, 9/8	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Jtilization review		0	0	3
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	179, 978	0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		179, 978	0	3
	Direct graduate medical education payments (from Wkst. E-4)		0		3
00	Fotal amount payable to the provider (sum of lines 38 and 39)		179, 978	0	4
	nterim payments		179, 978	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
00 F	Protested amounts (nonallowable cost report items) in accordance	with CMC Dub 1E 0	0	0	4

CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150048 Component CCN: 15T048	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre	
		Component CCN: 151048	10 12/31/2014	3/27/2015 9:5	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		1, 293		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		1, 293	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		1, 293	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				Ι.
00	Routine service charges		0	0	8
00 00	Ancillary service charges		4, 618	0	
	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10
	Total reasonable charges (sum of lines 8 through 11)		4, 618	0	
00	CUSTOMARY CHARGES		4,010	0	1''
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
00	basi s	services on a charge	0	0	``
00	Amounts that would have been realized from patients liable for	payment for services or	n 0	0	14
	a charge basis had such payment been made in accordance with 42				
00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.00000	15	
00	Total customary charges (see instructions)		4, 618	0	16
00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	3, 325	0	17
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	e 0	0	18
~~	16) (see instructions)			0	1
	Interns and Residents (see instructions)	ati ana)	0	0	
00 00	Cost of physicians' services in a teaching hospital (see instru Cost of covered services (enter the lesser of line 4 or line 16		1, 293	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c			0	2
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		2!
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	27
00	Customary charges (title V or XIX PPS covered services only)		0	0	28
00	Titles V or XIX (sum of lines 21 and 27)		1, 293	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 293	0	
	Deductibles		0	0	
00	Coinsurance		0	0	
00 00	Allowable bad debts (see instructions) Utilization review		0	0	3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	1, 293	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	1, 273	0	
00	Subtotal (line 36 $\pm$ line 37)		1, 293	0	
00	Direct graduate medical education payments (from Wkst. E-4)		1, 273	0	39
00	Total amount payable to the provider (sum of lines 38 and 39)		1, 293	0	
00	Interim payments		1, 293	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	
		e with CMS Pub 15-2,	-		

	Financial Systems REID HOSPITAL & HEA SHEET (If you are nonproprietary and do not maintain	Provi der	CCN: 150048 F	Period:	u of Form CMS-: Worksheet G	
und-ty	pe accounting records, complete the General Fund column on	l y)		From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
					3/27/2015 9:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	-
0	CURRENT ASSETS		1			
00 🛛	Cash on hand in banks	10, 387, 740			0	] 1
	Temporary investments	233, 145, 301			0	
	Notes receivable	24, 845, 502			0	
	Accounts receivable	163, 875, 726		-	0	
	Other receivable	-829, 334			0	
	Allowances for uncollectible notes and accounts receivable	-88, 122, 317			0	
	I nventory Prepai d'expenses	7, 268, 35 ² 4, 730, 37 ²			0	
	Other current assets	6, 706, 923			0	
	Due from other funds	(			0	
	Total current assets (sum of lines 1-10)	362, 008, 263			0	
	FIXED ASSETS		·	-	-	1
	Land	13, 405, 965	5 (	0 0	0	12
00	Land improvements	34, 157, 406	b (	0 0	0	13
. 00	Accumulated depreciation	-15, 139, 541	(	0 0	0	14
	Bui I di ngs	233, 945, 470		0 0	0	15
1	Accumulated depreciation	-78, 450, 916	1		0	
1	Leasehold improvements	10, 613, 686			0	
1	Accumulated depreciation	-3, 729, 448			0	
	Fixed equipment	2,083,496			0	
	Accumulated depreciation	-1, 010, 722			0	
	Automobiles and trucks	(			0	
	Accumulated depreciation Major movable equipment	148, 271, 713			0	
	Accumul ated depreciation	-119, 554, 224	1		0	
	Minor equipment depreciable	-119, 554, 222		-	0	
	Accumulated depreciation				0	
	HIT designated Assets				0	
	Accumul ated depreciation				0	
	Mi nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	224, 592, 885	5 (	0 0	0	30
C	DTHER ASSETS					
. 00	Investments	(			0	31
	Deposits on leases	0			0	
	Due from owners/officers	(			0	
	Other assets	17, 051, 958			0	
	Total other assets (sum of lines 31-34)	17, 051, 958			0	
	Total assets (sum of lines 11, 30, and 35)	603, 653, 106	6 (	0 0	0	36
-	CURRENT LI ABI LI TI ES	16 106 100	-		0	1 27
	Accounts payable Salarian waang and foos payable	16, 126, 125			0	
	Salaries, wages, and fees payable Payroll taxes payable	40, 116, 652 314, 591	1		0	
	Notes and Loans payable (short term)	3, 450, 000			0	
	Deferred income	3, 430, 000	1	0 0	0	
	Accelerated payments	2, 918, 038		0	0	42
	Due to other funds	_,,		0 0	0	
	Other current liabilities				0	
	Total current liabilities (sum of lines 37 thru 44)	62, 925, 406		0 0	0	45
L	LONG TERM LIABILITIES					1
5. 00 T	Mortgage payable	(	) (	0 0	0	46
. 00	Notes payable	167, 030, 000		0 0	0	47
	Unsecured Loans			0 0	0	
	Other long term liabilities	-3, 126, 061			0	
	Total long term liabilities (sum of lines 46 thru 49	163, 903, 939			0	
	Total liabilites (sum of lines 45 and 50)	226, 829, 345	5 (	0 0	0	51
_	CAPITAL ACCOUNTS	274 000 74		1		-
	General fund balance	376, 823, 761				52
	Specific purpose fund		(			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	50
	Total fund balances (sum of lines 52 thru 58)	376, 823, 76		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	603, 653, 106	1		0	
	59)	1 220, 200, 100	а <b>с</b>		0	1 50

	Financial Systems REID ENT OF CHANGES IN FUND BALANCES	HOSPI TAL & HEAL		CCN: 150048	Peri od: From 01/01/2014 To 12/31/2014		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	35 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	368, 208, 771 8, 614, 955 376, 823, 726 376, 823, 761 376, 823, 761 0 376, 823, 761				6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	Pl ant	Fund			
1.00	Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	000	0 0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0 0		18.00 19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150048		riod: om 01/01/2014 12/31/2014	Worksheet G-2 Parts I & II Date/Time Pre 3/27/2015 9:5	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
1 00	General Inpatient Routine Services		44.001.0	22		44 001 000	1 00
1.00			44, 931, 3			44, 931, 323	1.00
2.00 3.00	SUBPROVIDER - IPF SUBPROVIDER - IRF		12, 348, 1 2, 985, 8			12, 348, 107 2, 985, 841	3.00
4.00	SUBPROVIDER - TRF		2, 900, 0	41		2, 900, 041	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY			Ŭ		0	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)		60, 265, 2	71		60, 265, 271	
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		10, 988, 6	56		10, 988, 656	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T		1				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	10, 988, 6	56		10, 988, 656	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		71, 253, 9			71, 253, 927	17.00
18.00	Ancillary services		190, 676, 0		353, 769, 028	544, 445, 121	18.00
19.00	Outpatient services		4, 735, 8		41, 932, 827	46, 668, 662	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00							24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )		(71 (	70	1 7/0 000	2 440 701	25.00
26.00	HOSPI CE OTHER		671, 6		1, 769, 022	2, 440, 701	26.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkot	26, 363, 3 293, 700, 8		104, 511, 620 501, 982, 497	130, 874, 943	
28.00	G-3, line 1)	U WKSL.	293, 700, 8	57	501, 982, 497	795, 683, 354	28.00
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				373, 865, 945		29.00
30.00	ADD (SPECIFY)			0	070,000,710		30.00
31.00				Ő			31.00
32.00				Ő			32.00
33.00				õ			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			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			373, 865, 945		43.00
	to Wkst. G-3, line 4)						

Heal th Financial	Systems REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2	2552-10		
STATEMENT OF REVE	NUES AND EXPENSES	Provider CCN: 150048	Peri od:	Worksheet G-3			
			From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	pared: 1 am		
				1.00	1 00		
	ent revenues (from Wkst. G-2, Part I, column 3, line			795, 683, 354	1.00		
	actual allowances and discounts on patients' account	ts		435, 999, 654	2.00		
	t revenues (line 1 minus line 2)	(0)		359, 683, 700	3.00		
	operating expenses (from Wkst. G-2, Part II, line	43)		373, 865, 945			
	from service to patients (line 3 minus line 4)			-14, 182, 245	5.00		
OTHER INCO				(0) 201	( 00		
	ons, donations, bequests, etc			606, 304	6.00		
	m investments			8, 021, 765 0	7.00 8.00		
	8.00 Revenues from telephone and other miscellaneous communication services						
	<ul><li>10.00 Purchase di scounts</li><li>11.00 Rebates and refunds of expenses</li></ul>						
				41, 284	11. 00 12. 00		
12.00 Parking Ic				0	12.00		
	om laundry and linen service			291, 121			
	om meals sold to employees and guests			3, 099, 215	14.00 15.00		
	om rental of living quarters	ann nationta		0	15.00		
	om sale of medical and surgical supplies to other th	han patrents		0 5, 991			
	om sale of drugs to other than patients om sale of medical records and abstracts			- 1			
				95, 610			
	ees, sale of textbooks, uniforms, etc.)			49, 367	19.00 20.00		
	om gifts, flowers, coffee shops, and canteen			0			
	vending machines			6, 645 2, 832, 597			
	hospital space						
	al appropriations			0	23.00		
24.00 OTHER INCO				7, 168, 874			
	r income (sum of lines 6-24)			22, 797, 200			
	e 5 plus line 25)			8, 614, 955			
	NSES (SPECIFY)			0	27.00		
	r expenses (sum of line 27 and subscripts)			0	28.00		
29.00 INET INCOME	(or loss) for the period (line 26 minus line 28)		I	8, 614, 955	∠9. UU		

ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150048	Peri od:	Worksheet K	
			Hospi ce (	CCN: 151524	From 01/01/2014 To 12/31/2014	Date/Time Pre 3/27/2015 9:5	
					Hospi ce I	0/2//2010 7.0	
		Salaries (from	Employee	Transportati		Other	
		Wkst. K-1)	Benefits (from	(see inst.)			
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS			[	0	0	1 1 00
1.00 2.00	Capital Related Costs-Bldg and Fixt.				0	743	
	Capital Related Costs-Movable Equip.	0	0			/43	
3.00	Plant Operation and Maintenance	0	0		-	-	
4.00 5.00	Transportation - Staff Volunteer Service Coordination	0	0		0 0	0	
5.00 6.00		-	-	40.0	-	-	
0.00	Administrative and General INPATIENT CARE SERVICE	52, 354	60, 090	60, 2	12 0	387, 209	0.00
7.00	Inpatient - General Care	154, 784	10, 835		0 0	2, 826	7.00
8.00	Inpatient - Respite Care	0	0,000		0 0		
0.00	VI SI TI NG SERVI CES			<u> </u>	<u> </u>		0.00
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursi ng Care	660, 256	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathology	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	57, 183	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	50, 889	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0		
23.00	Analgesics	0	0		0 0		
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Patient Transportation	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	6	
30.00	Medical Supplies	0	0		0 0 0 0	95	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00 33.00	Radiation Therapy	0	0		0 0	-	
33.00 34.00	Chemotherapy Other	0	0		0 0		
54.00	HOSPICE NONREIMBURSABLE SERVICE	U U	0	<u> </u>	0 0	0	34.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0		
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	0	0		0 0	0	
		975, 466	70, 925		12 0		39.00

Heal th	Financial Systems REI	D HOSPITAL & HEA	AITH CARE SE	RVI CE	ES	Inlie	u of Form CMS-:	2552-10
	IS OF PROVIDER-BASED HOSPICE COSTS					Period:	Worksheet K	2002 10
ANALIS	IS OF TROVIDER-DASED HOSTICE COSTS		TIOVIC			From 01/01/2014	WOLKSHEEL K	
			Hospi o	ce CC		o 12/31/2014	Date/Time Pre	pared:
							3/27/2015 9:5	1 am
						Hospi ce I		
		Total (cols.	Recl assi fi c	ati S	ubtotal (col.	Adjustments	Total (col. 8	
		1-5)	on		6 ± col. 7)		± col. 9)	
		6.00	7.00		8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	C		0	C	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	743	3	0	743	0	743	2.00
3.00	Plant Operation and Maintenance	0		0	C	0 0	0	3.00
4.00	Transportation - Staff	0		0	C	0 0	0	4.00
5.00	Volunteer Service Coordination	0		o	C	0 0	0	5.00
6.00	Administrative and General	559, 865	5	0	559, 865	-317	559, 548	6.00
	INPATIENT CARE SERVICE	- I · · · ·			· · · ·		· · · ·	
7.00	Inpatient - General Care	168, 445	5	0	168, 445	j 0	168, 445	7.00
8.00	Inpatient - Respite Care	C		0	C		0	8.00
	VI SI TI NG SERVI CES							
9.00	Physician Services	0	b	0	(	0	0	9.00
10.00	Nursi ng Care	660, 256		0	660, 256	-	660, 256	
11.00	Nursing Care-Continuous Home Care	000,200		0	000, 200		000,200	11.00
12.00	Physi cal Therapy			0	(		0	
13.00	Occupational Therapy			0	(	-	0	13.00
14.00	Speech/ Language Pathol ogy					-	0	
14.00	Medical Social Services				(	, s	0	
16.00	Spiritual Counseling			0	(		0	
17.00	Di etary Counsel i ng			0	(	-	0	17.00
17.00	Counseling - Other			0	(	-	0	
	Home Health Aide and Homemaker	E7 102		0	-	-	-	
19.00		57, 183	5	Ч	57, 183		57, 183	
20.00	HH Aide & Homemaker - Cont. Home Care	F0.000		0	( 50.000	, s	0	20.00
21.00		50, 889	/	0	50, 889	0 0	50, 889	21.00
00.00	OTHER HOSPICE SERVICE COSTS						0	0.0.00
22.00	Drugs, Biological and Infusion Therapy	0	1	0	)	-	0	22.00
23.00	Anal gesi cs	144, 379		0	144, 379		144, 379	1
24.00	Sedatives / Hypnotics	(		0	0	, s	0	2
25.00	Other - Specify	(		0	0	-	0	25.00
26.00	Durable Medical Equipment/Oxygen	(		0	0	-	0	26.00
27.00	Patient Transportation	C		0	C	-	0	27.00
28.00	Imaging Services	C		0	C	-	0	28.00
29.00	Labs and Diagnostics	6		0	e		6	29.00
30.00	Medical Supplies	95	5	0	95		95	
31.00	Outpatient Services (including E/R Dept.)	C		0	(	-	0	31.00
32.00	Radiation Therapy	C		0	C	0 0	0	32.00
33.00	Chemotherapy	C		0	C	0 0	0	33.00
34.00	Other	0		0	C	0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	C	)	0	C	0 0	0	35.00
36.00	Volunteer Program Costs	0		0	C	0 0	0	36.00
37.00	Fundrai si ng	0		0	C	0 0	0	37.00
38.00	Other Program Costs	0		0	C	0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1, 641, 861		0	1, 641, 861	-317	1, 641, 544	39.00

Heal th	Financial Systems REID	) HOSPITAL & HEAL	TH CARE SERVI	CES		In Lieu	u of Form CMS-2	2552-10
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150048	Peri od:		Worksheet K-1	
			Hospi ce C	CN: 151524	From 01/0 To 12/3	1/2014 1/2014	Date/Time Pre 3/27/2015 9:5	
					Hospi ce	e I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi	sors	Nurses	
		1.00	2.00	3.00	4. 0	0	5.00	
	GENERAL SERVICE COST CENTERS	· · ·						
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0	0		0	0	0	5.00
6.00	Administrative and General	52, 354	0		0	0	0	6.00
	INPATIENT CARE SERVICE	· · · · ·						
7.00	Inpatient - General Care	0	0		0	0	0	7.00
8.00	Inpatient - Respite Care	0	0		0	0	0	8.00
	VI SI TI NG SERVI CES							1
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	660, 256	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	11.00
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	21.00
21.00	OTHER HOSPICE SERVICE COSTS				0			200
22.00	Drugs, Biological and Infusion Therapy					T		22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Pati ent Transportati on	0	0		0	0	0	27.00
28.00	Imaging Services	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medi cal Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radi ati on Therapy	0	0		0	0	0	32.00
32.00	Chemotherapy	0	0		0	0	0	33.00
33.00	Other	0	0		0	0	0	34.00
54.00	HOSPICE NONREIMBURSABLE SERVICE	<u>Ч</u>	0		0	<u> </u>	0	54.00
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundrai si ng	0	0		0	0	0	37.00
37.00	Other Program Costs	0	0		0	0	0	37.00
	Total (sum of lines 1 thru 38)	52, 354	0		0	0	660, 256	
57.00		52, 554	ų		<u> </u>	Ч	000, 200	1 37.00

	Financial Systems REID E COMPENSATION ANALYSIS SALARIES AND WAGES	HOSPITAL & HEALT		CCN: 150048	Period:	u of Form CMS-2552-1 Worksheet K-1
HUSPI C	E COMPENSATION ANALISIS SALARIES AND WAGES		PLOVIDEL	CCN. 150046	From 01/01/2014	WOLKSHEEL K-I
			Hospi ce C	CN: 151524		
						3/27/2015 9:51 am
	· · · · ·	Total	Aides	All-Other	Hospi ce I	
		Therapists	Ardes	AIT-Uther	Total (1)	
		6.00	7.00	8,00	9,00	
	GENERAL SERVICE COST CENTERS	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0		0 52, 354	6.00
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care		0	154, 7	84 154, 784	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
	VI SI TI NG SERVI CES					
9.00	Physi ci an Servi ces		0		0 0	9.00
10.00	Nursing Care		0		0 660, 256	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medical Social Services		0		0 0	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		57, 183		0 57, 183	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0	50, 8	89 50, 889	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen				_	26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00			0		0 0	34.00
25 00	HOSPICE NONREIMBURSABLE SERVICE	1			0	
35.00	Bereavement Program Costs		0		0 0	35.00
36.00 37.00	Volunteer Program Costs		0		0 0	36.00 37.00
37.00	Fundraising Other Program Costs		0			37.00
	Total (sum of lines 1 thru 38)	0	57, 183	205, 6	0	38.00
37.00	Total (Sum OF TITLES I LITLU SO)	U U	57, 183	205, 0	/ J 9/0, 400	39.00

		HOSPITAL & HEAL	TH CARE SERVI	CES	. In L	ieu of Form CMS	-2552-10
HOSPI C	E COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PA	AYROLL RELATED)	Provi der	CCN: 150048	Peri od:	Worksheet K-	2
			Hospi ce C	CCN: 151524	From 01/01/20 To 12/31/20		
					Hospi ce I		
		Admi ni strator	Director	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3,00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0 3.00
4.00	Transportation - Staff	0	0		0	0	0 4.00
5.00	Volunteer Service Coordination	0	0		0	0	0 5.00
6.00	Administrative and General	60, 090	0		0	0	0 6.00
	I NPATI ENT CARE SERVI CE	· · · · · ·					
7.00	Inpatient - General Care	0	0		0	0	0 7.00
8.00	Inpatient - Respite Care	0	0		0	0	0 8.00
	VI SI TI NG SERVI CES	· · · · · · · · · · · · · · · · · · ·					
9.00	Physi ci an Servi ces	0	0		0	0	0 9.00
10.00	Nursing Care	0	0		0	0	0 10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0 11.00
12.00	Physical Therapy	0	0		0	0	0 12.00
13.00	Occupational Therapy	0	0		0	0	0 13.00
14.00	Speech/ Language Pathology	0	0		0	0	0 14.00
15.00	Medical Social Services	0	0		0	0	0 15.00
16.00	Spiritual Counseling	0	0		0	0	0 16.00
17.00	Dietary Counseling	0	0		0	0	0 17.00
18.00	Counseling - Other	0	0		0	0	0 18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0 19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0 20.00
21.00	Other	0	0		0	0	0 21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0		0	0	0 27.00
28.00	Imaging Services	0	0		0	0	0 28.00
29.00	Labs and Diagnostics	0	0		0	0	0 29.00
30.00	Medical Supplies	0	0		0	0	0 30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0 31.00
32.00	Radiation Therapy	0	0		0	0	0 32.00
33.00	Chemotherapy	0	0		0	0	0 33.00
34.00	Other	0	0		0	0	0 34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	· · · ·					
35.00	Bereavement Program Costs	0	0		0	0	0 35.00
36.00	Volunteer Program Costs	0	0		0	0	0 36.00
37.00	Fundrai si ng	0	0		0	0	0 37.00
38.00	Other Program Costs	0	0		0		0 38.00
39.00	Total (sum of lines 1 thru 38)	60, 090	0		0	0	0 39.00

HOSPI CE COMPENSATI ON ANALYSI S EMPLOYEE BENEFI TS (PAYROLL RELATED)         Provider CON: 15008         Period: From 01/01/201           Hospice CON: 151824         Total         Ai des         Al I-Other         Total 1         Total 01/201         Bete/Time 2/27/2015           1.00         Capital Related Costs-Blog and Fixt: 0.00         6.00         7.00         8.00         9.00           2.00         Capital Related Costs-Movable Equip. Plant Operation and Maintenace         0         0         0         0           4.00         Plant Operation and Maintenace         0         0         0         0         0           0.00         Mainter Services Goord Inition         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <th>S-2552-10</th>	S-2552-10
Hospice CCN:         151524         To         12/31/2014         Date/Time Bate/Time 3/27/2015           Total         Ai des         Ai lotther         Total         11           Therapists         Ai des         Ai lotther         Total         11           100         Capital Related Costs-Bidg and Fixt.         0         0         0         0           2.00         Capital Related Costs-Movable Equip.         0         0         0         0           3.00         Plant Operation and Maintenance         0         0         0         0           0.00         Transportation - Staff         0         0         0         0           100         Represente Explice Correlination         0         0         0         0           100         Namiterin Caree Evol CC         -         -         0         0         0           1100         Nursing Care-Continuous Home Care         0         0         0         0         0           1100         Nursing Care-Continuous Home Care         0         0         0         0         0           100         Coupational Therapy         0         0         0         0         0           1100         Nu	2
Total         Al des         Al I - Other         Hospice I           100         Capital Related Costs-Movable Equip.         0         0         9.00           200         Capital Related Costs-Movable Equip.         0         0         0           3.00         Plant Operation and Maintenance         0         0         0         0           3.00         Volunteer Service Cost of Institution         0         0         0         0           3.00         Volunteer Service Cost and Costs-Movable Equip.         0         0         0         0           3.00         Volunteer Service Cost and Costs-Movable Equip.         0         0         0         0           3.00         Volunteer Service Costal Costs-Movable Equip.         0         0         0         0           4.00         Transportation - Staff         0         0         0         0         0           1.00         Nrsing Care-Continuous Home Care         0         0         0         0         0           1.00         Nursing Care-Continuous Home Care         0         0         0         0           1.00         Nursing Care-Continuous Home Care         0         0         0         0           1.00	repared
Total Therapists         Ai des Ai des         Al I - Other         Total (1)           0         Capital Related Costs-Bidg and Fixt.         6.00         7.00         8.00         9.00           1.00         Capital Related Costs-Bidg and Fixt.         0         0         0         0         0         0           3.00         Plant Operation and Maintenance         0         0         0         0         0           3.00         Plant Operation and Maintenance         0         0         0         0         0           4.00         Transportation - Staff         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <	: 51 am
Therapists         Image: Construction of the construc	
6.00         7.00         8.00         9.00           GENERAL SERVICE COST CENTERS	
GENERAL SERVICE COST CENTERS           1.00         Capital Related Costs-Bidg and Fixt.           2.00         Capital Related Costs-Bidg and Fixt.           3.00         Plant Operation and Maintenance         0           0.00         Plant Operation and Maintenance         0           0.00         Transportation - Staff         0         0           0.01         Anansportation - Staff         0         0           0.01         Anansportation - Staff         0         0           0.01         Anansportation - Staff         0         0         0           0.01         Anansportation - Staff         0         0         0           0.01         Inpatient - General Care         0         10.835         10.835           1.00         Narsing Care-Continuous Home Care         0         0         0           1.00	
1.00       Capital Related Costs-Bidg and Fixt.       0       0         2.00       Capital Related Costs-Wowhele Equip.       0       0         3.00       Plant Operation and Maintenance       0       0       0         0.00       Capital Related Costs-Mowhele Equip.       0       0       0         0.00       Visures Service Coordination       0       0       0       0         1NPATIENT CARE SERVICE       0       0       0       0       0       0         1NPATIENT CARE SERVICE       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td< td=""><td></td></td<>	
2.00       Capital Related Costs-Movable Equip.       0       0         3.00       Plant Operation and Maintenance       0       0       0         4.00       Transportation - Staff       0       0       0         5.00       Volunteer Service Coordination       0       0       0       0         6.00       Administrative and General       0       0       0       0         1NPATIENT CARE SERVICE       0       0       0       0       0         1Npatient - Respite Care       0       0       0       0       0         9.00       Physician Services       0       0       0       0         9.00       Nursing Care-Continuous Home Care       0       0       0       0         10.00       Nursing Care-Continuous Home Care       0       0       0       0         10.00       Cupational Therapy       0       0       0       0       0         10.00       Speech/ Language Pathology       0       0       0       0       0         10.00       Cupational Therapy       0       0       0       0       0       0         10.00       Speech/ Language Pathology       0       0	
3:00       Plant Operation and Maintenance       0       0       0         4:00       Transportation - Staff       0       0       0       0         0:00       Volunteer Service Coordination       0       0       0       0       0         1NPATIENT CARE SERVICE	1.00
4.00         Transportation - Staff         0         0         0           5.00         Volunteer Service Coordination         0         0         0         0           1NPATIENT CARE SERVICE         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	2.00
5.00         Volunteer Service Coordination         0         0         0           Administrative and General         0         0         60.090           INPATIENT CARE SERVICE         0         0         0           7.00         Inpatient - General Care         0         0         0           0         Physical Therespite Care         0         0         0           0         Wising Care         0         0         0           10.00         Nursing Care         0         0         0           11.00         Nursing Care-Continuous Home Care         0         0         0           11.00         Decent/ Language Pathology         0         0         0         0           11.00         Distary Counseling         0         0         0         0         0         0         0	3.00
6.00       Administrative and General       0       0       60.090         INPATIENT CARE SERVICE       0       10,835       10,835         7.00       Inpatient - General Care       0       0       0         9.00       Physician Services       0       0       0         9.00       Nursing Care       0       0       0       0         9.00       Nursing Care-Continuous Home Care       0       0       0       0         10.00       Nursing Care-Continuous Home Care       0       0       0       0         10.00       Physical Therapy       0       0       0       0       0         10.00       Speech/ Language Pathology       0       0       0       0       0         10.00       Speech/ Language Pathology       0       0       0       0       0         10.00       Speech/ Language Pathology       0       0       0       0       0       0         10.00       Dictary Counsel ing       0       0       0       0       0       0         10.00       Dictary Counsel ing       0       0       0       0       0       0       0       0       0       <	4.00
INPATI ENT CARE SERVICE           7.00         Inpatient - General Care         0         10,835         10,835           0.00         Inpatient - Respite Care         0         0         0           9.00         Physician Services         0         0         0           9.00         Nursing Care         0         0         0         0           9.00         Occupational Therapy         0         0         0         0           13.00         Occupational Therapy         0         0         0         0         0           14.00         Speech/ Language Pathology         0         0         0         0         0           16.00         Counseling - Other         0         0         0         0         0           17.00         Dietary Counseling         Other <td>5.00</td>	5.00
7.00         Inpatient - General Care         0         10,835         10,835           8.00         Inpatient - Respite Care         0         0         0           VISTING SERVICES         0         0         0         0           9.00         Physician Services         0         0         0         0           10.00         Nursing Care         0         0         0         0           11.00         Nursing Care-Continuous Home Care         0         0         0         0           10.00         Coupational Therapy         0         0         0         0         0           12.00         Decupational Therapy         0         0         0         0         0           13.00         Decupational Therapy         0         0         0         0         0           14.00         Speech/ Language Pathology         0         0         0         0         0           16.00         Spiritual Counseling         0         0         0         0         0         0           17.00         Dietary Counseling         0         0         0         0         0         0         0         0         0         0 <td>6.00</td>	6.00
8.00       Inpatient - Respite Care       0       0       0         VISITING SERVICES       0       0       0         9.00       Physic can Services       0       0       0         11.00       Nursing Care-Continuous Home Care       0       0       0         12.00       Physic cal Therapy       0       0       0       0         13.00       Occupational Therapy       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Haide & Homemaker       0       0       0       0       0         21.00       Other       0       0       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0	
VISITING SERVICES         0         0           9.00         Physician Services         0         0         0           10.00         Nursing Care         0         0         0           11.00         Nursing Care-Continuous Home Care         0         0         0           11.00         Nursing Care-Continuous Home Care         0         0         0           12.00         Occupational Therapy         0         0         0         0           13.00         Occupational Therapy         0         0         0         0           14.00         Speech/Language Pathology         0         0         0         0         0           15.00         Medical Social Services         0         0         0         0         0           16.00         Spiritual Counseling         0         0         0         0         0           17.00         Dietary Counsel ing         0         0         0         0         0         0         0           18.00         Counsel ing - Other         0         0         0         0         0         0         0           19.00         Hhaide & Homemaker         - Cont. Home Care         0 <td>7.00</td>	7.00
9.00       Physician Services       0       0       0         10.00       Nursing Care-Continuous Home Care       0       0       0         11.00       Nursing Care-Continuous Home Care       0       0       0         12.00       Physical Therapy       0       0       0       0         13.00       Occupational Therapy       0       0       0       0         13.00       Speech/Language Pathology       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         10.00       Home Healt h ide and Homemaker       0       0       0       0         10.01       Other       0       0       0       0       0         10.01       Other       0       0       0       0       0       0       0         10.01       Home Healt h ide and Homemaker       0       0       0 <t< td=""><td>8.00</td></t<>	8.00
10.00       Nursing Care       0       0       0         11.00       Nursing Care-Continuous Home Care       0       0       0         12.00       Physical Therapy       0       0       0       0         13.00       Occupational Therapy       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         16.00       Dietary Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0         21.00       Other       Other       0       0       0       0       0         22.00       Durusis, Biological and Infusion Therapy       0	
11.00       Nursing Care-Continuous Home Care       0       0       0         12.00       Physical Therapy       0       0       0         13.00       Occupational Therapy       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Health Aide and Homemaker       0       0       0       0         20.00       Drugs, Biological and Infusion Therapy       0       0       0       0         21.00       Other       Specify       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         23.00       Anal gesics       0       0       0	9.00
12.00       Physical Therapy       0       0       0       0         13.00       Occupational Therapy       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0       0         16.00       Speech/Language Pathology       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         10.01       Other       0       0       0       0       0       0         20.00       Purgs, Biological and Infusion Therapy       0       0       0       0       0         21.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         22.00       Drugs, Biologi	10.00
13.00       Occupational Therapy       0       0       0       0         14.00       Speech/Language Pathology       0       0       0       0         15.00       Medical Services       0       0       0       0         15.00       Medical Services       0       0       0       0         16.00       Spiritual Counseling       0       0       0       0         17.00       Dietary Counseling       0       0       0       0         18.00       Counseling - Other       0       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0       0         19.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0         10.00       Other       0       0       0       0       0         10.01       Other       0       0       0       0       0         20.00       Drugs, Biological and Infusion Therapy       2       0       0       0       0         21.00       Drugs, Biological Explore       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy </td <td>11.00</td>	11.00
14.00       Speech / Language Pathology       0       0       0       0         15.00       Medical Social Services       0       0       0         16.00       Spiritual Counseling       0       0       0         16.00       Spiritual Counseling       0       0       0         17.00       Dietary Counseling       0       0       0         18.00       Counseling - Other       0       0       0         19.00       Home Heal th Ai de and Homemaker       0       0       0         20.00       HH Ai de & Homemaker       0       0       0         21.00       Other       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0         23.00       Anal gesics       2       0       0       0         24.00       Sedatives / Hypnotics       2       0       0       0         25.00       Other - Specify       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         26.00       Imaging Services       0       0       0       0	12.00
15.00       Medical Social Services       0       0       0         16.00       Spiritual Counseling       0       0       0         17.00       Dietary Counseling       0       0       0         18.00       Counseling - Other       0       0       0         19.00       Home Heal th Ai de and Homemaker       0       0       0       0         19.00       HH Ai de & Homemaker       0       0       0       0       0         10.00       Other       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	13.00
16.00       Spiritual Counseling       0       0       0         17.00       Dietary Counseling       0       0       0         18.00       Counseling - Other       0       0       0         19.00       Home Healt h Aide and Homemaker       0       0       0         19.00       Home Healt h Aide and Homemaker       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0         21.00       Other       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0       0         23.00       Anal gesics       24.00       Sedatives / Hypnotics       0       0       0         24.00       Sedatives / Hypnotics       0       0       0       0       0         25.00       Other - Specify       0       0       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       0         27.00       Patient Transportation       0       0       0       0       0         28.00       Imaging Services       0       0	14.00
17.00       Di etary Counsel ing       0       0       0         18.00       Counsel ing - Other       0       0       0         19.00       Home Heal th Ai de and Homemaker       0       0       0         20.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0         21.00       Other       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0         23.00       Anal gesics       0       0       0         24.00       Sedatives / Hypnotics       0       0       0         25.00       Other - Specify       0       0       0       0         26.00       Durable Medical Equipment/Oxygen       0       0       0       0         27.00       Pati ent Transportation       0       0       0       0         27.00       Labs and Di agnostics       0       0       0       0         30.00       Medical Supplies       0       0       0       0         30.00       Medical Supplies       0       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0	15.00
18.00       Counseling - Other       0       0       0         19.00       Home Heal th Aide and Homemaker       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0         0       0       0       0       0       0         0       0       0       0       0       0         0       0       0       0       0       0         0       0       0       0       0       0         22.00       Drugs, Biological and Infusion Therapy       0       0       0         23.00       Anal gesics       1       1       1         24.00       Sedatives / Hypnotics       1       1       1         25.00       Other - Specify       1       1       1         26.00       Durable Medical Equipment/Oxygen       0       0       0         27.00       Patient Transportation       0       0       0         29.00       Labs and Diagnostics       0       0       0       0         30.00       Medical Supplies       0<	16.00
19:00Home Heal th Ai de and Homemaker00020:00HH Ai de & Homemaker - Cont. Home Care00021:00Other0000Other0000Orugs, Biological and Infusion Therapy0020:00Anal gesics0021:00Sedatives / Hypnotics0023:00Anal gesics0024:00Sedatives / Hypnotics0025:00Other - Specify0026:00Durable Medical Equipment/Oxygen0027:00Patient Transportation0000Labs and Diagnostics0000Medical Supplies0000Outpatient Services (including E/R Dept.)000000001:0000001:0100001:0200001:03:00Radi ation Therapy0002:0000003:00Chemotherapy0003:00Chemotherapy0003:00Other0004:0100005:0200006:0200007:03:0300009:04:04:04:04:05:05:05:05:05:05:05:05:05:05:05:05:05:	17.00
20.00HH Ai de & Homemaker - Cont. Home Care00021.00Other000OTHER HOSPICE SERVICE COSTS22.00Drugs, Bi ol ogi cal and Infusi on Therapy23.00Anal gesi cs24.00Sedati ves / Hypnoti cs25.00Other - Speci fy26.00Durable Medi cal Equipment/Oxygen27.00Pati ent Transportati on00028.00Imagi ng Servi ces00029.00Labs and Di agnosti cs00030.00Medi cal Suppli es00030.00Radi ati on Therapy00031.00Outpati ent Servi ces (incl udi ng E/R Dept.)00032.00Radi ati on Therapy00033.00Chemotherapy00040.00Other00033.00Chemotherapy00040.00Other00033.00Chemotherapy00040.00Other00040.00Other00040.00Other00040.00Other00040.00Other00040.00Other00040.00Other000	18.00
21.00OtherOOOTHER HOSPICE SERVICE COSTS22.00Drugs, Biological and Infusion Therapy23.00Analgesics24.00Sedatives / Hypnotics25.00Other - Specify26.00Durable Medical Equipment/Oxygen27.00Patient Transportation28.00Imaging Services29.00Labs and Diagnostics20.00Medical Supplies21.00O22.00Outpatient Services (including E/R Dept.)23.00Chemotherapy24.00O25.00O25.00O0O0O27.00Patient Transportation0O0O29.00Labs and Diagnostics0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O0O<	19.00
OTHER HOSPICE SERVICE COSTS22.00Drugs, Biological and Infusion Therapy23.00Analgesics24.00Sedatives / Hypnotics25.00Other - Specify26.00Durable Medical Equipment/Oxygen27.00Patient Transportation0028.00Imaging Services0029.00Labs and Diagnostics000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000 <td>20.00</td>	20.00
22.00Drugs, Biological and Infusion Therapy23.00Analgesics24.00Sedatives / Hypnotics25.00Other - Specify26.00Durable Medical Equipment/Oxygen27.00Patient Transportation0028.00Imaging Services0029.00Labs and Diagnostics000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000	21.00
23.00       Anal gesics         24.00       Sedatives / Hypnotics         25.00       Other - Specify         26.00       Durable Medical Equipment/Oxygen         27.00       Patient Transportation         28.00       Imaging Services         0       0         29.00       Labs and Diagnostics         0       0         30.00       Medical Supplies         0       0         31.00       Outpatient Services (including E/R Dept.)         32.00       Radiation Therapy         33.00       Chemotherapy         34.00       Other         HOSPICE NONREI MBURSABLE SERVICE       0	
24.00Sedatives / Hypnotics25.00Other - Specify26.00Durable Medical Equipment/Oxygen27.00Patient Transportation28.00Imaging Services00029.00Labs and Di agnostics0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000	22.00
25.00Other - Specify26.00Durable Medical Equipment/Oxygen27.00Patient Transportation27.00Patient Transportation28.00Imaging Services00029.00Labs and Diagnostics0000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000000	23.00
26.00Durable Medical Equipment/Oxygen0027.00Pati ent Transportation0028.00Imaging Services0029.00Labs and Diagnostics0030.00Medical Supplies0031.00Outpatient Services (including E/R Dept.)0032.00Radiation Therapy0033.00Chemotherapy0034.00Other00	24.00
27.00       Pati ent Transportation       0       0       0         28.00       Imaging Services       0       0       0         29.00       Labs and Diagnostics       0       0       0         30.00       Medical Supplies       0       0       0         31.00       Outpatient Services (including E/R Dept.)       0       0       0         32.00       Radiation Therapy       0       0       0         33.00       Chemotherapy       0       0       0         34.00       Other       0       0       0	25.00
28.00Imaging Services00029.00Labs and Diagnostics00030.00Medical Supplies00031.00Outpatient Services (including E/R Dept.)00032.00Radiation Therapy00033.00Chemotherapy00034.00Other000	26.00
29.00         Labs and Diagnostics         0         0         0           30.00         Medical Supplies         0         0         0           31.00         Outpatient Services (including E/R Dept.)         0         0         0           32.00         Radiation Therapy         0         0         0           33.00         Chemotherapy         0         0         0           34.00         HOSPICE NONREI MBURSABLE SERVICE	27.00
30.00         Medical Supplies         0         0         0           31.00         Outpatient Services (including E/R Dept.)         0         0         0           32.00         Radiation Therapy         0         0         0           33.00         Chemotherapy         0         0         0           34.00         Other         0         0         0	28.00
31.00       Outpatient Services (including E/R Dept.)       0       0       0         32.00       Radiation Therapy       0       0       0         33.00       Chemotherapy       0       0       0         34.00       Other       0       0       0         HOSPICE NONREI MBURSABLE SERVICE	29.00
32.00       Radiation Therapy       0       0       0         33.00       Chemotherapy       0       0       0         34.00       Other       0       0       0         HOSPICE NONREI MBURSABLE SERVICE	30.00
33.00         Chemotherapy         0         0         0           34.00         Other         0         0         0         0           HOSPI CE         NONREI MBURSABLE         SERVI CE	31.00
33.00         Chemotherapy         0         0         0           34.00         Other         0         0         0         0           HOSPI CE         NONREI MBURSABLE         SERVI CE	32.00
34.00     Other     0     0       HOSPICE NONREI MBURSABLE SERVICE	33.00
HOSPI CE NONREI MBURSABLE SERVI CE	34.00
35.00 Bereavement Program Costs 0 0 0	
	35.00
36.00 Volunteer Program Costs 0 0 0	36.00
37.00 Fundraising 0 0 0	37.00
38.00 Other Program Costs 0 0 0	38.00
39.00 Total (sum of lines 1 thru 38) 0 0 10,835 70,925	39.00

Heal th	Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES		u of Form CMS-:	2552-10
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST		Provider Hospice C	CCN: 150048 CCN: 151524	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
					Hospi ce I	3/27/2015 9:5	i am
			CAPI TAL RE	LATED COST	- nospi ce i		
			on the ne				
		NET EXPENSES FOR COST ALLOCATI ON	BUI LDI NGS & FI XTURES	MOVABLE EQUI PMENT	PLANT OPERATI ON & MAI NT.	TRANSPORTATI ON	
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	743			0		2.00
3.00	Plant Operation and Maintenance	0	0		0 0		3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	559, 548	0		0 0	0	6.00
	INPATIENT CARE SERVICE					_	
7.00	Inpatient - General Care	168, 445	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VISITING SERVICES					_	
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	660, 256	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	57, 183	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	50, 889	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS	<b>1</b>				-	
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0		22.00
23.00	Anal gesi cs	144, 379	0		0 0		
24.00	Sedatives / Hypnotics	0	0		0 0		
25.00	Other - Specify	0	0		0 0	-	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0		
27.00	Patient Transportation	0	0		0 0		27.00
28.00	Imaging Services	0	0		0 0	-	28.00
29.00	Labs and Diagnostics	6	0		0 0	-	29.00
30.00	Medi cal Supplies	95	0		0 0	-	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	e e e e e e e e e e e e e e e e e e e	
32.00	Radiation Therapy	0	0		0 0		32.00
33.00	Chemotherapy	0	0		0 0		33.00
34.00		0	0		0 0	0	34.00
05 00	HOSPI CE NONREI MBURSABLE SERVI CE						05 65
35.00	Bereavement Program Costs	0			0 0	-	35.00
36.00	Volunteer Program Costs	0	0		0 0	-	
37.00	Fundrai si ng	0	0		0 0		37.00
38.00	Other Program Costs	0	0		0 0		
37.00	Total (sum of lines 1 thru 38)	1, 641, 544	0	l	0 0	I 0	39.00

COST A	Financial Systems REID LLOCATION - HOSPICE GENERAL SERVICE COST		LTH CARE SERVI	CCN: 150048	Peri od:	u of Form CMS- Worksheet K-4	
0001 A	LECONTON - HOSTIGE GENERAL SERVICE COST				From 01/01/2014	Part I	
			Hospi ce	CCN: 151524	To 12/31/2014	Date/Time Pre 3/27/2015 9:5	epared: 51 am
					Hospi ce I	0/2//2010 /.0	
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI	VETOTAL (col. 5A		
		SERVI CES	(cols. 0 - 5)	& GENERAL	± col. 6)		
		COORDINATOR		6.00	7.00		
		5.00	5A	6.00	7.00		-
1.00	GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Brug and Fixt.						2.00
2.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
4.00 5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	559, 54	B 559, 5	48		6.00
0.00	I NPATI ENT_CARE_SERVI CE		007,01	5 007,0			0.00
7.00	Inpatient - General Care	0	168, 44	5 87, 1	70 255, 615		7.00
8.00	Inpatient - Respite Care	0		)	0 0		8.00
	VI SI TI NG SERVI CES			•			
9.00	Physician Services	0	(	C	0 0		9.00
10.00	Nursing Care	0	660, 25	5 341, 6	83 1, 001, 939		10.00
11.00	Nursing Care-Continuous Home Care	0	(	b	0 0		11.00
12.00	Physical Therapy	0	(	C	0 0		12.00
13.00	Occupational Therapy	0	(	C	0 0		13.00
14.00	Speech/ Language Pathol ogy	0	(	C	0 0		14.00
15.00	Medical Social Services	0	(	C	0 0		15.00
16.00	Spiritual Counseling	0		C	0 0		16.00
17.00	Dietary Counseling	0		C	0 0		17.00
18.00	Counseling - Other	0	(	C	0 0		18.00
19.00	Home Health Aide and Homemaker	0	57, 18	3 29, 5	92 86, 775		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0		20.00
21.00		0	50, 88	9 26, 3	35 77, 224		21.00
22.00	OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy	0		2	0 0		22.00
22.00	Anal gesi cs	0	144, 37	5 9 74,7	-		22.00
23.00	Sedatives / Hypnotics	0	144, 37	7 74,7	0 219,095		23.00
24.00	Other - Specify	0			0 0		24.00
26.00	Durable Medical Equipment/Oxygen	0			0 0		26.00
27.00	Pati ent Transportati on	0			0 0		27.00
28.00	Imaging Services	0			0 0		28.00
29.00	Labs and Diagnostics	0		6	3 9		29.00
30.00	Medical Supplies	0	9	5	49 144		30.00
31.00	Outpatient Services (including E/R Dept.)	0		0	0 0		31.00
32.00	Radi ati on Therapy	0			0 0		32.00
33.00	Chemotherapy	0	(	D C	0 0		33.00
34.00	Other	0	(	b	0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	(	C	0 0		35.00
36.00	Volunteer Program Costs	0	(	C	0 0		36.00
37.00	Fundrai si ng	0	(	C	0 0		37.00
38.00	Other Program Costs	0	(	C	0 0		38.00
	Total (sum of lines 1 thru 38)	0	1, 640, 80	11	1, 640, 801		39.00

	Financial Systems REID ALLOCATION - STATISTICAL BASIS	HOSPI TAL & HEA		CCN: 150048	Period: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet K-4 Part II Date/Time Pre 3/27/2015 9:5	epared:
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUI LDI NGS & FI XTURES (SQ. FT.)	MOVABLE EQUI PMENT (\$ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)		SERVI CES COORDI NATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00 2.00 3.00 4.00 5.00 6.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip. Plant Operation and Maintenance Transportation - Staff Volunteer Service Coordination Administrative and General		0 0 0 0			0	
0.00	I NPATI ENT_CARE_SERVI CE	0	0		0 0	0	0.00
7.00 8.00	Inpatient - General Care Inpatient - Respite Care VISITING SERVICES	0			0 0 0 0	0	
9.00 10.00	Physician Services Nursing Care	0			0 0	0	
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathology	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	
17.00	Di etary Counsel i ng	0	0		0 0	0	
18.00	Counseling - Other	0	0		0 0	0	
19.00	Home Health Aide and Homemaker	0	0		0 0	0	
20. 00 21. 00	HH Aide & Homemaker - Cont. Home Care Other		-		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	0	0		0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0			0 0	0	
24.00	Sedatives / Hypnotics	0			0 0	0	
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00	Radiation Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	0	0	1	0 0	0	34.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	-		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	0	0		0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0		0 0	0	
40.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0. 000000	0.000000	40.00

OST A	Financial Systems REID ILLOCATION - STATISTICAL BASIS		H CARE SERVICES Provider CCN: 150048	Peri od:	of Form CMS-255 Worksheet K-4
			Hospi ce CCN: 151524		Part II Date/Time Prepar 3/27/2015 9:51 a
				Hospi ce I	0/2//2010 7.01 4
		RECONCI LI ATI ON AD	MI NI STRATI VE	· · · · ·	
			& GENERAL		
			(ACC. COST)		
	GENERAL SERVICE COST CENTERS	6A	6.00		
00	Capital Related Costs-Bldg and Fixt.	0			-
00	Capital Related Costs-Movable Equip.	0			
00	Plant Operation and Maintenance	0			
00	Transportation - Staff	0			
00	Volunteer Service Coordination	0			Ę
00	Administrative and General	-559, 548	1, 081, 253		
00	I NPATI ENT_CARE_SERVI CE	337, 340	1,001,200		`
00	Inpatient - General Care	0	168, 445		
00	Inpatient - Respite Care	0	0		
	VISITING SERVICES				
00	Physi ci an Servi ces	0	0		
00	Nursi ng Care	0	660, 256		10
00	Nursing Care-Continuous Home Care	0	0		1
00	Physical Therapy	0	o		12
00	Occupational Therapy	0	0		13
00	Speech/ Language Pathol ogy	0	o		14
. 00	Medi cal Soci al Servi ces	0	o		15
. 00	Spiritual Counseling	0	o		10
.00	Dietary Counseling	0	o		1
00	Counseling - Other	0	0		18
. 00	Home Health Aide and Homemaker	0	57, 183		19
. 00	HH Aide & Homemaker - Cont. Home Care	0	o		20
00	Other	0	50, 889		2
	OTHER HOSPICE SERVICE COSTS		· · ·		
00	Drugs, Biological and Infusion Therapy	0	0		22
00	Anal gesi cs	0	144, 379		23
00	Sedatives / Hypnotics	0	o		24
00	Other - Specify	0	0		25
00	Durable Medical Equipment/Oxygen	0	0		20
00	Patient Transportation	0	0		27
00	I maging Services	0	0		28
00	Labs and Diagnostics	0	6		29
00	Medical Supplies	0	95		30
00	Outpatient Services (including E/R Dept.)	0	0		31
00	Radiation Therapy	0	0		32
. 00	Chemotherapy	0	0		33
. 00	Other	0	0		34
	HOSPICE NONREIMBURSABLE SERVICE				
. 00	Bereavement Program Costs	0	0		35
. 00	Volunteer Program Costs	0	0		36
00	Fundrai si ng	0	0		37
. 00	Other Program Costs	0	0		38
. 00	Cost to be Allocated (per Wkst. K-4, Part I)		559, 548		39
00	Unit Cost Multiplier		0. 517500		40

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
	TI ON OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150048 CCN: 151524	Period: From 01/01/2014	Worksheet K-5 Part I	pared:
					Hospi ce I		
			CAF	I TAL RELATED			
			0, 11		00010		
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	NEW CAP BLDG	& NEW MVBLE	EMPLOYEE	
		Bal ance (1)	FLXT	FIXT - OFFSI		BENEFI TS	
						DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	-	8, 174		0 0	101, 960	1.00
2.00	Inpatient - General Care	255, 615			0 0	0	2.00
3.00	Inpatient - Respite Care	200,010			0 0	0	3.00
4.00	Physi ci an Servi ces	0			0 0	0	4.00
5.00	Nursing Care	1,001,939			0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	1,001,737			0 0	0	6.00
7.00	Physical Therapy	0			0 0	0	
8.00	Occupational Therapy	0			0 0	0	
9.00	Speech/ Language Pathol ogy	0			0 0	0	
10.00	Medical Social Services	0			0 0	0	10.00
11.00	Spiritual Counseling	0			0 0	0	11.00
12.00	Dietary Counseling	0			0 0	0	12.00
		0			0 0		
13.00	Counseling - Other	0 775				0	13.00
14.00	Home Health Aide and Homemaker	86, 775			0 0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	
16.00	Other	77, 224		D D	0 0	0	
17.00	Drugs, Biological and Infusion Therapy	0		D	0 0	0	
18.00	Analgesics	219, 095		D	0 0	0	18.00
19.00	Sedatives / Hypnotics	0		D	0 0	0	
20.00	Other - Specify	0		D	0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0		D	0 0	0	
22.00	Patient Transportation	0		D	0 0	0	22.00
23.00	Imaging Services	0		D	0 0	0	
24.00	Labs and Diagnostics	9		D	0 0	0	
25.00	Medical Supplies	144		D	0 0	0	
26.00	Outpatient Services (including E/R Dept.)	0	(	D	0 0	0	26.00
27.00	Radiation Therapy	0	(	D	0 0	0	27.00
28.00	Chemotherapy	0	(		0 0	0	28.00
29.00	Other	0			0 0	0	29.00
30.00	Bereavement Program Costs	0		D	0 0	0	30.00
31.00	Volunteer Program Costs	0	(		0 0	0	31.00
32.00	Fundrai si ng	0			0 0	0	32.00
33.00	Other Program Costs	0	(		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1, 640, 801	8, 174	1	0 0	101, 960	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

		HOSPI TAL & HEA				u of Form CMS-2	
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150048	Period:	Worksheet K-5	
			Hospi ce (	CCN: 151524	From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	nared
			nospi ce v	101021	10 12/01/2011	3/27/2015 9:5	
					Hospi ce I		
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG		CASHI ERI NG/ACC	
		TELEPHONES	PROCESSI NG	RECEIVING AN	ID	OUNTS	
				STORES		RECEI VABLE	
1.00		5.01	5.02	5.03	5.04	5.05	1 00
1.00	Administrative and General	1, 588	25, 827			19, 647	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00 20.00
20.00 21.00	Other – Specify Durable Medical Equipment/Oxygen	0	0		0 0	0	20.00
21.00	Patient Transportation	0	0		0 0	0	21.00
22.00	Imaging Services	0	0		0 0	0	22.00
23.00	Labs and Diagnostics	0	0		0 0	0	23.00
24.00 25.00	Medical Supplies	0	0		0 0	0	24.00
25.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	25.00
28.00	Radiation Therapy	0	0		0 0	0	28.00
27.00	Chemotherapy	0	0		0 0	0	27.00
28.00	Other	0	0			0	28.00
29.00 30.00	Bereavement Program Costs	0	0			0	30.00
30.00	Volunteer Program Costs	0			0 0	0	30.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
32.00	Other Program Costs	0	0		0 0	0	32.00
33.00	Total (sum of lines 1 thru 33) (2)	1, 588	25, 827		-	19, 647	34.00
	Unit Cost Multiplier (see instructions)	1, 000	23, 027	103, 4	7,430	17,047	34.00
55.00		i I		I	ļ.	I	1 33.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS         Provider CCN: 150048         Period: From 01/01/2014         Worksheet K-5 proprint (2012)         Worksheet K-5 proprint (2012) <th>Heal th</th> <th>Financial Systems REID</th> <th>HOSPITAL &amp; HEA</th> <th>LTH CARE SERVI</th> <th>CES</th> <th>In Lie</th> <th>eu of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
Cost Center Description         Subtotal         OTHER         DPERATION OF PLANT         Hospice I           1.00         Administrative and General         270,102         5.06         7.00         8.00         9.00           2.00         Inpatient - General Care         255,615         15,647         0         0         0         2.00           3.00         Inpatient - General Care         255,615         15,647         0         0         0         2.00           3.00         Inpatient - Respite Care         0         0         0         0         2.00         1.00         3.00         0         0         0         2.00         1.00         3.00         0         0         0         0         0         2.00         1.00         3.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS			From 01/01/2014	Part I	
Cost Center Description         Subtotal ADM INISTRATIVE AND GENERATION OF AND CENTRATIVE AND CENTRATINE AND CENTRATIVE AND CENTRATIVE AND CENTRATION AND CENTRATIVE AND				nospi ce c	JON. 131324	10 12/31/2014		
ADMINISTRATIVE         PLANT         LINEN SERVICE           1.00         Administrative and General         57.05         5.06         7.00         8.00         9.00           2.00         Inpatient - General Care         270.102         16.497         0         0         17.672         1.00           3.00         Inpatient - Respite Care         0         0         0         0         2.00           3.00         Inpatient - Respite Care         0         0         0         0         3.00           4.00         Physic Can Services         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<								
AND GENERAL         AND GENERAL         AND GENERAL           1.00         Inpatient - General Care         270,102         16,497         0         0         17,672         1.00           2.00         Inpatient - General Care         255,015         15,612         0         0         2.00         3.00           3.00         Inpatient - General Care         0         0         0         0         3.00           4.00         Physic classervices         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		Cost Center Description					HOUSEKEEPI NG	
5A.05         5.06         7.00         8.00         9.00           1.00         Administrative and General         270,102         16,497         0         0         17,672         1.00           2.00         Inpatient - General Care         255,615         15,612         0         0         0         2.00           3.00         Inpatient - Respite Care         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					PLANT	LINEN SERVICE		
1.00         Admin is strative and General         270, 102         16, 497         0         0         17, 672         1.00           2.00         Inpatient - General Care         255, 615         15, 612         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			EA OF		7.00	0.00	0.00	
2.00         Inpatient - General Care         255,615         15,612         0         0         0         2.00           3.00         Inpatient - Respite Care         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	1 00	Administrative and Conoral			7.00			1 00
3.00         Impatient - Respite Care         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<						-		
4.00       Physician Services       0       0       0       4.00         5.00       Nursing Care       1,001,939       61,194       0       0       5.00         6.00       Nursing Care-Continuous Home Care       0       0       0       0       6.00         0.00       Physical Therapy       0       0       0       0       0       6.00         0.00       Speech/Language Pathology       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
5.00         Nursing Care         1,001,939         61,194         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			0				-	
6.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			1 001 030	61 104			-	
7.00         Physical Therapy         0         0         0         0         7.00           8.00         Occupational Therapy         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td>1,001,939</td> <td>01, 194</td> <td></td> <td></td> <td></td> <td></td>			1,001,939	01, 194				
8.00         Occupational Therapy         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			0	0			-	
9.00         Speech/Language Pathology         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         10.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <			0				-	
10.00       Medical Social Services       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0								
11.00       Spiritual Counseling       0       0       0       0       11.00         12.00       Dietary Counseling       0       0       0       0       12.00         13.00       Counseling - Other       0       0       0       0       12.00         13.00       Counseling - Other       86,775       5,300       0       0       14.00         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       77,224       4,717       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00       23.00         22.00       Patient Transportation       0       0       0       0       22.00       23.00         24.00       Labs and Diagnostics       9			0					
12.00       Dietary Counseling       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
13.00       Counseling - Other       0       0       0       0       13.00         14.00       Home Heal th Ai de and Homemaker       86,775       5,300       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       77,224       4,717       0       0       0       16.00         17.00       Drugs, Biol ogical and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td></td> <td></td>			0			0 0		
14.00       Home Heal th Ai de and Homemaker       86,775       5,300       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       77,224       4,717       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       21.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00       0       21.00       22.00       0       22.00       0       0       0       0       22.00       22.00       0       22.00       0       0       0       0       22.00       22.00       22.00       22.00       0       22.00       0       0       22.00       22.00       22.00       23			0			0 0	-	
15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       15.00         16.00       Other       77,224       4,717       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         22.00       Pati ent Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00       23.00         24.00       Labs and Di agnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       24.00         25.00       Other       0 <t< td=""><td></td><td></td><td>86 775</td><td>5 300</td><td></td><td>0 0</td><td></td><td></td></t<>			86 775	5 300		0 0		
16.00       Other       77,224       4,717       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       22.00         22.00       Pati ent Transportation       0       0       0       0       22.00         24.00       Labs and Diagnostics       9       1       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       25.00         26.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td>-</td> <td></td>						0 0	-	
17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       17.00         18.00       Anal gesics       219,095       13,382       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       22.00         24.00       Labs and Diagnostics       9       1       0       0       25.00         25.00       Medical Supplies       144       9       0       0       26.00         27.00       Radiation Therapy       0       0       0       26.00       27.00         28.00       Chemotherapy       0       0       0       0       28.00       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00			77.224	4.717		0 0		
18.00       Anal gesi cs       219,095       13,382       0       0       18.00         19.00       Sedati ves / Hypnoti cs       0       0       0       0       0       19.00         20.00       Other - Speci fy       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       20.00         21.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       22.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medi cal Supplies       1444       9       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radi ati on Therapy       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0			0	0		0 0	0	
19.00       Sedatives / Hypnotics       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00       28.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         32.			219,095	13, 382		0 0	0	
20.00       0ther - Specify       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       29.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       20.00         31.00       Vol unteer Program Costs       0       0       0       0       0       31.00         32.00	19.00		0	0		0 0	0	19.00
21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       0       31.00         32.00       Therea Stand       0       0       0       0       0       32.00         33.00	20,00		0	0		0 0	0	20.00
22.00       Pati ent Transportation       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       23.00         24.00       Labs and Diagnostics       9       1       0       0       0       24.00         25.00       Medical Supplies       9       1       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00       29.00         29.00       Other       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       0       30.00         32.00       Fundraising       0       0       0       0       32.00       33.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903 <td>21.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td></td>	21.00		0	0		0 0	0	
24.00       Labs and Diagnostics       9       1       0       0       24.00         25.00       Medical Supplies       144       9       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	22.00		0	0		0 0	0	22.00
25.00       Medical Supplies       144       9       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	23.00	Imaging Services	0	0		0 0	0	23.00
26.00Outpatient Services (including E/R Dept.)000026.0027.00Radiation Therapy000027.0028.00Chemotherapy000028.0029.00Other000029.0030.00Bereavement Program Costs000029.0031.00Volunteer Program Costs000031.0032.00Fundraising000032.0033.00Other Program Costs000033.0034.00Total (sum of Lines 1 thru 33) (2)1,910,903116,7120017,67234.00	24.00	Labs and Diagnostics	9	1		0 0	0	24.00
27.00       Radiation Therapy       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       29.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	25.00	Medical Supplies	144	9		0 0	0	25.00
28.00       Chemotherapy       0       0       0       0       28.00         29.00       Other       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
29.00       0ther       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       31.00         32.00       Fundraising       0       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       32.00         34.00       Total (sum of Lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	27.00	Radiation Therapy	0	0		0 0	0	27.00
30.00         Bereavement Program Costs         0         0         0         30.00         30.00           31.00         Volunteer Program Costs         0         0         0         0         31.00           32.00         Fundraising         0         0         0         0         32.00           33.00         Other Program Costs         0         0         0         0         32.00           34.00         Total (sum of Lines 1 thru 33) (2)         1, 910, 903         116, 712         0         0         17, 672         34.00	28.00	Chemotherapy	0	0		0 0	0	28.00
31. 00       Volunteer Program Costs       0       0       0       31. 00         32. 00       Fundraising       0       0       0       0       32. 00         33. 00       Other Program Costs       0       0       0       0       33. 00         34. 00       Total (sum of lines 1 thru 33) (2)       1, 910, 903       116, 712       0       0       17, 672       34. 00	29.00	Other	0	0		0 0	0	29.00
32.00       Fundraising       0       0       0       32.00         33.00       Other Program Costs       0       0       0       0       33.00         34.00       Total (sum of lines 1 thru 33) (2)       1,910,903       116,712       0       0       17,672       34.00	30.00	Bereavement Program Costs	0	0		0 0	0	30.00
33.00         Other Program Costs         0         0         0         0         33.00           34.00         Total (sum of lines 1 thru 33) (2)         1,910,903         116,712         0         0         17,672         34.00	31.00	Volunteer Program Costs	0	0		0 0	0	31.00
34.00         Total (sum of lines 1 thru 33) (2)         1,910,903         116,712         0         0         17,672         34.00			0	0		0 0	-	
	33.00		0	0		0 0		
35.00  Unit Cost Multiplier (see instructions) 0.000000   35.00						0 0	17,672	
	35.00	Unit Cost Multiplier (see instructions)	0. 000000					35.00

		HOSPI TAL & HEAL					u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150048	Perio	od: 01/01/2014	Worksheet K-5 Part I	
			Hospi ce (	CCN: 151524		12/31/2014		pared: 1 am
					H	ospice I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG		CENTRAL	PHARMACY	
				ADMI NI STRATI	ON S	ERVICES &		
						SUPPLY		
		10.00	11.00	13.00		14.00	15.00	
1.00	Administrative and General	0	7, 482		0	0	158, 505	1.00
2.00	Inpatient - General Care	0	0		0	20	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00	Physi ci an Servi ces	0	0		0	0	0	4.00
5.00	Nursing Care	0	0		0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	0	6.00
7.00	Physical Therapy	0	0		0	0	0	7.00
8.00	Occupational Therapy	0	0		0	0	0	8.00
9.00	Speech/ Language Pathology	0	0		0	0	0	9.00
10.00	Medical Social Services	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	11.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
13.00	Counseling - Other	0	0		0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Pati ent Transportati on	0	0		0	0	0	22.00
23.00	I magi ng Servi ces	0	0		0	0	0	23.00
24.00	Labs and Di agnosti cs	0	0		0	0	0	24.00
25.00	Medical Supplies	0	0		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00	Chemotherapy	0	0		0	0	0	28.00
29.00	Other	0	0		0	0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	0	31.00
32.00	Fundraising	0	0		U	0	0	32.00
33.00	Other Program Costs	0	0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	7, 482		0	20	158, 505	34.00
35.00	Unit Cost Multiplier (see instructions)			I	I	I		35.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	_TH CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150048 CN: 151524	Period: From 01/01/2014 To 12/31/2014		pared:
					Hospi ce I	0/2//2010 /:0	
	Cost Center Description	MEDI CAL S	SOCIAL SERVICE	I NSERVI CE	PARAMED ED	Subtotal	
	Cost center bescription	RECORDS &	SOUTHE SERVICE	EDUCATION	PRGM	(col s. 4A-23)	
		LI BRARY		EDUCATION	T IXOW		
		16.00	17.00	17.01	23.00	24.00	
1.00	Administrative and General	18, 764	0	31, 9			1.00
2.00	Inpatient - General Care	0	0	01, 7	0 0		2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	-	4.00
5.00	Nursing Care	0	0			-	5.00
6.00	Nursing Care-Continuous Home Care	0	0			1,003,133	6.00
	Physical Therapy	0	0				
7.00		0	0			0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	92, 075	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	81, 941	•
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	232, 477	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	10	24.00
25.00	Medical Supplies	0	0		0 0	153	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0	0	29.00
30,00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		õ o	0	31.00
32.00	Fundrai si ng	0	0			0	32.00
33.00	Other Program Costs	0	0			-	33.00
34.00	Total (sum of lines 1 thru 33) (2)	18, 764	0	31, 9	а С		34.00
	Unit Cost Multiplier (see instructions)	10, 704	0	51, 7		2,201,777	35.00
55.00		I I	I		1	I	1 33.00

ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	r centers	Provi der	CCN: 150048	Peri od:	Worksheet K-5
			Hospi ce (		From 01/01/2014 To 12/31/2014	Part I
					Hospi ce I	
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice	
	•	Residents Cost	(cols. 24 ±	Hospice A&G	Costs (cols.	
		& Post	25)	(See Part II	) 26 ± 27)	
		Stepdown				
		Adjustments				
		25.00	26.00	27.00	28.00	
1.00	Administrative and General					1.0
2.00	Inpatient - General Care	0	271, 247	81, 1	61 352, 408	2.0
3.00	Inpatient - Respite Care	0	0		0 0	3.0
4.00	Physi ci an Servi ces	0	0		0 0	4.0
5.00	Nursing Care	0	1, 063, 133	318, 1	05 1, 381, 238	5. C
6.00	Nursing Care-Continuous Home Care	0	0		0 0	6.0
7.00	Physical Therapy	0	0		0 0	7.0
B. 00	Occupational Therapy	0	0		0 0	8.0
9.00	Speech/ Language Pathology	0	0		0 0	9.0
10.00	Medical Social Services	0	0		0 0	10.0
11.00	Spiritual Counseling	0	0		0 0	11.0
12.00	Dietary Counseling	0	0		0 0	12.0
13.00	Counseling - Other	0	0		0 0	13.0
14.00	Home Health Aide and Homemaker	0	92, 075	27, 5	50 119, 625	14.0
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	15.0
16.00	Other	0	81, 941	24, 5	18 106, 459	16.0
17.00	Drugs, Biological and Infusion Therapy	0	0	, -	0 0	17.0
18.00	Anal gesi cs	0	232, 477	69, 5	302, 037	18.0
19.00	Sedatives / Hypnotics	0	0		0 0	19.0
20.00	Other - Specify	0	0		0 0	20.0
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	21.0
22.00	Patient Transportation	0	0		0 0	22.0
23.00	I magi ng Servi ces	0	0		0 0	23.0
24.00	Labs and Diagnostics	0	10		3 13	24.0
25.00	Medical Supplies	0	153		46 199	
26.00	Outpatient Services (including E/R Dept.)	0	.00		0 0	26.0
27.00	Radi ati on Therapy	0	0		0 0	27.0
8.00	Chemotherapy	0	0		0 0	28.0
29.00	Other	0	0		0 0	29.0
30.00	Bereavement Program Costs	0	0		0 0	30.0
31.00	Volunteer Program Costs	0	0		0 0	31.0
32.00	Fundrai si ng		0		0 0	32.0
33.00	Other Program Costs	0	0		0 0	33.0
34.00	Total (sum of lines 1 thru 33) (2)	0	2, 261, 979		2, 261, 979	
54.00	Unit Cost Multiplier (see instructions)	0	2,201,7/7	0, 2992		35.0

Heal th	Financial Systems REID	HOSPI TAL & HEALT	H CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150048	Peri od:	Worksheet K-5	
STATI S	STICAL BASIS				From 01/01/2014	Part II	
			Hospi ce C	CN: 151524	To 12/31/2014	Date/Time Pre	
					llooni oo l	3/27/2015 9:5	I am
		CADLT	AL RELATED CO	272	Hospi ce I		
		CAPIT	AL KELATED CU	1313			
	Cost Center Description	NEW BLDG & NE	W CAP BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
			XT - OFFSITE		BENEFITS	TELEPHONES	
		(SQUARE FEET)		(SQUARE FEET		(PHONES)	
			SQUARE FEET)	<b>、</b>	(GROSS		
			,		SALARI ES)		
		1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	445	0		0 975, 466	13	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	I maging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	-		-	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	-		-	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	-		0 0	0	28.00
29.00	Other	0	0		0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00 32.00	Volunteer Program Costs Fundraising		0		0 0	0	31.00 32.00
32.00	Other Program Costs	0	0		0 0	0	32.00
33.00	Total (sum of lines 1 thru 33) (2)	445	0		0 975, 466	13	33.00
34.00	Total cost to be allocated	8, 174	0		0 975, 488	1, 588	35.00
	Unit Cost Multiplier (see instructions)	18. 368539	0. 000000	0.0000			
50.00	Tom coost multiplier (see fistructions)	10. 300337	0.000000	0.0000	0.104324	122. 133040	30.00

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (	CCN: 150048 CCN: 151524	Period: From 01/01/2014 To 12/31/2014	Worksheet K-5 Part II Date/Time Pre 3/27/2015 9:5	pared:
			_	_	Hospi ce I		
	Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliation	
		PROCESSI NG	RECEIVING AND	(TOTAL	OUNTS		
		(TERMI NALS)	STORES	REVENUE)	RECEI VABLE		
			(SUPPLY		(TOTAL		
			EXPENSE)		REVENUE)		
		5.02	5.03	5.04	5.05	5A. 06	
1.00	Administrative and General	3	274, 667	2, 440, 6	37 2, 440, 637	0	1.00
2.00	Inpatient - General Care	0			0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0			0 0	0	4.00
5.00	Nursi ng Care	0			0 0	0	5.00
6.00	Nursing Care-Continuous Home Care				0 0	0	6.00
7.00	Physical Therapy	0			0 0	0	7.00
8.00	3	0	0		0 0	0	8.00
8.00 9.00	Occupational Therapy Speech/ Language Pathology	0			0 0	0	9,00
		0			0	-	
10.00	Medical Social Services	0	0		0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radi ati on Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other				0 0	0	29.00
30.00	Bereavement Program Costs				0 0	0	30.00
30.00	Volunteer Program Costs				0 0	0	31.00
31.00	Fundrai si ng				0 0	0	31.00
					0 0	0	
33.00	Other Program Costs	0		2 440 4		0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3	274, 667				34.00
35.00	Total cost to be allocated	25, 827					35.00
30.00	Unit Cost Multiplier (see instructions)	8, 609. 000000	0. 376711	0.0038	66 0. 008050		36.00

1.00 Ac 2.00 Ir 3.00 Ir 4.00 Pr 5.00 Nu	ON OF GENERAL SERVICE COSTS TO HOSPICE COST CAL BASIS Cost Center Description dministrative and General npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0	Hospi ce C	CCN: 150048 CN: 151524 LAUNDRY & LI NEN SERVIC (POUNDS OF LAUNDRY) 8.00	Peri od: From 01/01/2014 To 12/31/2014 Hospi ce I HOUSEKEEPI NG E (HOURS OF SERVI CE) 9.00 0 107 0 0 0	Worksheet K-5 Part II Date/Time Prej 3/27/2015 9:5 DI ETARY (MEALS SERVED) 10.00 0	pared:
1.00 Ac 2.00 Ir 3.00 Ir 4.00 Pr 5.00 Nu	Cost Center Description dministrative and General npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care	ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0 0	OPERATI ON OF PLANT (SQUARE FEET) 7.00 0 0	LAUNDRY & LI NEN SERVI C (POUNDS OF LAUNDRY)	To         12/31/2014           Hospi ce I         HOUSEKEEPI NG (HOURS OF SERVI CE)           9.00         0	Date/Time Pre 3/27/2015 9:5 DI ETARY (MEALS SERVED) 10.00 0	1 am
2.00 In 3.00 In 4.00 Ph 5.00 Nu	dministrative and General hpatient - General Care hpatient - Respite Care hysician Services ursing Care ursing Care	ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0 0	OPERATI ON OF PLANT (SQUARE FEET) 7.00 0 0	LAUNDRY & LI NEN SERVI C (POUNDS OF LAUNDRY)	Hospi ce I HOUSEKEEPI NG (HOURS OF SERVI CE) 9.00 0 107	3/27/2015 9:5 DI ETARY (MEALS SERVED) 10.00	1 am
2.00 In 3.00 In 4.00 Ph 5.00 Nu	dministrative and General hpatient - General Care hpatient - Respite Care hysician Services ursing Care ursing Care	ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0 0	PLANT (SQUARE FEET) 7.00 0 0	LINEN SERVIC (POUNDS OF LAUNDRY)	E HOUSEKEEPI NG E (HOURS OF SERVI CE) 9.00 0 107	DI ETARY (MEALS SERVED) 10.00 0	
2.00 In 3.00 In 4.00 Ph 5.00 Nu	dministrative and General hpatient - General Care hpatient - Respite Care hysician Services ursing Care ursing Care	ADMI NI STRATI VE AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0 0	PLANT (SQUARE FEET) 7.00 0 0	LINEN SERVIC (POUNDS OF LAUNDRY)	E (HOURS OF SERVICE) 9.00 0 107	(MEALS SERVED) 10.00 0	1.00
2.00 In 3.00 In 4.00 Ph 5.00 Nu	dministrative and General hpatient - General Care hpatient - Respite Care hysician Services ursing Care ursing Care	AND GENERAL (ACCUM. COST) 5.06 270,102 255,615 0 0	(SQUARE FEET) 7.00 0 0	(POUNDS OF LAUNDRY)	SERVI CE) 9.00 0 107	10.00	1.00
2.00 In 3.00 In 4.00 Ph 5.00 Nu	npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care-Continuous Home Care	(ACCUM. COST) 5.06 270,102 255,615 0 0	7.00 0 0	LAUNDRY)	9.00 0 107	0	1.00
2.00 In 3.00 In 4.00 Ph 5.00 Nu	npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care-Continuous Home Care	5.06 270,102 255,615 0 0	0 0		0 107	0	1.00
2.00 In 3.00 In 4.00 Ph 5.00 Nu	npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care-Continuous Home Care	270, 102 255, 615 0 0	0 0	8.00	0 107	0	1.00
2.00 In 3.00 In 4.00 Ph 5.00 Nu	npatient - General Care npatient - Respite Care nysician Services ursing Care ursing Care-Continuous Home Care	255, 615 0 0	0				1.00
3.00 I n 4.00 Ph 5.00 Nu	npatient – Respite Care nysician Services ursing Care ursing Care-Continuous Home Care	0			0 0	0	
4.00 Ph 5.00 Nu	nysician Services ursing Care ursing Care-Continuous Home Care	0	0			0	2.00
5.00 Nu	ursing Care ursing Care-Continuous Home Care	-			0 0	0	3.00
	ursing Care-Continuous Home Care		0		0 0	0	4.00
6.00 Nu		1, 001, 939	0		0 0	0	5.00
		0	0		0 0	0	6.00
7.00 Ph	nysi cal Therapy	0	0		0 0	0	7.00
	ccupational Therapy	0	0		0 0	0	8.00
9.00 Sp	peech/ Language Pathol ogy	0	0		0 0	0	9.00
	edi cal Soci al Servi ces	0	0		0 0	0	10.00
11.00 Sp	piritual Counseling	0	0		0 0	0	11.00
12.00 Di	etary Counseling	0	0		0 0	0	12.00
13.00 Cc	punseling - Other	0	0		0 0	0	13.00
14.00 Hc	ome Health Aide and Homemaker	86, 775	0		0 0	0	14.00
15.00 HH	H Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00 Ot	ther	77, 224	0		0 0	0	16.00
17.00 Dr	rugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00 Ar	nal gesi cs	219, 095	0		0 0	0	18.00
19.00 Se	edatives / Hypnotics	0	0		0 0	0	19.00
20. 00 Ot	ther - Specify	0	0		0 0	0	20.00
21.00 Du	urable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00 Pa	atient Transportation	0	0		0 0	0	22.00
	naging Services	0	0		0 0	0	23.00
24.00 La	abs and Diagnostics	9	0		0 0	0	24.00
	edical Supplies	144	0		0 0	0	25.00
26.00 OL	utpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00 Ra	adiation Therapy	0	0		0 0	0	27.00
	nemotherapy	0	0		0 0	0	28.00
	ther	0	0		0 0	0	29.00
30. 00 Be	ereavement Program Costs	0	0		0 0	0	30.00
	olunteer Program Costs	0	0		0 0	0	31.00
	undrai si ng	0	0		0 0	0	32.00
	ther Program Costs	0	0		0 0	0	33.00
	otal (sum of lines 1 thru 33) (2)	1, 910, 903	0		0 107	0	34.00
	otal cost to be allocated	116, 712	0		0 17,672	0	35.00
	nit Cost Multiplier (see instructions)	0. 061077	0. 000000	0.0000		-	

Heal th	Financial Systems REID	HOSPITAL & HEA	ITH CARE SERVI	CES	Inlie	u of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			CCN: 150048	Peri od:	Worksheet K-5	
STATI S	STICAL BASIS				From 01/01/2014		
			Hospi ce (	CCN: 151524	To 12/31/2014		
						3/27/2015 9:5	1 am
	Cast Castas Description	CAFETERI A	NURSI NG	CENTRAL	Hospi ce I PHARMACY	MEDI CAL	
	Cost Center Description		ADMI NI STRATI ON			RECORDS &	
		(WANDOURS)		SUPPLY	(DRUGS)	LIBRARY	
			(DI RECT	(MED SUPPLIE	S	(TOTAL	
			NURSING HRS)		5)	REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	34, 943			0 144, 379	2, 440, 637	1.00
2.00	Inpatient - General Care	01, 710			95 0	2, 110, 007	2.00
3.00	Inpatient - Respite Care	0			0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursing Care	0			0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0			0 0	0	6.00
7.00	Physi cal Therapy	0				0	7.00
8.00	Occupational Therapy	0			0 0	0	8.00
9.00	Speech/ Language Pathol ogy					0	9,00
10.00	Medi cal Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0				0	11.00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0			0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	°		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	-		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	-		0 0	0	17.00
18.00	Anal gesi cs	0			0 0	0	18.00
19.00	Sedatives / Hypnotics	0	, s		0 0	0	19.00
20.00	Other - Specify	0	-		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	, °		0 0	0	21.00
22.00	Patient Transportation	0			0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0			0 0	0	24.00
25.00	Medi cal Supplies	0			0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0			0 0	0	26.00
27.00	Radi ati on Therapy	0			0 0	0	27.00
28.00	Chemotherapy	0			0 0	0	28.00
29.00	Other	0			0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	34, 943	-		95 144, 379	-	34.00
35.00	Total cost to be allocated	7, 482			20 158, 505		35.00
	Unit Cost Multiplier (see instructions)	0. 214120					

ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150048	Peri od:	Worksheet K	S-2552-10 -5
	STICAL BASIS		Hospi ce C		From 01/01/201 To 12/31/201	4 Part II	repared:
					Hospi ce I		
	Cost Center Description	SOCI AL SERVI CE	I NSERVI CE	PARAMED ED	)		
			EDUCATI ON	PRGM			
			(IN HOUSE ED)	(TIME SPENT	)		
1 00		17.00	17.01	23.00			1.00
1.00	Administrative and General	0	543		0		1.00
2.00	Inpatient - General Care	0	0		0		2.00
3.00	Inpatient - Respite Care	0	0		0		3.00
4.00	Physi ci an Servi ces	0	0		0		4.00
5.00	Nursing Care	0	0		0		5.00
6.00	Nursing Care-Continuous Home Care	0	0		0		6.00
7.00	Physi cal Therapy	0	0		0		7.00
8.00	Occupational Therapy	0	0		0		8.00
9.00	Speech/ Language Pathol ogy	0	0		0		9.00
10.00	Medical Social Services	0	0		0		10.00
11.00	Spiritual Counseling	0	0		0		11.00
12.00	Dietary Counseling	0	0		0		12.00
13.00	Counseling - Other	0	0		0		13.00
14.00	Home Health Aide and Homemaker	0	0		0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0		15.00
16.00	Other	0	0		0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0		17.00
18.00	Anal gesi cs	0	0		0		18.00
19.00	Sedatives / Hypnotics	0	0		0		19.00
20.00	Other - Specify	0	0		0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0		21.00
22.00	Patient Transportation	0	0		0		22.00
23.00	Imaging Services	0	0		0		23.00
24.00	Labs and Diagnostics	0	0		0		24.00
25.00	Medical Supplies	0	0		0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0		26.00
27.00	Radiation Therapy	0	0		0		27.00
28.00	Chemotherapy	0	0		0		28.00
29.00	Other	0	0		0		29.00
30.00	Bereavement Program Costs	0	0		0		30.00
31.00	Volunteer Program Costs	0	0		0		31.00
32.00	Fundrai si ng	0	0		0		32.00
33.00	Other Program Costs	0	0		0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	543		0		34.00
35.00	Total cost to be allocated	0	31, 921		0		35.00
	Unit Cost Multiplier (see instructions)	0. 000000	58. 786372	0.0000	00		36.00

Heal th	Fi nanci a	I Syst	tems	
COMPLIT	ATLON OF	ΤΟΤΛΙ	HOSPI CE	SHVIS

COMPUT	ATI ON OF TOTAL HOSPI CE SHARED COSTS			Period: From 01/01/2014		
		Hospi ce U	CN: 151524	Го 12/31/2014	Date/Time Prep 3/27/2015 9:5	
				Hospi ce I		
	Cost Center Description	Wkst. C, Part	Cost to Charge	e Total Hospice		
		I, col. 11	Rati o	Charges	Ancillary	
		line			Costs (cols. 1	
				Records)	x 2)	
		0	1.00	2.00	3.00	
	ANCI LLARY SERVI CE COST CENTERS			. 1		
1.00	PHYSI CAL THERAPY	66.00		в О	0	
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00			0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			0	5.00
6.00	LABORATORY	60.00	0. 16824	7 0	0	6.00
6.01	BLOOD LABORATORY	60. 01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			0	
8.00	PATIENT CARE CENTER - OCC	93.00		6 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00			0	
10. 01	NEURODI AGNOSTI C	76.01			0	
10. 97	CARDI AC REHABI LI TATI ON	76.97	0.44706	1 0	0	
11.00	Totals (sum of lines 1-10)	1		1	0	11.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2						2552-10
CALCULATION OF HOSPICE PER DIEM COST		Provi der	CCN: 150048	Peri od:	Worksheet K-6	
		Hospi ce (	CCN: 151524	From 01/01/2014 To 12/31/2014		
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00 Tota	l cost (see instructions)				2, 261, 979	1.00
2.00 Tota	I Unduplicated Days (Worksheet S-9, column 6, line 5)				8, 260	2.00
3.00 Aver	age cost per diem (line 1 divided by line 2)				273.85	3.00
4.00 Updu 5)	plicated Medicare Days (Worksheet S-9, column 1, line	8, 260				4.00
5.00 Aggr	egate Medicare cost (line 3 time line 4)	2, 262, 001				5.00
6.00 Undu	plicated Medicaid Days (Worksheet S-9, column 2, line			0		6.00
7.00 Aggr	egate Medicaid cost (line 3 time line 60)			0		7.00
8.00 Updu	plicated SNF Days (Worksheet S-9, column 3, line 5)	7, 275				8.00
9.00 Aggr	egate SNF cost (line 3 time line 8)	1, 992, 259				9.00
10.00 Undu	plicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggr	egate NF cost (line 3 times line 10)			0		11.00
12.00 Othe	r Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00 Aggr	egate cost for other days (line 3 times line 12)			0		13.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 CALCULATION OF CAPITAL PAYMENT Provider CCN: 150048 Peri od: Worksheet L From 01/01/2014 Parts I-II Date/Time Prepared: 3/27/2015 9:51 am То 12/31/2014 Title XVIII Hospi tal PPS 1.00 PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 3, 391, 946 1.00 Model 4 BPCI Capital DRG other than outlier 1.01 Ο 1 01 Capital DRG outlier payments 2.00 314,850 2.00 Model 4 BPCI Capital DRG outlier payments 2.01 0 2.01 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 100.13 3.00 4.00 Number of interns & residents (see instructions) 0.00 4.00 5.00 Indirect medical education percentage (see instructions) 0.00 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01) 6.00 0 6.00 7 00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 0.00 7 00 30) (see instructions) 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 Allowable disproportionate share percentage (see instructions) 10.00 10.00 0.00 11.00 Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01) 0 11.00 12.00 Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11) 3, 706, 796 12.00 1.00 PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) 1.00 0 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 Total inpatient program capital cost (line 1 plus line 2) 3.00 0 3.00 Capital cost payment factor (see instructions) 4.00 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 Program inpatient capital costs (see instructions) 1.00 1.00 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 0 2.00 Net program inpatient capital costs (line 1 minus line 2) 3.00 0 3.00 4.00 Applicable exception percentage (see instructions) 0.00 4.00 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 5.00 6 00 Percentage adjustment for extraordinary circumstances (see instructions) 0.00 6 00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 7.00 0 7.00 8.00 Capital minimum payment level (line 5 plus line 7) 0 8.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 0 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 10.00 10.00 0 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 0 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 13.00 0 Carryover of accumulated capital minimum payment level over capital payment for the following period 14.00 0 14.00 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00

0

0 17.00

16.00

Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

16.00