Provider 1. [x] [lectronically filed cost report Date: 5/25/2017 Time: 3:16 pm 3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report 4. [r] Medicare Utilization. Enter "" for fullo "L" for low. Contractor S. [1] Cost Report Status 6. Date Received: 10. NPR Date: 10. NPR Date: (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 10. NPR Date: 10. NPR Date: (3) Settled without Audit 9. [N] Final Report for this Provider CCN 10. NPR Date: 10. NPR Date: (4) Reponend (5) Amended 10. NPR Date: 10. NPR Date: PART II - CERTIFICATION (6) REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES ADM/CR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED ON PROCURED THROUGH THE PAYMENT DIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES ADM/CR IMPRISONMENT WARE REPORT and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REDI MOSTRATIA CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report were provide price by provision of health care services, and that the services (15 -0048) for the cost report were provide by EDI MOSTRATIA & HALTH CARE SERVICES (15-0048) for the	<u>Health Financial Systems</u> This report is required by law (42 USC 1395g; payments made since the beginning of the cost		ailure to repor	rt can result	in all interim	OMB NO. 0938	ED 8-0050
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MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR INFRISOMMENT INDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIE DIN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR INFRISOMMENT MAY RESULT. CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RED HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and recovide of in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of healt care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. Encryption Information SockPPAKE225/2017 Time: 3:16 pm SockPPAKE25/2017 Time: 3:16 pm SockPPAKE25/2017 Time: 3:16 pm </td <td>use only (1) As Submitted 7. (2) Settled without Audit 8. (3) Settled with Audit 9. (4) Reopened</td> <td>Contractor No. [N] Initial Report</td> <td>for this Provi or this Provide</td> <td>der CCN 12.[</td> <td>ntractor's Vend 0]If line 5, c</td> <td>olumn 1 is 4:</td> <td></td>	use only (1) As Submitted 7. (2) Settled without Audit 8. (3) Settled with Audit 9. (4) Reopened	Contractor No. [N] Initial Report	for this Provi or this Provide	der CCN 12.[ntractor's Vend 0]If line 5, c	olumn 1 is 4:	
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I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HALTH CARE SERVICES (15-0048.) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I an familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. Encryption Information ECR: Date: 5/25/2017 Time: 3:16 pm SNOCHYMMSZEYS101 JuupE&UTMAIIO XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 JuupE&UTMAIIO XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 JuupE&UTMAIIO XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 JuupE&UTMAIIO XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 XILISEOMEDIO NETTION XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 XILISEOMEDIO NETION XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS101 XILISEOMEDIO NETION XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS10 XILISEOMEDIO NETION XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS10 XILISEOMEDIO NETION XILISEOMEDIO PI: Date: 5/25/2017 Time: 3:16 pm SNOCHYMSZEYS10 XILISEOMEDIO NETI	MISREPRESENTATION OR FALSIFICATION OF ANY INFO ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMEN PROVIDED OR PROCURED THROUGH THE PAYMENT DIREC	IT UNDER FEDERAL LAW. TLY OR INDIRECTLY OF	FURTHERMORE,	IF SERVICES	IDENTIFIED IN T	HIS REPORT WER	RE
electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and "Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. Encryption Information ECR: Date: 5/25/2017 Time: 3:16 pm SXOCMYMSZZySIG1JuupsEBurNat10 Titles provider in the such laws and regulations and regulations regarding the provider pikoweccF3ccFCDXTUBZ and j0.79200KySAh MITTIZes@nb210 PT: Date: 5/25/2017 Time: 3:16 pm SXOCMYMSZZySIG1JUUPSEBUTNATIO Title pikoweccF3ccFCDXTUBZ and j0.79200KySAh MITTI - SETTLEMENT SUMMARY PART III - SETTLEMENT SUMMARY No Subprovider - IPF 0 138,402 77 0 0 1.00 Subprovider - IPF 0 138,402 77 0 0 2.00 Subprovider - IPF 0 138,402 77 0 0 2.00 Subprovider - IPF 0 138,402 77 0 0 2.00 Subprovider - IFF 0 383.992 301,020 639,960 0 0.00 Sub swing bed - SNF 0 78,743 -20 0 0 30.963 0 0.00 Subprovider - IFF 0 383.992 301,020 639,960 0 200.00 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. Cording to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it information collection. If you have any compets sentering the data needed, and complete and review the information to the PAR terview to Complex and review the information collection. If you have any comparison contenting the accuracy of the time estimate(5) or suggestions for improving the form, place write to: CMS, formation collection burden approved inder the associated OWS control	CERTIFICATION BY OFFICER OR A	DMINISTRATOR OF PROV	IDER(S)				
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00	Hospital-Based Health Clinic - RHC										15
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01	Did this hospital receive interim un				s cost r	reporting	Y			Y	22
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00	determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible unpai 4, Medicaid days in column 5, and other Medicaid days in column 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	<pre>? (see instructic e cost reporting no, for the porti ic reclassificati statistical area no for the portic 2, "Y" for yes or r after October 1 t more than 499 b "Y" for yes or "N dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state</pre>	ns) Enter period pri on of the on of the on of the of "N" for n 1. (see ins eds (as co v" for no. nes 24 and 3 if data g period di paid days 1.00 870	in col ior to cost r rban to by CMS cost re of for structiounted d/or 25 e of di ifferen r Medic eligi unpa da 2.0	e paymer umn 1, " October eporting rural a in FY20 porting the port ons) Doe in accor below? scharge. below? scharge. caid ble Me aid pa /s 00 325	Ats to be Y" for ye 1. Enter g period c as a resul 15? Enter period ion of th s this rdance wit In columr Is the the methoco Dut-of State edicaid id days 3.00 528	n N t N h h State I Medi cai d el i gi bl e unpai d 4. 00	Medica HMO da 5.00	id (ys Me 674	N Other dicaid days 6.00	22 23 23
00 00	determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in column 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	<pre>? (see instructic e cost reporting no, for the porti ic reclassificati statistical area no for the portic 2, "Y" for yes or after October 1 t more than 499 b "Y" for yes or "M dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,</pre>	ns) Enter period pri on of the on of the on of the of "N" for n 1. (see ins eds (as co v" for no. nes 24 and 3 if data g period di paid days 1.00 870	in col ior to cost r rban to by CMS cost re of for structiounted d/or 25 e of di ifferen r Medic eligi unpa da 2.0	e paymer umn 1, " October eporting rural a in FY20 porting the port ons) Doe in accor below? scharge. below? scharge. caid ble Me aid pa /s 00 325	Ats to be Y" for ye 1. Enter g period c as a resul 15? Enter period ion of th s this rdance wit In columr Is the the methoco Dut-of State edicaid id days 3.00 528	n N t N h h State I Medi cai d el i gi bl e unpai d 4. 00	Medica HMO da 5.00	id (ys Me 674	N Other dicaid days 6.00	22 23 23
00 00	determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per lin-state Medicaid paid days in colum Medicaid eligible unpaid days in colum 4, Medicaid HMO paid and eligible unpai 4, Medicaid days in column 5, and other Medicaid days in column 1 f this provider is an IRF, enter th Medicaid paid days in column 1, the	<pre>? (see instructic e cost reporting no, for the porti ic reclassificati statistical area no for the portic 2, "Y" for yes or after October 1 t more than 499 b "Y" for yes or "N dicaid days on li f census days, or is cost reporting iod? In column 2 , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state</pre>	ns) Enter period pri on of the on of the on of the of "N" for n 1. (see ins eds (as co v" for no. nes 24 and 3 if data g period di paid days 1.00 870	in col ior to cost r rban to by CMS cost re of for structiounted d/or 25 e of di ifferen r Medic eligi unpa da 2.0	e paymer umn 1, " October eporting rural a in FY20 porting the port ons) Doe in accor below? scharge. below? scharge. caid ble Me aid pa /s 00 325	Ats to be Y" for ye 1. Enter g period c as a resul 15? Enter period ion of th s this rdance wit In columr Is the the methoco Dut-of State edicaid id days 3.00 528	n N t N h h State I Medi cai d el i gi bl e unpai d 4. 00	Medica HMO da 5.00	i d og ys Me 674	N Other dicaid days 6.00	22. 22. 23. 02 24. 25.

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/2 o 12/31/2		Workshe Part I Date/Ti		
							5/25/20)17 3:1	
					Urban/Rura 1.00	IS	Date of 2.0		-
26.00	Enter your standard geographic classification (not wa	nge) sta	atus at the beg	inning of the	1.00	2	2.0		26.00
7. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassif	nge) sta "2" fo	atus at the end or rural. If ap			2			27.00
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		1			35.00
					Begi nni ng	g:	Endi		-
6.00	Enter applicable beginning and ending dates of SCH st	atus (Subscript Lipo	26 for number	1.00 01/01/201	16	2.0 12/31/		36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.			01/01/20	0	12/31/	2010	37.00
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.0
8. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.0
	enter subsequent dates.				Y/N		Y/	N	
					1.00		2.0		
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente uiremen or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)	N		N		39.00
0.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjus [.] ber 1. l	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40.00
					-	V 1.00	XVIII 2.00	XI X 3.00	-
5.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	e share in acc	cordance	N	N	N	45.00
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					Ν	N	N	46.00
7.00 8.00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.00 48.00
6.00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	For yes	Y			56.00
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th' (", comp	r "N" for no in his cost report plete Worksheet	column 1. If ing period? I	column 1 Enter "Y"	N			57.00
8.00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemen	nt for physicia	ns' services a	is	Ν			58.0
9.00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		Ν			59.0
0.00	Are you claiming nursing school and/or allied health					Y			60.0
	provider-operated criteria under §413.85? Enter "Y"	Y/N	IME	Direct GME	I ME		Di rect	GME	
1.00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	0. 00	5.0		61.0
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	0.00			0.00		0.00	
1.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.0					61. C
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. OC	0.0					61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0					61.0
1. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the surgery actions and a partial (see instructions)		0.00	0.0	þ				61.0
	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		O. OC	0.0					61. 0

OSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	ΛTΑ	Provider CC	N: 15-0048 Pe Fr Tc	eriod: com 01/01/2016 0 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/25/2017 3:1	pared
			Y/N	IME	Direct GME	I ME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
I. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61.(
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	1
1. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
I. 20	3	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61.
	· · · · · · · · · · · · · · · · · · ·						1.00	
0.00	ACA Provisions Affecting the Hea Enter the number of FTE resident					od for which	0.00	62.
2.00	your hospital received HRSA PCRE	funding (see instruc	ctions)					
2. 01	during in this cost reporting pe	riod of HRSA THC prog	gram. (s	ee instruction		your nospi tai	0.00	62.
3. 00	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
					Unwei ghted FTEs		Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te 1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J		•	0	his base year	is your cost r	eporting	
1. 00	· · ·	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty train n-primar all non d non-pr n column	ed residents y care provider imary care 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
- 65		1.00		2.00	3.00	4.00	5.00	1-
5. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column				0.00	0.00	0. 000000	

Heal th	Financial Systems	RELD HOSPITAL	L & HEALTH CARE	SERVI C	ES	In L	ieu o	f Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Prov	ider CC		eriod: rom 01/01/20 o 12/31/20	16 Pa 16 Da	art I ate/Tir	et S-2 me Prep 17 3:15	oared:
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	l Rat		ol. 1/ + col.	<u>5 pm</u>
				-	1.00	2.00		3.00	0	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider S	Setti ngs	sEffective fo	or cost repor	rti ng	peri o	ds	
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider setting ry care residen 3 the ratio of	IS.	0.00	0.	00	0. (000000	66.00
		Program Name	Program Co	ode	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital		tio (co pl. 3 4))	+ col.	
		1.00	2.00		Si te 3. 00	4.00		5.00	0	
	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. OC		00			67.00
			1	1						
	Inpatient Psychiatric Facility F	PPS				1.	. 00	2.00	3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does i	t conta	in an IPF subp	provi der?	Y			70. 00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" lity train res (D)? Enter "Y"	for ye idents for ye	s or "N" for r in a new teach s or "N" for r	no. (see ni ng no.	N		0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	/ (IRF), or doe	es it co	ntain an IRF		Y			75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 2004? new teaching p for no. Column	PEnter program 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	N	N	0	76.00
							-	1.00	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospita	(TCU)2 Enton "\/"	for yos and "N	" for "	0			N		80.00
	Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? Ente	r	N		80.00
86.00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit)).	N		85. 00 86. 00
87.00	Is this hospital a "subclause (I			886(d)(1)(B)(iv)(II)?	PEnter "Y"		Ν		87.00
	for yes or "N" for no.					V 1.00		XI X 2.00		
90.00	Title V and XIX Services Does this facility have title V		hospital servi	ces? En	ter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th			either in	N		Y		91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual cert	i fi cati	on)? (see			N		92.00
	instructions) Enter "Y" for yes Does this facility operate an IC	F/IID facility for pu			XIX? Enter	N		N		93.00
94.00	"Y" for yes or "N ["] for no in the Does title V or XIX reduce capit applicable column.	applicable column.				N		N		94.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES II HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0048 Period: From 01/01/ To 12/31/	/2016 /2016	Workshee Part I Date/Tim	CMS-2552-10 t S-2 e Prepared: 7 3:15 pm
V 1.00		XI X	
1.00 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N applicable column. N		2.00 0.00 N	
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00)	0.00	97.00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)? N 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment N			105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R N training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. N			108.00
Physical Occupational Speed		Respi ra	
1.00 2.00 3.00 109.00 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)	4. OC N	109.00
	-	1.00)
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)fo the current cost reporting period? Enter "Y" for yes or "N" for no.	r	N	110.00
	1.00	2.00	3.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1	N	1 1	0 115.00
is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.			0 115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. 117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for	Y N		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is	1		118.00
claim-made. Enter 2 if the policy is occurrence. Premiums Losse	IS	Insurar	nce
1.00 2.00	<u> </u>	3.00)
118.01 List amounts of malpractice premiums and paid losses: 0	0	0.00	0 118. 01
1.00)	2.00)
118.02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N			118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		Ν	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices charged to Y patients? Enter "Y" for yes or "N" for no.			121.00
122.00 Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" Y for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		5.06	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If			125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the certification date			126.00
in column 1 and termination date, if applicable, in column 2. 127.00 f this is a Medicare certified heart transplant center, enter the certification date			127.00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter the certification date			127.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification date in			120.00
column 1 and termination date, if applicable, in column 2.			
130.00 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

Health Financial Systems	REID HOSPITAL & HEAL	TH CARE SERVIC	CES		١n	Li eu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-004				Worksheet S-2	
				Fron To	n 01/01/2 12/31/2		Part I Date/Time Pre	arod
				10	12/31/2		5/25/2017 3:1	
				_	1.00		2.00	
133.00 If this is a Medicare certified ot	her transplant center, ent	er the certifi	cation da	ate	1.00		2.00	133.00
in column 1 and termination date,								
134.00 If this is an organ procurement or		e OPO number i	n column	1				134.00
and termination date, if applicabl All Providers	e, in column 2.							
140.00 Are there any related organization	or home office costs as d	lefined in CMS	Pub. 15-1	1,	Y			140.00
chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office co					
are claimed, enter in column 2 the			i ons)					
1.00 If this facility is part of a chai	2.00		ugh 142 t	ho namo	3.00		f tho	
home office and enter the home off					anu auur	635 0	i the	
141.00Name:	Contractor's Name:			actor's	Number:			141.00
142.00 Street:	PO Box:							142.00
143.00 Ci ty:	State:		Zip (Code:				143.00
						-	1.00	
144.00 Are provider based physicians' cos	ts included in Worksheet A	?				-	Y	144.00
							· · ·	
					1.00		2.00	
145.00 If costs for renal services are cl					Y			145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc								
period? Enter "Y" for yes or "N"		TOT THIS COST	τεροιτιή	9				
146.00 Has the cost allocation methodolog		sly filed cost	report?		Ν			146.00
Enter "Y" for yes or "N" for no in	column 1. (See CMS Pub. 1	5-2, chapter 4	i0, §4020)) If				
yes, enter the approval date (mm/d	d/yyyy) in column 2.							
						-	1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for v	es or "N" for	no			-	N	147.00
148.00 Was there a change in the order of							N	148.00
149.00 Was there a change to the simplifi		2		for no.			Ν	149.00
	_	Part A	Part		Title V	/	Title XIX	
		1.00	2.00		3.00		4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "								
155. 00 Hospi tal	N TOT HO TOT Each compone	N	N	D. (366	N N	3413.	N	155.00
156.00 Subprovi der – IPF		N	N		N		N	156.00
157.00 Subprovider - IRF		Ν	N		Ν		Ν	157.00
158. 00 SUBPROVI DER								158.00
159.00 SNF 160.00 HOME HEALTH AGENCY		N	N		N		N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC		Ν	N N		N N		N N	160. 00 161. 00
					IN		in .	101.00
							1.00	
Multicampus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has one	e or more campu	uses in di	fferent	CBSAs?		Ν	165. 00
	Name	County	State	Zip Co	de CBS	SA	FTE/Campus	
	0	1.00	2.00	3.00			5.00	
166.00 If line 165 is yes, for each							0.00	166.00
campus enter the name in column								
0, county in column 1, state in								
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
	· · · · · · · · · · · · · · · · · · ·						1.00	
Health Information Technology (HIT 167.00 Is this provider a meaningful user					ct		Y	167.00
168.00 If this provider is a CAH (line 10					ter the			167.00
reasonable cost incurred for the H			, 13	. <i>)</i> , cn			C	
168.01 If this provider is a CAH and is n	ot a meaningful user, does	this provider			ardshi p			168. 01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N"	for no. (see i	nstructio	ons)				1/0 00
169.00 If this provider is a meaningful u transition factor. (see instructio		is not a CAH (iine 105	ıs "N")	, enter 1	ine	0.25	169.00
	1.57					1		l.

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	Period:	Worksheet S-2 Part I	2				
		From 01/01/2 To 12/31/2					
				5/25/2017 3:1	<u>5 pm</u>		
			Begi nni ng	Endi ng			
			1.00	2.00			
170.00 Enter in columns 1 and 2 the EHR begin period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00				
			1.00	2.00			
171.00 If line 167 is "Y", does this provide	r have any days for indiv	iduals enrolled in	N	(171.00		
section 1876 Medicare cost plans repo	rted on Wkst. S-3, Pt. I,	line 2, col. 6? Enter					
"Y" for yes and "N" for no in column	1. If column 1 is yes, en	iter the number of sectio	n				
1876 Medicare days in column 2. (see	instructions)						

)SPI T <i>i</i>	Financial Systems REID HOSPITAL & HEA	Provider C	CN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet S- Part II Date/Time Pr 5/25/2017 3:	epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	I for all NO re	sponses. Ente	er all dates in t	he	_
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1. (
	reporting period: IT yes, enter the date of the change in t	Joi unin 2. (366	Y/N	Date	V/I	
			1.00	2.00	3.00	1
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.	Program? If nn 3, "V" for	N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit red	conciliation.				
				Y/N	Legal Oper.	
	Approved Educational Activitica			1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.
	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	Y Y		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	0	al education	Y		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	Y		10.
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	ions		Y	12.
. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	oolicy change d	luring this co		N	13.
	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	structions.	N	14.
	Bed Complement Did total beds available change from the prior cost reporti	1 × 1	<u>yes, see inst</u> t A	ructions. Par	N + P	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/18/2017	Y	04/18/2017	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		Ν		19.

Health Financial Systems

REID HOSPITAL	&	HEALTH	CARE	SERVI CES	

In Lieu of Form CMS-2552-10

HOSPI T	HOSPI TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE		CN: 15-0048	Period: From 01/01/2016 To 12/31/2016		repared:
			iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)			
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	a instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense		sals made dur	ing the cost	N	23.00
24 00	reporting period? If yes, see instructions.	ad into during	this seat ra	norting poriod?	N	24.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	0			N	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repor	rting period?	lf yes, see	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	the cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th	ne cost reportir	ng period? If	yes, submit	Ν	27.00
	copy. Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ring the cost	reporting	N	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service R	eserve Fund)	Y	29.00
30.00	Has existing debt been replaced prior to its scheduled mat instructions.	, see	Y	30.00		
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	, see	Ν	31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through co	ntractual	Y	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	Y	33.00
	Provi der-Based Physi ci ans				1	
34.00	Are services furnished at the provider facility under an a	arrangement with	n provi der-ba	sed physi ci ans?	N	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	visting agroomor	ats with the	providor based	N	35.00
35.00	physicians during the cost reporting period? If yes, see i					35.00
				Y/N 1.00	Date 2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00
39 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth	nd of the home o	offi ce.			39.00
	see instructions.		5	,		
40.00	If line 36 is yes, did the provider render services to the instructions.	e 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/position held by the cost report preparer in columns 1, 2, and 3,	BKD, LLP		BKD, LLP		41.00
	respectivel y.					
42.00	Enter the employer/company name of the cost report	BKD, LLP				42.00
43.00	preparer. Enter the telephone number and email address of the cost	5025810435		LVCOSTREPORTS@	BKD. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems	REID HOSPITAL & HEA	ALTH CARE SERVICES	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEM	ENT QUESTI ONNAI RE	Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet S-2 Part II	
			To 12/31/2016		
		3.00			
Cost Report Preparer Contact Informati	on				
41.00 Enter the first name, last name and th	e title/position	BKD, LLP			41.00
held by the cost report preparer in co	lumns 1, 2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the	e cost report				42.00
preparer.					
43.00 Enter the telephone number and email a	ddress of the cost				43.00
report preparer in columns 1 and 2, re	especti vel y.				

	Financial Systems REID AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	HOSPITAL & HEA AL DATA	Provider CC	CN: 15-0048	Peri od:	Worksheet S-3	3
					From 01/01/2016 To 12/31/2016		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	135	49, 41	0 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
2.00	HMO IPF Subprovider						3.00
4.00	HMO I RF Subprovi der						4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	
5.00 5.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		135	49, 41	0 0.00		
/.00	beds) (see instructions)		155	47,4	0.00		1 7.00
8.00	INTENSI VE CARE UNI T	31.00	30	10, 98	0.00	0	8.00
9.00	CORONARY CARE UNIT	01.00	00	10, 70	0.00		9.00
10.00	BURN I NTENSI VE CARE UNI T						10.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	
14.00	Total (see instructions)	10.00	165	60, 39	0.00		
15.00	CAH visits		100	00, 01	0.00	0	
16.00	SUBPROVIDER - IPF	40.00	38	13, 90	8	0	
17.00	SUBPROVIDER - IRF	41.00	20	7, 32		0	
18.00	SUBPROVIDER			.,			18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE	116.00	0		0		24.0
24.10	HOSPICE (non-distinct part)	30.00					24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
27.00	Total (sum of lines 14-26)		223				27.0
28.00	Observation Bed Days					0	28.0
29.00	Ambulance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
13 00	LTCH non-covered days					1	33.0

ISPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/25/2017 3:1	epare
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18, 255	713	29, 81			1
00	HMO and other (see instructions)	3, 042	6, 671				2
00	HMO IPF Subprovider	689	0				3
00	HMO IRF Subprovider	190	267				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
00	Hospital Adults & Peds. Swing Bed NF		0		0		6
00	Total Adults and Peds. (exclude observation beds) (see instructions)	18, 255	713	29, 81			
0	INTENSIVE CARE UNIT	2, 007	114	4,70	19		8
0	CORONARY CARE UNI T						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGICAL INTENSIVE CARE UNIT						11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY		49	2, 02			1
00	Total (see instructions)	20, 262	876	36, 55	4 4.39	2, 293. 77	1
00	CAH visits	0	0		0		1!
00	SUBPROVIDER - IPF	7, 681	0	10, 56	0.00	64.57	10
00	SUBPROVI DER – I RF	2, 326	0	3, 51	7 0.00	20.64	17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY						10
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						2
00	HOME HEALTH AGENCY						22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPICE	14, 518	683	16, 35	0.00	19.24	24
10	HOSPICE (non-distinct part)	0	0		0		24
00	CMHC – CMHC						25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26
00	Total (sum of lines 14-26)				4.39	2, 398. 22	2
00	Observation Bed Days		149	2, 83	4		28
00	Ambul ance Tri ps	0					29
00	Employee discount days (see instruction)			61			30
00	Employee discount days - IRF			2	9		3
00	Labor & delivery days (see instructions)	0	102	14	9		32
01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						1
00	LTCH non-covered days	0				1	3

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/25/2017 3:1	pared
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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)		0			10, 232	1. (
00 00	HMO and other (see instructions) HMO IPF Subprovider			71	16 0 0		2. 3.
00 00 00 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation				0		4. 5. 6. 7.
00	beds) (see instructions) INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						9. 10. 11.
. 00 . 00 . 00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0. 00	0	5, 39	94 303	10, 232	12 13 14
. 00 . 00	CAH visits SUBPROVIDER - IPF	0.00	0		37 0	784	15
. 00 . 00 . 00 . 00 . 00 . 00 . 00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0. 00	0	18	30 0	255	17 18 19 20 21 22 23
00 10 00 00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					24 24 25 26
. 25 . 00 . 00 . 00 . 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0. 00 0. 00					26. 27. 28. 29. 30.
. 00 . 00 . 00 . 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						31 32 32

Health Financial Systems

REI D	HOSPI TA	L &	HEALTH	CARE	SERVI CES	

In Lieu of Form CMS-2552-10

	AL WAGE INDEX INFORMATION			Provider CC	F	veriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/25/2017 3:1	pare 5 pr
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	-
	PART II – WAGE DATA SALARIES							1
0	Total salaries (see	200.00	154, 415, 758	3 0	154, 415, 758	4, 997, 413. 98	30. 90	1
0	instructions) Non-physician anesthetist Part		(0	C	0.00	0.00	
0	A Non-physician anesthetist Part		(0	C	0.00	0.00	
0	Physician-Part A - Administrative		(0	C	0.00	0.00	
1	Physicians - Part A - Teaching Physician and Non		(C	0.00		
0	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		(0 0	C	0.00	0.00	0
0	services Interns & residents (in an approved program)	21.00	(314, 039	314, 039	11, 185. 50	28.08	-
1	Contracted interns and residents (in an approved programs)		(0 0	C	0.00	0. 00	
o	Home office and/or related organization personnel		(0 0	C	0.00		
	SNF Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS	44.00	(74, 815, 040	0 0 0 78, 412	C 74, 893, 452	0. 00 1, 742, 718. 90		
	Contract Labor: Direct Patient		5, 725, 16	1 0	5, 725, 161	126, 303. 56	45.33	1
00	Care Contract Labor: Top Level			0	C			
	management and other management and administrative services							
00	Contract Labor: Physician-Part A - Administrative		(0 0	C	0.00	0.00	1:
00	Home office and/or related orgainzation salaries and wage-related costs		(0 0	C	0.00	0.00	1
01	Home office salaries		(0 0	C	0.00	0.00	1
02	Related organization salaries		(0 0	C	01.00		
	Home office: Physician Part A - Administrative		(0	C			
	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS			0 0	C	0.00	0.00	
	Wage-related costs (core) (see		21, 604, 04	7 0	21, 604, 047			1
00	instructions) Wage-related costs (other) (see instructions)		(o o	C			1
00	Excluded areas Non-physician anesthetist Part		13, 602, 400 (5 O 0 O	13, 602, 406 C			1
00	A Non-physician anesthetist Part		(0	C			2
00	B Physician Part A - Administrative		(o o	C			2
	Physician Part A - Teaching Physician Part B		(C			2
00	Wage-related costs (RHC/FQHC) Interns & residents (in an		(79, 878		C 79, 878	5		24
50 51	approved program) Home office wage-related Related orgainzation		(C			2! 2!
	wage-related Home office: Physician Part A		(c			2
53	- Administrative - wage-related Home office & Contract		,		C			2!
	Physicians Part A - Teaching - wage-related							
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>S</u> 4.00	1, 947, 24	4 0	1, 947, 244	59, 661. 22	32.64	1
	Administrative & General	4.00 5.00	15, 780, 519					

Heal th	Financial Systems	REI D	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016		
						Го 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		4, 415, 489	0	4, 415, 489	61, 192. 97	72.16	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	2, 159, 339	0	2, 159, 339	9 101, 814. 00	21. 21	30.00
31.00	Laundry & Linen Service	8.00	395, 593	-78, 412	317, 18 ⁻	1 23, 466. 78	13. 52	31.00
32.00	Housekeepi ng	9.00	1, 474, 789	0	1, 474, 789	9 108, 168. 32	13.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10. 00	2, 447, 398	-1, 992, 897	454, 501	1 30, 968. 88	14.68	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	1, 992, 897	1, 992, 89	7 135, 799. 44	14.68	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	159, 275	243, 381	402, 650	6, 808. 42	59.14	38.00
39.00	Central Services and Supply	14.00	588, 438	0	588, 438	40, 998. 42	14.35	39.00
40.00	Pharmacy	15.00	3, 808, 036	0	3, 808, 030	5 121, 713. 85	31. 29	40.00
41.00	Medical Records & Medical	16.00	2, 107, 005	0	2, 107, 00	5 125, 539. 61	16. 78	41.00
42.00	Records Library Social Service	17.00	2 0 4 7 2 4 7		2 047 24	2 22 072 04	00.70	42.00
42.00		17.00	3, 047, 347	0	3, 047, 34			
43.00	Other General Service	18.00	0	I U	l (0.00	0.00	43.00

Heal th	Financial Systems	REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPI 1	TAL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2016	Worksheet S-3 Part III	
						o 12/31/2016		
		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)	,	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		i		1	•	
1.00	Net salaries (see		158, 831, 247	-314, 039	158, 517, 208	3 5,047,421.45	31. 41	1.00
	instructions)							
2.00	Excluded area salaries (see		74, 815, 040	78, 412	74, 893, 452	2 1, 742, 718. 90	42. 98	2.00
2 00	instructions)		04 01/ 007	202 451		2 204 702 55	05.00	2 00
3.00	Subtotal salaries (line 1 minus line 2)		84, 016, 207	-392, 451	83, 623, 756	3, 304, 702. 55	25.30	3.00
4.00	Subtotal other wages & related		5, 725, 161	0	5, 725, 161	126, 303. 56	45.33	4.00
4.00	costs (see inst.)		5,725,101	0	5,725,10	120, 303. 30	45.55	4.00
5.00	Subtotal wage-related costs		21, 604, 047	0	21, 604, 047	0.00	25.83	5.00
	(see inst.)		,	-	,			
6.00	Total (sum of lines 3 thru 5)		111, 345, 415	-392, 451	110, 952, 964	3, 431, 006. 11	32.34	6.00
7.00	Total overhead cost (see		38, 330, 472	-78, 412	38, 252, 060	1, 413, 069. 25	27.07	7.00
	instructions)							
		-		-	-		-	

)SPI T	AL WAGE RELATED COSTS	Provider CCN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Pre 5/25/2017 3:1	pare
				Amount Reported	
	Γ			1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				-
	RETIREMENT COST				
00	401K Employer Contributions			0	1 .
00	Tax Sheltered Annuity (TSA) Employer Contribution			6, 572, 730	
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)				
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				
00	Health Insurance (Purchased or Self Funded)			0	-
01	Health Insurance (Self Funded without a Third Party Administra			0	
02	Health Insurance (Self Funded with a Third Party Administrato	r)		15, 838, 505	
03	Health Insurance (Purchased)			0	-
00	Prescription Drug Plan			730, 386	
00	Dental, Hearing and Vision Plan			764, 394	
00	Life Insurance (If employee is owner or beneficiary)			158, 400	
. 00	Accident Insurance (If employee is owner or beneficiary)			0	
00	Disability Insurance (If employee is owner or beneficiary)			327, 849	13
. 00	Long-Term Care Insurance (If employee is owner or beneficiary))		0	
. 00	'Workers' Compensation Insurance			837, 687	15
. 00	Retirement Health Care Cost (Only current year, not the extra	ordinary accrual require	ed by FASB 106.	0	16
	Non cumulative portion)				
	TAXES				
. 00	FICA-Employers Portion Only			9, 473, 070	
. 00	Medicare Taxes - Employers Portion Only			0	
. 00	Unemployment Insurance			60, 111	
00	State or Federal Unemployment Taxes OTHER			0	20
. 00	Executive Deferred Compensation (Other Than Retirement Cost Re	eported on lines 1 throu	ugh 4 above. (see	0	21
	instructions))				
. 00	Day Care Cost and Allowances			0	22
. 00	Tuition Reimbursement			523, 199	
. 00	Total Wage Related cost (Sum of lines 1 -23)			35, 286, 331	24
	Part B - Other than Core Related Cost				

		HOSPITAL & HEALTH CARE SERVICES		u of Form CMS-2	
HOSPII	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet S-3 Part V	
			To 12/31/2016		nared
			10 12/31/2010	5/25/2017 3:1	
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identif	ïcation:			
1.00	Total facility's contract labor and benefit o	cost	5, 725, 161	35, 286, 331	1.00
2.00	Hospi tal		5, 725, 161	34, 658, 783	2.00
3.00	Subprovider - IPF		0	367, 285	3.00
4.00	Subprovider - IRF		0	134, 266	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospital-Based Hospice		0	125, 997	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

Heal th	Financial Systems	RELD	HOSPITAL & HEA	LIH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED HOSPICE IDENTIFICATION	DATA		Provider C	CN: 15-0048	Peri od:	Worksheet S-9	
						From 01/01/2016		
				Hospi ce CC	N: 15-1524	To 12/31/2016		
							5/25/2017 3:1	5 pm
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility			-,	
		1.00	2,00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
3.00 4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days				1 0015		<u> </u>	5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6.00
	hospice care							
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8.00
	/line 6)						1	
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include t	the days report	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
						other	col s. 1	
							through 3)	
				1.00	2.00	3,00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST PEDORTING					4.00	
10.00	Hospice Continuous Home Care	COST KLFOKTING	FLKIODS DEGIN		LK OCTOBER 1,	0 54	55	10.00
	Hospice Continuous Home Care			13, 803	6			
11.00						12 979		
12.00	Hospice Inpatient Respite Care			74		0 3		12.00
13.00	Hospice General Inpatient Care			640		11 120		
14.00	Total Hospice Days			14, 518		33 1, 156		14.00
	PART IV - CONTRACTED STATISTIC		ST REPORTING PE	RIODS BEGINNIN	G ON OR AFTER			
15.00	Hospice Inpatient Respite Care			0		0 0	0	
16.00	Hospice General Inpatient Care			0		0 0	0	16.00

Heal th	Financial Systems REID HOSPITAL & HEAL	TH CARE SERVICES	In Lie	eu of Form CMS-2	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0048	Peri od:	Worksheet S-1	0
			From 01/01/2016 To 12/31/2016		narad.
			10 12/31/2010	Date/Time Pre 5/25/2017 3:1	
			•		
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	divided by line 202 colum	n 8)	0. 292451	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			12, 898, 869	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplement		d?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments f	rom Medicaid		0	5.00
6.00	Medicaid charges			51, 478, 575	6.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	m (lipo 7 minus sum of li	noc 2 and E. if	15, 054, 961 2, 156, 092	7.00 8.00
0.00	<pre>cero then enter zero)</pre>		nes z anu o, m	2, 150, 092	0.00
	Children's Health Insurance Program (CHIP) (see instructions	for each line)			
9.00	Net revenue from stand-al one CHIP			0	9.00
10.00	Stand-al one CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHII	P (line 11 minus line 9;	if < zero then	0	12.00
	enter zero)				
	Other state or local government indigent care program (see in				
	Net revenue from state or local indigent care program (Not in			0	13.00
14.00	Charges for patients covered under state or local indigent ca	are program (Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line	14)		0	15.00
	Difference between net revenue and costs for state or local		ne 15 minus line	0	16.00
10.00	13; if < zero then enter zero)			, i i i i i i i i i i i i i i i i i i i	10.00
	Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to	funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of	f hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and lo	cal indigent care program	s (sum of lines	2, 156, 092	19.00
	8, 12 and 16)	Uni nsured	Incurred	Total (col. 1	
		patients	Insured patients	+ col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instruction				20.00
21.00	Cost of patients approved for charity care (line 1 times line				
22.00	Partial payment by patients approved for charity care		0 0		22.00
23.00	Cost of charity care (line 21 minus line 22)	1, 397, 9	1, 564, 431	2, 962, 353	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patie		of stay limit	N	24.00
25 00	imposed on patients covered by Medicaid or other indigent ca				25 00
25.00 26.00	If line 24 is "yes," charges for patient days beyond an indi Total bad debt expense for the entire hospital complex (see		in or stay limit	0	25.00 26.00
26.00 27.00	Medicare bad debts for the entire hospital complex (see inst			21, 126, 503 1, 664, 531	26.00
27.00	Non-Medicare and non-reimbursable Medicare bad debt expense			19, 461, 972	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense		e 28)	5, 691, 673	
27.00	lesse of their mode out of and their termbul subject mode out of bad debt			1 3, 571, 575	200

30.00Cost of uncompensated care (line 23 column 3 plus line 29)31.00Total unreimbursed and uncompensated care cost (line 19 plus line 30)

8, 654, 026 30. 00 10, 810, 118 31. 00

02/100	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		Period: From 01/01/2016	Worksheet A	
					To 12/31/2016		
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	r					÷
	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE		0		0 6, 910, 668		
	00200 NEW CAP BLDG & FIXT - OFFSITE		0		0 19, 034, 154 0 0	19,034,154	
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 947, 244	21, 784, 459				
01	00540 NONPATI ENT TELEPHONES	243, 262	20, 473	263, 73	5 0	263, 735	
	00550 DATA PROCESSI NG	3, 904, 861	17, 480, 568				
	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	882, 963 1, 846, 331	685, 376 1, 224, 795			1, 739, 870 3, 060, 256	
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 098, 759	4, 000, 144				
	00590 OTHER A&G	6, 804, 343	12, 660, 708				
	00700 OPERATION OF PLANT	2, 159, 339	2, 897, 509				
	00800 LAUNDRY & LINEN SERVICE	395, 593	469, 471	865,06		680, 969	
	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 474, 789 2, 447, 398	562, 878 3, 045, 145			2, 037, 667 1, 019, 984	
	01100 CAFETERIA	0	0,010,110		0 4, 472, 559		
	01300 NURSI NG ADMI NI STRATI ON	159, 275	117, 446			520, 102	
	01400 CENTRAL SERVICES & SUPPLY	588, 438	2, 929, 020			3, 517, 458	
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	3, 808, 036 2, 107, 005	28, 119, 167 1, 649, 841	31, 927, 20 3, 756, 84		31, 950, 046 3, 747, 961	
	01700 SOCIAL SERVICE	2, 148, 342	550, 302			2, 698, 644	
. 01	01701 I NSERVI CE EDUCATI ON	899, 005	1, 548, 218			2, 447, 223	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0 335, 815		
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	352, 371	544, 575				
	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	210, 364	36, 132	246, 49	6 0	246, 496	23
	03000 ADULTS & PEDIATRICS	15, 350, 822	5, 983, 051	21, 333, 87	3 -16, 779	21, 317, 094	30
	03100 INTENSIVE CARE UNIT	3, 052, 332	2, 277, 428				
	04000 SUBPROVIDER - IPF	3, 235, 157	421, 908			3, 657, 065	
	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 199, 857	331, 186 100, 219			1, 531, 043	
-	ANCI LLARY SERVICE COST CENTERS	375, 865	100, 219	476, 08	4 0	476, 084	43
	05000 OPERATI NG ROOM	1, 655, 346	42, 165, 132	43, 820, 47	8 -10, 337, 313	33, 483, 165	50
	05200 DELIVERY ROOM & LABOR ROOM	505, 975	228, 845			734, 820	
	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	5, 451, 506 1, 512, 286	6, 051, 472 9, 122, 204				
	06000 LABORATORY	3, 380, 403	9, 122, 204 7, 493, 473				
	06500 RESPIRATORY THERAPY	1, 354, 264	493, 001	1, 847, 26			
	06600 PHYSI CAL THERAPY	4, 773, 665	1, 131, 193				
	06900 ELECTROCARDI OLOGY	843, 272	651, 628			1, 494, 696	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	271, 168 0	92, 938 0		6 0 0 0		
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 15, 554, 267		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	07400 RENAL DI ALYSI S	0	656, 069	656, 06	9 0	656, 069	
	03950 ANCI LLARY – OTHER 07697 CARDI AC REHABI LI TATI ON	0 185, 409	0 90, 464	275, 87	0 0 3 -37,939	0 237, 934	
	DUTPATIENT SERVICE COST CENTERS	103, 407	70, 404	275,07	-57,757	237, 734	
	09100 EMERGENCY	4, 540, 138	2, 298, 655	6, 838, 79	3 0	6, 838, 793	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	04040 PATIENT CARE CENTER - OCC	1, 188, 146	345, 847	1, 533, 99	3 -148, 569	1, 385, 424	93
	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	892, 767	2, 049, 693	2, 942, 46	0 -69, 441	2, 873, 019	96
	SPECIAL PURPOSE COST CENTERS	072,707	2,047,073	2, 742, 40	0 07,441	2,073,017	1 ~
	11300 INTEREST EXPENSE		6, 015, 613				113
	11600 HOSPI CE	1, 052, 772	1,077,915			2, 130, 687	
3. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	85, 298, 868	189, 404, 161	274, 703, 02	9 26, 254, 118	300, 957, 147	1118
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	Ő	6, 988, 045		-		
	07950 RENTAL SPACE	0	15, 551, 369			1, 870, 502	
	07951 FOUNDATION	154, 627	162, 308			316, 745	
	07952 RETALL SERVICES 07953 RELD CONTRACTED SERVICES	104, 987 144, 879	13, 754 10, 391	118, 74 155, 27		118, 741 339, 365	
	07953 REID CONTRACTED SERVICES	67, 731, 467	46, 735, 783				
	07955 OTHER NRCC	0	0		0 0	0	194
	07956 VACANT SPACE	0	0		0 0	0	194
	07958 CAMBRIDGE RHC	980, 930	933, 287	1, 914, 21	7 -625, 164	1, 289, 053	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	From 01/01/2016	heet A
				To 12/31/2016 Date/	'Time Prepare '2017 3:15 pm
	Cost Center Description		Net Expenses		
		(See A-8) F 6.00	For Allocation 7.00		
7	GENERAL SERVICE COST CENTERS	0100			
	00100 NEW CAP REL COSTS-BLDG & FIXT	-6, 019, 034	891, 634		1.
	00101 NEW CAP BLDG & FIXT - OFFSITE	-2,964	19, 031, 190		1.
	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	10 500 700		2.
	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	-5, 466, 166 0	19, 529, 792 263, 735		4.
	00550 DATA PROCESSING	-1, 032, 831	203, 735		5
	00560 PURCHASING RECEIVING AND STORES	-479, 337	1, 260, 533		5
	00570 ADMI TTI NG	-20	3, 060, 236		5
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-87	6, 011, 887		5
	00590 OTHER A&G	-10, 423, 166	12, 226, 229		5
	00700 OPERATION OF PLANT	-14, 782	5,015,391		7
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	680, 969		8
	01000 DI ETARY	- 40 - 575, 597	2, 037, 627 444, 387		9
	01100 CAFETERI A	-2, 988, 329	1, 484, 230		11
	01300 NURSI NG ADMI NI STRATI ON	0	520, 102		13
00	01400 CENTRAL SERVICES & SUPPLY	0	3, 517, 458		14
	01500 PHARMACY	-127, 821	31, 822, 225		15
	01600 MEDICAL RECORDS & LIBRARY	-47,358	3, 700, 603		16
	01700 SOCIAL SERVICE	1 210 447	2, 698, 644		17
	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	-1, 319, 447 0	1, 127, 776 335, 815		17
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	-448, 626	112, 505		22
	02300 PARAMED ED PRGM	-39, 291	207, 205		23
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	-3, 230, 528	18, 086, 566		30
	03100 I NTENSI VE CARE UNI T	-490	5, 329, 270		31
	04000 SUBPROVIDER - IPF	-262	3, 656, 803		40
	04100 SUBPROVI DER – I RF 04300 NURSERY	-119, 417 0	1, 411, 626 476, 084		41
	ANCI LLARY SERVICE COST CENTERS	0	470,004		43
	05000 OPERATING ROOM	-10,008,459	23, 474, 706		50
	05200 DELIVERY ROOM & LABOR ROOM	0	734, 820		52
	05400 RADI OLOGY-DI AGNOSTI C	-101, 853	11, 266, 096		54
	05900 CARDI AC CATHETERI ZATI ON	-536	5, 400, 571		59
	06000 LABORATORY 06500 RESPI RATORY THERAPY	-863, 304	9, 971, 946 1, 846, 401		60 65
	06600 PHYSI CAL THERAPY	-546 -52, 199	5, 646, 680		66
	06900 ELECTROCARDI OLOGY	-60, 747	1, 433, 949		69
	07000 ELECTROENCEPHALOGRAPHY	-94	364, 012		70
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71
	07200 IMPL. DEV. CHARGED TO PATIENT	0	15, 554, 267		72
	07300 DRUGS CHARGED TO PATIENTS	0	0		73
	07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	0	656, 069		74
	07697 CARDI AC REHABI LI TATI ON	-2, 396	235, 538		76
	OUTPATIENT SERVICE COST CENTERS	2,070	200,000		
00	09100 EMERGENCY	-1, 266, 793	5, 572, 000		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
	04040 PATIENT CARE CENTER - OCC	0	1, 385, 424		93
	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	-877, 804	1, 995, 215		96
	SPECIAL PURPOSE COST CENTERS	-077,004	1, 775, 215		70
	11300 INTEREST EXPENSE	0	0		113
	11600 HOSPI CE	-441	2, 130, 246		116
3. 00		-45, 570, 765	255, 386, 382		118
	NONREI MBURSABLE COST CENTERS		0		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0 2, 924, 159		190 192
	07950 RENTAL SPACE	0	1, 870, 502		192
	07951 FOUNDATI ON	0	316, 745		194
	07952 RETAIL SERVICES	o	118, 741		194
	07953 REI D CONTRACTED SERVICES	o	339, 365		194
4. 04	07954 REID PHYSICIAN ASSOC.	0	106, 399, 144		194
1 05	07955 OTHER NRCC	0	0		194
	ATAL CRACE		0		194
4. 06	07956 VACANT SPACE 07958 CAMBRI DGE RHC	Ŭ	1, 289, 053		194

Health Financial Systems RECLASSIFICATIONS

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10 Worksheet A-6

SSI FI CATI ONS			Provider CCN:	15-0048	Period: From 01/01/2016	Worksheet A-6
					To 12/31/2016	Date/Time Prep 5/25/2017 3:15
	Increases				1	1 57 2 57 2 6 17 5. 15
Cost Center	Line #	Salary	Other			
2.00 A - ALLOCATION & SUPPORT RECL	3.00	4.00	5.00			
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	434, 246			
DATA PROCESSING	5.02	Ö	2, 437, 509			
PURCHASING RECEIVING AND	5.03	О	171, 531			
STORES	5.0/					
OTHER A&G	5.06	0	4, 164, 549			
PHARMACY			<u>31, 904</u> <u>7, 239, 739</u>			
B - CAPITAL EXPENSE RECLASS		<u> </u>	1,237,137			
NEW CAP REL COSTS-BLDG &	1.00	0	779, 422			
FLXT						
NEW CAP BLDG & FIXT -	1.01	0	16, 592, 992			
OFFSITE NEW CAP REL COSTS-BLDG &	1.00	0	33, 099			
FLXT	1.00	Ŭ	55, 077			
NEW CAP BLDG & FIXT -	1.01	o	315, 682			
OFFSI TE						
NEW CAP REL COSTS-BLDG &	1.00	0	82, 534			
FIXT NEW CAP BLDG & FIXT -	1.01	0	2, 125, 480			
OFFSITE	1.01	0	2, 125, 460			
	0.00	о	0			
	0.00	0	0			
	0.00	0	0			
	0.00	0	0			
	0.00 0.00	0	0			
	0.00	0	0			
	0.00	0	0			
	0.00	О	0			
	0.00	0	0			
	0.00	0	0			
	0.00 0.00	0	0			
	0.00	0	0			
	0.00	o	0			
	0.00	0	0			
	0.00	0	0			
	0.00	0	0			
		0	<u> </u>			
C - CAFETERIA RECLASS		9	17, 727, 207			
CAFETERI A	11.00	1, 992, 897	2, 479, 662			
0		1, 992, 897	2, 479, 662			
D - LAUNDRY RECLASS						
REID CONTRACTED SERVICES	1 <u>94.</u> 03	78, 412	10 <u>5, 683</u>			
O E - NURSING VP RECLASS		78, 412	105, 683			
NURSI NG ADMI NI STRATI ON	13.00	243, 381	0			
		243, 381	<u>0</u>			
H - IMPLANTABLE DEVICES RECLA	SS					
IMPL. DEV. CHARGED TO	72.00	0	15, 554, 267			
PATI ENT	0.00		0			
	0.00 0.00	0	0			
0		of	15, 554, 267			
J - INTEREST RECLASS						
NEW CAP REL COSTS-BLDG &	1.00	0	6, 015, 613			
<u>FIX</u> T	+					
O K – INTERN AND RESIDENT		0	6, 015, 613			
I&R SERVICES-SALARY &	21.00	314, 039	21, 776			
FRI NGES_APPRVD	21.00	517,057	21,770			
0		314, 039	21, 776			
L - WORKERS COMP						
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	837, 687			
	0.00	0_	0			
TOTALS	I		837, 687			

In Lieu of Form CMS-2552-10 Worksheet A-6

EULAS	STELCATIONS			Provider C	From 01/01/2016	eet A-6 ime Prepared
		Decreases				017 3:15 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - ALLOCATION & SUPPORT RECL					
. 00	REID PHYSICIAN ASSOC.	194.04	0	4, 965, 635	0	1.
. 00	REID PHYSICIAN ASSOC.	194.04	0	865, 111	0	2.
. 00	CAMBRI DGE RHC	194.08	0	619, 593	0	3.
. 00	REID PHYSICIAN ASSOC.	194.04	О	337, 653	0	4.
. 00	REID PHYSICIAN ASSOC.	194.04	О	451, 747	0	5.
	0		0	7, 239, 739		1
	B - CAPITAL EXPENSE RECLASS		· ·			
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 678	9	1.
. 00	DATA PROCESSING	5.02	0	12, 187	9	2.
. 00	ADMI TTI NG	5.04	0	10, 870	13	3.
. 00	CASHI ERI NG/ACCOUNTS	5.05	0	86, 929	13	4.
	RECEI VABLE					
. 00	OTHER A&G	5.06	0	63, 457	10	5.
. 00	OPERATION OF PLANT	7.00	0	26, 675	10	6.
. 00	PHARMACY	15.00	0	9, 061	0	7.
8. 00	MEDICAL RECORDS & LIBRARY	16.00	0	8, 885	0	8.
. 00	ADULTS & PEDIATRICS	30.00	0	16, 779	0	9.
0.00	OPERATING ROOM	50.00	0	35, 666	0	10.
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	115, 792	0	11.
2.00	LABORATORY	60.00	0	38, 626	0	12.
3.00	RESPI RATORY THERAPY	65.00	0	318	0	13.
4.00	PHYSI CAL THERAPY	66.00	0	205, 979	0	14.
5.00	ELECTROCARDI OLOGY	69.00	0	204	0	15.
6.00	CARDIAC REHABILITATION	76.97	0	37, 939	0	16.
7.00	PATIENT CARE CENTER - OCC	93.00	0	148, 569	0	17.
8.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	69, 441	0	18.
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4, 063, 886	0	19.
0. 00	RENTAL SPACE	194.00	0	13, 680, 867	0	20.
1. 00	FOUNDATI ON	194.01	0	190	0	21.
2.00	REID PHYSICIAN ASSOC.	194.04	0	1, 222, 906	0	22.
3.00	REID PHYSICIAN ASSOC.	194.04	0	9, 927	0	23.
4.00	CAMBRI DGE RHC	194.08	0	5, 571	0	24.
5.00	REID PHYSICIAN ASSOC.	194.04	0	50, 807	0	25.
	0			19, 929, 209		
	C – CAFETERIA RECLASS					
. 00	DI ETARY	10.00	1, 992, 897	2, 479, 662	0	1.
	0		1, 992, 897	2, 479, 662		
	D - LAUNDRY RECLASS					
. 00	LAUNDRY & LINEN SERVICE	8.00	7 <u>8, 4</u> 12	10 <u>5, 6</u> 83	0	1.
	0		78, 412	105, 683		
	E - NURSING VP RECLASS					
. 00	OTHER A&G	5.06	243, 381	0	0	1.
	0		243, 381	0		
	H - IMPLANTABLE DEVICES RECLA	ISS				
. 00	OPERATING ROOM	50.00	0	10, 301, 647		1.
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 237	0	2.
. 00	CARDIAC CATHETERIZATION	59.00	0	5, 233, 383	0	3.
	0		0	15, 554, 267		
	J – INTEREST RECLASS					
. 00	INTEREST EXPENSE	113.00	0	6, 015, 613	11	1.
	0			6,015,613		
	K - INTERN AND RESIDENT					
. 00	I&R SERVICES-OTHER PRGM.	22.00	314, 039	21, 776	0	1.
	COSTS APPRVD					
	0		314, 039	21, 776		[
	L - WORKERS COMP					
. 00	L - WORKERS COMP OTHER A&G	5.06	0	673, 367	0	1.
. 00		5.06 194.04	0 0	673, 367 164, 320		
2. 00	OTHER A&G				O	1. 2.

REID HOSPITAL & HEALTH CARE SERVICES

Provi der CCN: 15-0048

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2016 Part I

						om 01/01/2016		
					То	12/31/2016		
							5/25/2017 3:1	5 pm
				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 ASSE	F BALANCES						
1.00	Land	13, 419, 665	159, 372		0	159, 372	0	1.00
2.00	Land Improvements	35, 314, 060	236, 053		0	236, 053	0	2.00
3.00	Buildings and Fixtures	248, 316, 742	32, 640, 769		0	32, 640, 769	0	3.00
4.00	Building Improvements	12, 253, 567	90, 876		0	90, 876	0	4.00
5.00	Fixed Equipment	2,094,880	0		0	0	4, 265	5.00
6.00	Movable Equipment	159, 945, 803	11, 423, 887		0	11, 423, 887	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	471, 344, 717	44, 550, 957		0	44, 550, 957	4, 265	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	471, 344, 717	44, 550, 957		0	44, 550, 957	4, 265	10.00
		Endi ng Bal ance	Fully					
		J J J J J J J J J J J J J J J J J J J	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	13, 579, 037	0					1.00
2.00	Land Improvements	35, 550, 113	0					2.00
3.00	Buildings and Fixtures	280, 957, 511	0					3.00
4.00	Building Improvements	12, 344, 443	0					4.00
5.00	Fixed Equipment	2,090,615	0					5.00
6.00	Movable Equipment	171, 369, 690	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	515, 891, 409	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	515, 891, 409	0					10.00
							'	

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

					rom 01/01/2016 o 12/31/2016		
			SL	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	V 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
		SUMMARY OF	F CAPI TAL				
		0.1					
	Cost Center Description		Fotal (1) (sum				
		Capital - Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions) 14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2	·		
1.00	NEW CAP REL COSTS-BLDG & FIXT	SHELL A, COLOMI	12, LINLS I a				1.00
1.00	NEW CAP BLDG & FIXT - OFFSITE	0	0				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2.00	Total (sum of lines 1-2)	0	0				3.00
5.00	Tiotal (Sum of Times 1-2)	U	0				3.00

Heal	th Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
RECO	DNCILIATION OF CAPITAL COSTS CENTERS		Provider C	-	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	pared:
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		-			-	
1.00		344, 521, 719					1.00
1.01		171, 369, 690	0	171, 369, 69			1.01
2.00		0	0		0. 000000		2.00
3.00) Total (sum of lines 1-2)	515, 891, 409		515, 891, 40			3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate	cols. 5			
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 776, 001	82, 534	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0		0 16, 590, 028	2, 125, 480	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0 0	2.00
3.00) Total (sum of lines 1-2)	0	0		0 17, 366, 029	2, 208, 014	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		

					d Costs (see	through 14)		
					instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	33, 099	0	891, 634	1.00	
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	315, 682	0	19, 031, 190	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	348, 781	0	19, 922, 824	3.00	

RELD HOSPITAL & HEALTH CARE SERVICES

Heal th	Financial Systems	REIDI	HOSPI TAL & HEA	LTH CARE SERVICES	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2016	Worksheet A-8	
					To 12/31/2016	Date/Time Pre	
				Expense Classification or	Worksheet A	5/25/2017 3: 1	5 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5. 00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
	2)						
1.01	Investment income - NEW CAP			NEW CAP BLDG & FIXT -	1.01	0	1. 01
	BLDG & FIXT - OFFSITE (chapter 2)			OFFSI TE			
2.00	Investment income - NEW CAP			NEW CAP REL COSTS-MVBLE	2.00	0	2.00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
1.00	discounts (chapter 8)		0		0.00	0	1.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
7.00	stations excluded) (chapter		0		0.00	0	7.00
0.00	21)		0		0.00		0.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00		9.00
10.00	Provider-based physician adjustment	A-8-2	-9, 330, 601			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	-6, 412, 857			0	12.00
	transactions (chapter 10)		0, 112, 00,				
	Laundry and linen service Cafeteria-employees and guests	В	0 -2, 988, 329		0.00 11.00		13.00 14.00
15.00	Rental of quarters to employee	D	-2, 700, 327		0.00		15.00
1/ 00	and others		0		0.00	0	1/ 00
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17 00	patients		0		0.00		17 00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and	В	-47, 320	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts Nursing school (tuition, fees,	В	-39, 252	PARAMED ED PRGM	23.00	0	19.00
	books, etc.)						
20.00 21.00	Vending machines Income from imposition of	В	-16, 928 0	DI ETARY	10.00 0.00		
21100	interest, finance or penalty		0		0.00		200
22 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
22.00	overpayments and borrowings to		0		0.00		22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of	A-0-3	0		03.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
24.00	therapy costs in excess of	A-0-3	0	FITSTORE THERAFT	00.00		24.00
25 00	limitation (chapter 14) Utilization review –		0	*** Coot Coptor Dolotod ***	114 00		25.00
25.00	physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
o / . oo	(chapter 21)		0		1.00		a
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26. 01	Depreciation - NEW CAP BLDG &		0	NEW CAP BLDG & FIXT -	1.01	0	26. 01
27.00	FIXT - OFFSITE Depreciation - NEW CAP REL			OFFSITE NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
28.00 29.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
30.00	Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***			30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		-				

REID HOSPITAL & HEALTH CARE SERVICES

leal th	Financial Systems	REID H	HOSPITAL & HEA	ALTH CARE SERVICES	In Lie	u of Form CMS-2	<u>2552</u> -10
	MENTS TO EXPENSES			Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet A-8	
					Го 12/31/2016	Date/Time Pre 5/25/2017 3:1	
				Expense Classification on To/From Which the Amount is			
	Cost Contor Description	Pacis (Cada (2)	Amount	Cost Contor	line #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	5.00	
31.00	Adjustment for speech	A-8-3		*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for		O		0.00	0	32.00
	Depreciation and Interest		0	,	0.00	0	32.00
	MISCELLANEOUS INCOME	В	-558, 361		10.00	0	
	MI SCELLANEOUS I NCOME	В		EMPLOYEE BENEFITS DEPARTMENT		0	
	MI SCELLANEOUS I NCOME	B B			5.02	0	33.02
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS SUBPROVIDER - IRF	30.00 41.00	0	33.03 33.04
	MI SCELLANEOUS I NCOME	B	-40		5.06	-	
	MI SCELLANEOUS I NCOME	B		CARDI AC CATHETERI ZATI ON	59.00		
	MI SCELLANEOUS I NCOME	В		PURCHASI NG RECEI VI NG AND STORES	5. 03	0	33.07
3. 08	MI SCELLANEOUS I NCOME	В	-123, 947	PHARMACY	15.00	0	33.08
	MI SCELLANEOUS I NCOME	В		INSERVICE EDUCATION	17.01	0	33.09
	MI SCELLANEOUS I NCOME	В			5.04	0	
-	MI SCELLANEOUS I NCOME	В		PHYSICAL THERAPY	66.00	0	
	MI SCELLANEOUS I NCOME	B B		OPERATING ROOM	50.00 54.00		33. 12 33. 13
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C LABORATORY	60.00		
	MI SCELLANEOUS I NCOME	B		EMERGENCY	91.00		
	MI SCELLANEOUS I NCOME	B		DURABLE MEDICAL EQUI P-RENTED			
	MI SCELLANEOUS I NCOME	В		I &R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		33. 17
	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00		
	MI SCELLANEOUS I NCOME I NTEREST I NCOME	B A		HOUSEKEEPING NEW CAP REL COSTS-BLDG &	9.00 1.00		00
	UNNECESSARY BORROWING	A		FLXT NEW CAP REL COSTS-BLDG &	1.00		
	SELF INSURANCE ADJUSTMENT	A		FIXT EMPLOYEE BENEFITS DEPARTMENT			
	CARRYFORWARD DEPRECIATION	A		NEW CAP REL COSTS-BLDG & FIXT	1.00		33. 24
3. 25	PATIENT ENTERTAINMENT SYSTEM	A	-177, 160	OTHER A&G	5.06	0	33. 25
	LI FELI NE SUPPORT	A		OTHER A&G	5.06	0	
	LI FELI NE SUPPORT	A		NEW CAP BLDG & FIXT - OFFSITE	1.01	9	33. 27
	LI FELI NE SUPPORT	A		NEW CAP REL COSTS-BLDG &	1.00		33.28
	COUNTRY CLUB DUES	A		OTHER A&G	5.06		
	AHA/IHA LOBBYING MARKETING/ADVERTISING	A A		OTHER A&G EMPLOYEE BENEFITS DEPARTMENT	5.06 4.00		
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A		CASHI ERI NG/ACCOUNTS RECEI VABLE	4.00 5.05		
	MARKETI NG/ADVERTI SI NG	A	-2,635,826	OTHER A&G	5.06	0	
	MARKETI NG/ADVERTI SI NG	A		DIETARY	10.00		
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A A		PHARMACY I &R SERVICES-OTHER PRGM.	15.00 22.00		
3. 37	MARKETI NG/ADVERTI SI NG	А	_0 /0/	COSTS APPRVD ADULTS & PEDIATRICS	30.00	0	33. 37
	MARKETING/ADVERTISING MARKETING/ADVERTISING	A		SUBPROVIDER – IPF	40.00		
	MARKETI NG/ADVERTI SI NG	A		SUBPROVIDER - IRF	40.00	0	33.39
	MARKETI NG/ADVERTI SI NG	A		OPERATI NG ROOM	50.00	0	
	MARKETI NG/ADVERTI SI NG	А		PHYSICAL THERAPY	66.00		
	MARKETI NG/ADVERTI SI NG	A		CARDIAC REHABILITATION	76.97	0	
	MARKETI NG/ADVERTI SI NG	A		DURABLE MEDICAL EQUIP-RENTED		0	
	MARKETING/ADVERTISING NON-ALLOWABLE EXPENSES	A A		HOSPICE EMPLOYEE BENEFITS DEPARTMENT	116.00 4.00	0	33.44 33.45
	NON-ALLOWABLE EXPENSES	A		CASHI ERI NG/ACCOUNTS RECEI VABLE	4.00 5.05		33.46
3. 47	NON-ALLOWABLE EXPENSES	A	-89, 166	OTHER A&G	5.06	0	33. 47
	NON-ALLOWABLE EXPENSES	A		MEDICAL RECORDS & LIBRARY	16.00		
	NON-ALLOWABLE EXPENSES	A		INSERVICE EDUCATION	17.01	0	
	NON-ALLOWABLE EXPENSES	A		I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00		
	NON-ALLOWABLE EXPENSES	A		PARAMED ED PRGM	23.00		
	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		ADULTS & PEDIATRICS	30.00 31.00		
	NON-ALLOWABLE EXPENSES	A		SUBPROVIDER - IRF	41.00		

Heal th	Fi nanci al	Systems
AD JUST	MENTS TO I	EXPENSES

RELD HOSPITAL & HEALTH CARE SERVICES

Health Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVICES	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				rom 01/01/2016		
				Fo 12/31/2016	Date/Time Pre 5/25/2017 3:1	
			Expense Classification or	Worksheet A	5/25/2017 5.1	
			To/From Which the Amount is			
				····,		
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.55 NON-ALLOWABLE EXPENSES	A		OPERATING ROOM	50.00		
33.56 NON-ALLOWABLE EXPENSES	A		RADI OLOGY-DI AGNOSTI C	54.00		00.00
33.57 NON-ALLOWABLE EXPENSES	A		CARDIAC CATHETERIZATION	59.00		33.57
33.58 NON-ALLOWABLE EXPENSES	A		RESPI RATORY THERAPY	65.00		33.58
33.59 NON-ALLOWABLE EXPENSES	A		PHYSICAL THERAPY	66.00		
33.60 NON-ALLOWABLE EXPENSES	A		ELECTROCARDI OLOGY	69.00		00.00
33.61 NON-ALLOWABLE EXPENSES	A		ELECTROENCEPHALOGRAPHY	70.00		
33.62 NON-ALLOWABLE EXPENSES	A	-1, 390	EMERGENCY	91.00	0	33.62
33.63 NON-ALLOWABLE EXPENSES	A	-1, 535	DURABLE MEDICAL EQUIP-RENTE	96.00	0	33.63
33.64 NON-ALLOWABLE EXPENSES	A	-124	HOSPICE	116.00	0	33.64
33.65 HAF EXPENSE	A	-6, 561, 611	OTHER A&G	5.06	0	33.65
33.67 BOND REFUNDING 2015	A	922, 001	OTHER A&G	5.06	0	33.67
33.68 BOND REFUNDING 2016	A	17, 766	OTHER A&G	5.06	0	33.68
33.69 OCC MEDICINE - EMPLOYEE COST	A	-483, 303	EMERGENCY	91.00	0	33.69
50.00 TOTAL (sum of lines 1 thru 49)		-45, 570, 765				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						
(1) Description - all chapter referen	ces in this col	umn pertain to	o CMS Pub. 15-1.			
(2) Basis for adjustment (see instruc	tions).					
A. Costs - if cost, including appli		can be deterr	ni ned.			
B. Amount Received - if cost cannot						
(3) Additional adjustments may be mad	e on lines 33 t	hru 49 and sub	oscripts thereof			

(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
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0048	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2016		
				To 12/31/2016		pared:
					5/25/2017 3:1	5 pm
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	16, 987, 793	23, 400, 650	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	lo		lo	16 987 793	23 400 650	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

				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownership		Ownership				
	1.00	2.00	3.00	4,00	5.00				
				1.00	0.00	<u> </u>			
	B. INIERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:						

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

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

1 CT IIIDUI					
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 provider.

col. 5)* 6.00 7.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS -6, 412, 857 0 0 0 0 0 0 0 0 0 0 0

5.00 -6, 412, 857 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.	
Related Organization(s)	
and/or Home Office	
Type of Business	
6.00	
B. INTERRELATIONSHIP TO RELATED 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 7.00 8.00 9.00 10.00 100.00	6.00	0
7.00	7.00	
8.00	8.00	0
9.00	9.00	
10.00	10.00	0
100.00	100.00	0

(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

Provider CCN: 15-0048

In Lieu of Form CMS-2552-10

From 01/01/2016

12/31/2016

Worksheet A-8-1

Date/Time Prepared: 5/25/2017 3:15 pm

1.00

2.00

3.00

4.00

4.01

4 02

Peri od:

То

S	0F	SERVI CES	FROM	RELATED	1

Wkst. A-7 Ref

Heal	th	Fin	nanc	i al	Sy	ste	ms
STA	TEM	ENT	0F	COS	ΤS	0F	SE
OFF	I CE	COS	STS				

1.00

2.00

3.00

4.00

4.01

4 02

Net Adjustments (col. 4 minus Health Financial Systems PROVIDER BASED PHYSICIAN ADJUSTMENT REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048 Period:

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

PROVIDER BASED PHYSICIAN ADJUSIMENT				Provider (Period: From 01/01/2016	Worksheet A-8	3-2
						To 12/31/2016		epared:
							5/25/2017 3:1	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		INSERVICE EDUCATION	312, 963					1.00
2.00	22.00	I &R SERVICES-OTHER PRGM.	417, 327	417, 327	C	197, 500	0	2.00
		COSTS APPRVD		0.044.500		470.000		
3.00		ADULTS & PEDIATRICS	3, 216, 529					3.00
4.00		SUBPROVIDER - IRF	117, 475					4.00
5.00		OPERATI NG ROOM	3, 582, 678			,		5.00
6.00		LABORATORY	842, 084			200,000		6.00
7.00		ELECTROCARDI OLOGY	60, 450					7.00
8.00		EMERGENCY	781, 095					8.00
9.00	0.00		0				-	9.00
10.00	0.00		0	-	-	-	-	10.00
200.00			9, 330, 601				0	2001.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit		Memberships &		of Malpractice Insurance	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		I NSERVI CE EDUCATI ON	0.00					1.00
2.00		I &R SERVICES-OTHER PRGM.	0	-				2.00
2.00	22.00	COSTS APPRVD)	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	c c	0	0	3.00
4.00		SUBPROVIDER - IRF	0	-			-	4.00
5.00		OPERATING ROOM	0	0			0	5.00
6.00		LABORATORY	0	0			0	6.00
7.00		ELECTROCARDI OLOGY	0	0) C	0	0	7.00
8.00		EMERGENCY	0	0) C	0	0	8,00
9.00	0.00		0	0) C	0	0	9.00
10,00	0,00		0	0) C	0	0	10.00
200.00			0	0) C	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	17.01	INSERVICE EDUCATION	0	0	C	312, 963		1.00
2.00	22.00	I&R SERVICES-OTHER PRGM.	0	0	C	417, 327		2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	0	-	-			3.00
4.00		SUBPROVIDER – IRF	0					4.00
5.00		OPERATING ROOM	0	-		-,,		5.00
6.00		LABORATORY	0	-				6.00
7.00		ELECTROCARDI OLOGY	0	-				7.00
8.00		EMERGENCY	0	-	-			8.00
9.00	0.00		0					9.00
10.00	0.00		0	-	-	-		10.00
200.00			0	0	C	9, 330, 601		200.00

Health Financial Systems REID COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2016	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/25/2017 3:1	pared:
		CAP	ITAL RELATED CO	STS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP BLDG & FIXT - OFFSITE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES	891, 634 19, 031, 190 0 19, 529, 792 263, 735 22, 777, 920 1, 260, 533	891, 634 C 3, 234 4, 601 15, 166 18, 961	0 19, 031, 190 27, 636 0 75, 653	0 0 0 0 0	19, 560, 662 31, 209 500, 966 113, 278	5. 01 5. 02
5.04 00570 ADMI TTI NG 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.06 00590 OTHER A&G 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	3, 060, 236 6, 011, 887 12, 226, 229 5, 015, 391 680, 969 2, 037, 627	174 987 30, 395 220, 709 14, 945 8, 209	563, 772 487, 428 287, 275 0 0		236, 871 269, 256 841, 725 277, 028 40, 692 189, 205	5.05 5.06 7.00 8.00 9.00
10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE	444, 387 1, 484, 230 520, 102 3, 517, 458 31, 822, 225 3, 700, 603 2, 698, 644	15, 227 11, 962 2, 369 10, 190 8, 809 4, 249 1, 504	2 0 0 0 0 0 406, 455 0	0 0 0 0 0 0 0	58, 309 255, 675 51, 658 75, 492 488, 544 270, 314 275, 617	11.00 13.00 14.00 15.00 16.00 17.00
17. 01 01701 I NSERVI CE EDUCATI ON 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 23. 00 02300 PARAMED ED PRGM INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 127, 776 335, 815 112, 505 207, 205 18, 086, 566	12, 611 C 1, 285 132, 358	0 0 185, 161	0 0 0 0	115, 336 40, 289 4, 918 26, 988 1, 969, 403	21.00 22.00 23.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	5, 329, 270 3, 656, 803 1, 411, 626 476, 084	29, 746 27, 066 21, 684 3, 248	0 0 0	0 0 0	391, 593 415, 048 153, 933 48, 221	31.00 40.00 41.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC 59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 65.00 06500 RESPIRATORY THERAPY	23, 474, 706 734, 820 11, 266, 096 5, 400, 571 9, 971, 946 1, 846, 401	58, 719 10, 075 73, 638 16, 452 16, 895 1, 995	0 110, 544 0 0 0 0	0 0 0 0 0 0	212, 369 64, 913 699, 390 194, 016 433, 682 173, 743	52.00 54.00 59.00 60.00 65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 73. 00 07300 DRUGS CHARGED TO PATI ENTS	5, 646, 680 1, 433, 949 364, 012 0 15, 554, 267 0	9, 794 8, 494 C C C C	0 268, 897 0 0 0 0 0		612, 428 108, 186 34, 789 0 0 0	69.00 70.00 71.00 72.00 73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS 00100	656, 069 0 235, 538	1, 805 C 5, 480	0000	0 0 0	0 0 23, 787	76. 00 76. 97
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 93.00 04040 PATI ENT CARE CENTER - OCC OTHER REI MBURSABLE COST CENTERS	5, 572, 000	27, 590 10, 825		0	582, 468	92.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UNDERLICE	1, 995, 215	2, 149		0		113.00
NONREL MBURSABLE COST CENTERS 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 130, 246 255, 386, 382	539 844, 139 	6, 627, 987	0 0 0	135, 063 10, 683, 369	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE 194. 01 07951 FOUNDATI ON 194. 02 07952 RETAI L SERVI CES 194. 03 07953 REI D CONTRACTED SERVI CES	2, 924, 159 1, 870, 502 316, 745 118, 741 339, 365	302 C 25C 2, 835 C	169, 684 1, 314, 778 0 0 0 0	0 0 0 0 0	0 0 19, 838 13, 469 28, 647	192.00 194.00 194.01 194.02 194.03
194.04 07954 REID PHYSICIAN ASSOC. 194.05 07955 0THER NRCC 194.06 07956 VACANT SPACE 194.08 07958 CAMBRIDGE RHC 200.00 Cross Foot Adjustments	106, 399, 144 0 0 1, 289, 053	41, 785 645 1, 678 C	0 1, 186, 133	0 0 0 0	0 125, 846	194. 05 194. 06

Health Financial Systems	REID HOSPITAL & HEA	In Lie	eu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
				rom 01/01/2016 o 12/31/2016		pared:
					5/25/2017 3:1	5 pm
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		NEW CAP BLDG & FIXT - OFFSITE		EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
201.00 Negative Cost Centers		C	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	368, 644, 091	891, 634	19, 031, 190	0	19, 560, 662	202.00

Heal th	Fi nanci al	Systems	
COCT A			

	Financial Systems REID ALLOCATION - GENERAL SERVICE COSTS	HOSPITAL & HEAI			In Lie	eu of Form CMS-2 Worksheet B	2552-1
00017					om 01/01/2016	Part I	
	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	- p
		5.01	5.02	5.03	5.04	5.05	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00100 NEW CAP REL COSTS-BEDG & FIXT						1.0
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES	299, 545					5. Oʻ
5.02	00550 DATA PROCESSING	24, 613	23, 394, 318				5.02
5.03	00560 PURCHASING RECEIVING AND STORES	3, 268	2, 438, 829		0 700 05/		5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	9, 192 14, 400	358, 651 153, 708		3, 799, 256	7, 019, 846	5.04 5.05
5.05	00590 OTHER A&G	12,051	286, 921		0	7,019,840	5.00
7.00	00700 OPERATION OF PLANT	5, 923	2007 721		0	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	613	20, 494		0	0	8.00
9.00	00900 HOUSEKEEPI NG	613	30, 742		0	0	9.00
10.00	01000 DI ETARY	8, 987	348, 404		0		10.00
11.00 13.00		0	142 441	-	0	0	11.00 13.00
14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 838 1, 021	143, 461 122, 966		0	0	14.00
15.00		4, 392	409, 887		0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	6, 945	860, 763		0	0	16.00
17.00	01700 SOCIAL SERVICE	3, 472	286, 921	2, 690	0	0	17.00
17.01	01701 I NSERVI CE EDUCATI ON	4, 698	1, 516, 583		0	0	17.0
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	C		0	0	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	0 306	102 472	1,000	0	0	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	300	102, 472	1,014	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	23, 285	2, 438, 829	248, 977	220, 594	407, 565	30.00
31.00	03100 INTENSIVE CARE UNIT	5, 311	358, 651		41, 813		
40.00	04000 SUBPROVI DER – I PF	2, 247	153, 708	39, 162	56, 681	104, 722	40.00
41.00	04100 SUBPROVIDER - IRF	3, 268	286, 921		18, 768		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	C	19, 516	10, 698	19, 765	43.00
50.00	05000 OPERATING ROOM	19, 302	891, 505	574, 135	724, 194	1, 338, 426	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 392	327, 910		32, 028		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 626	1, 557, 572		589, 377		54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 962	102, 472		380, 530		59.00
60.00		6, 536	594, 337		389, 383		60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	613 9, 192	122, 966 1, 065, 707		77, 171 86, 590		65.00 66.00
69.00	06900 ELECTROCARDI OLOGY	919	502, 112		115, 026		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	715	81, 977		19, 210		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	722		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	C	-	134, 490		
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	C 20, 404		542, 302		
74.00 76.00	03950 ANCI LLARY - OTHER	511	20, 494	5, 562	4, 013 0		74.00 76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1, 226	20, 494	2, 697	5, 873	-	76.9
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	8, 375	768, 539	131, 400	268, 113	495, 360	91.00
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	E 021	200 640	24 445	25 204	14 E47	92.00
93.00	OTHER REIMBURSABLE COST CENTERS	5, 821	399, 640	26, 465	25, 204	46, 567	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 553	122, 966	127, 583	31, 777	58, 711	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
		1, 328	30, 742		24, 699		
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	216, 514	16, 928, 344	3, 413, 938	3, 799, 256	7, 019, 846	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	6, 638	10, 247	-	0		192.00
	07950 RENTAL SPACE	9, 907	C	15, 582	0		194.00
			(4 . 4 . 6 .	104	0	0	194. 0 [.]
194.01	07951 FOUNDATI ON	715	61, 483		0	1 1	
194. 01 194. 02	07951 FOUNDATI ON 207952 RETAIL SERVI CES	715 0	61, 483 368, 899	616	0		
194. 01 194. 02 194. 03	07951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES	0	368, 899 C	616 0 0	0	0	194. 0
194. 01 194. 02 194. 03 194. 04	07951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 407954 REID PHYSICIAN ASSOC.	1		616 0 0	000000000000000000000000000000000000000	0 0	194. 03 194. 04
194.01 194.02 194.03 194.04 194.05	07951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 107954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	0	368, 899 C	616 0 0		0 0 0	194. 02 194. 03 194. 04 194. 05 194. 05
194.01 194.02 194.03 194.04 194.04 194.06	07951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 407954 REID PHYSICIAN ASSOC.	0	368, 899 C	616 0 0	0 0 0 0 0 0 0	0 0 0	194. 03 194. 04 194. 05 194. 06
194.01 194.02 194.03 194.04 194.05 194.06 194.06	07951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 507955 OTHER NRCC 07956 VACANT SPACE 307958 CAMBRIDGE RHC	0	368, 899 C	616 0 392, 856 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0	194. 03 194. 04 194. 08 194. 08 194. 08 200. 00
194.01 194.02 194.03 194.04 194.05 194.06	07951FOUNDATION07952RETALL SERVICES07953REID CONTRACTED SERVICES07954REID PHYSICIAN ASSOC.07955OTHER NRCC07956VACANT SPACE07958CAMBRIDGE RHC0Cross Foot Adjustments0Negative Cost Centers	0	368, 899 C	616 0 392, 856 0 0 0 9 9, 826 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 3, 799, 256	0 0 0 0	194. 03 194. 04 194. 05 194. 06 194. 06 200. 00 201. 00

Heal th	Fi nanci al	Systems	
OOCT A		OFNEDAL	OFF

Heal th F	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
	LOCATI ON - GENERAL SERVI CE COSTS		Provider C	CN: 15-0048 P	eriod: rom 01/01/2016	Worksheet B Part I	
	Cost Center Description	Subtotal 5A. 05	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	
G	ENERAL SERVICE COST CENTERS	5A. U5	5.06	7.00	8.00	9.00	
1.00 0 1.01 0 2.00 0 4.00 0 5.01 0 5.02 0 5.03 0 5.04 0 5.05 0 7.00 0 8.00 0 9.00 0 10.00 0	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 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00500 OHERA A&G 00500 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 010000 DI ETARY	13, 909, 499 5, 844, 403 758, 796 2, 323, 566 913, 432	13, 909, 499 229, 165 29, 753 91, 109 35, 817	6, 073, 568 120, 627 63, 467	909, 176 0	2, 478, 142	
13.00 0 14.00 0 15.00 0 16.00 0 17.00 0 21.00 0 22.00 0 23.00 0	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	1, 751, 867 720, 848 4, 088, 275 33, 027, 372 5, 253, 117 3, 268, 848 2, 782, 321 376, 104 118, 509 524, 431	68, 692 28, 265 160, 305 1, 295, 980 128, 175 109, 098 14, 747 4, 647 20, 563	19, 118 82, 253 68, 846 11, 364 4, 283 91, 162 0 0	0 23, 141 0 0 0 0 0 0 0 0 0	103, 098 3, 437 0 15, 293 9, 451 24, 056 0 0	13.00 14.00 15.00 16.00 17.00 17.01 21.00 22.00
30.00 0	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	23, 527, 577 6, 377, 400	922, 540 250, 064				
40.00 C 41.00 C	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	4, 455, 437 1, 954, 572	174, 702 76, 641	218, 469 175, 029	52, 725 29, 633	113, 065 82, 479	40.00 41.00
	04300 NURSERY NCILLARY SERVICE COST CENTERS	577, 532	22, 646	26, 218	39, 710	3, 093	43.00
50.00 0	DSOOO DERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	28, 197, 810 1, 277, 368	1, 105, 664 50, 087				
	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	15, 802, 793	619, 643			120, 453	
	06000 LABORATORY	7, 267, 228 12, 170, 222	284, 955 477, 207			31, 961 123, 203	
	06500 RESPI RATORY THERAPY	2, 467, 736	96, 762	11, 676	0	21, 135	65.00
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	10, 532, 608 2, 428, 919	412, 994 95, 240			19, 245 42, 786	
	07000 ELECTROENCEPHALOGRAPHY	808, 492	31, 702				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 056	81		-		
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	15, 937, 238 1, 544, 247	624, 915 60, 551		-		72.00 73.00
	07400 RENAL DIALYSIS	695, 869	27, 286		-		74.00
76.00 0	03950 ANCI LLARY - OTHER	0	0	0		0	76.00
	07697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS	305, 945	11, 996	0	0	9, 107	76.97
91.00 0	09100 EMERGENCY	7, 853, 845	307, 957	222, 693	109, 809	252, 076	91.00
93.00 0	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 04040 PATI ENT CARE CENTER - OCC 0THER REI MBURSABLE COST CENTERS	0 2, 110, 896	82, 770	3, 961	9, 630	31, 101	92.00 93.00
	09600 DURABLE MEDICAL EQUIP-RENTED	2, 653, 916	104, 063	36, 692	0	1, 718	96.00
	SPECIAL PURPOSE COST CENTERS			1			
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	2, 477, 361 227, 088, 455	97, 140 8, 358, 958		-		113.00 116.00 118.00
	IONREI MBURSABLE COST CENTERS			1			1.0-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 3, 112, 977	0 122, 063				190. 00 192. 00
	07950 RENTAL SPACE	3, 210, 769	125, 897			0	194.00
	07951 FOUNDATION	399, 135	15, 650				194.01
	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES	504, 560 368, 012	19, 784 14, 430				194.02 194.03
	07954 REID PHYSICIAN ASSOC.	131, 347, 002	5, 150, 252		-		
194.050	07955 OTHER NRCC	645	25	5, 203	0	0	194.05
	07956 VACANT SPACE	1, 187, 811	46, 575		0		194.06 194.08
200.00	07958 CAMBRIDGE RHC Cross Foot Adjustments	1, 424, 725 0	55, 865		0	0	200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	368, 644, 091	13, 909, 499	6, 073, 568	909, 176	2, 478, 142	1202.00

JST AL	LLOCATION - GENERAL SERVICE COSTS		Provider C	Fr	riod: om 01/01/2016	Worksheet B Part I	
				То	12/31/2016	Date/Time Pre 5/25/2017 3:1	pareo
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	5 pm
		10.00	11.00	13.00	SUPPLY 14.00	15.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.
01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.
00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00540 NONPATIENT TELEPHONES						5.
	00550 DATA PROCESSI NG						5.
	00560 PURCHASING RECEIVING AND STORES						5.
							5.
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5. 5.
	00700 OPERATION OF PLANT						5. 7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPING						9.
	01000 DI ETARY	1, 100, 292					10.
	01100 CAFETERI A	0	1, 917, 110				11.
. 00	01300 NURSI NG ADMI NI STRATI ON	0	3, 452				13.
. 00	01400 CENTRAL SERVICES & SUPPLY	0	20, 789	0	4, 378, 200		14.
. 00	01500 PHARMACY	0	61, 718	0	5, 146	34, 458, 118	15.
	01600 MEDICAL RECORDS & LIBRARY	0	63, 658		0	8	16.
	01700 SOCIAL SERVICE	0	C	0	0	0	17.
	01701 I NSERVI CE EDUCATI ON	0	17, 227		144	20	17.
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	5, 672		0	0	21.
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	0	1, 210 2, 834		0	0	22. 23.
	INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 034	0	0	0	23.
	03000 ADULTS & PEDI ATRI CS	653, 582	273, 408	319, 962	2, 632	4, 415	30.
	03100 I NTENSI VE CARE UNI T	100, 948	52, 886		3, 968	5, 606	31.
	04000 SUBPROVI DER - I PF	226, 378	68, 101		0	884	40.
. 00	04100 SUBPROVI DER – I RF	75, 952	21, 765		0	579	41.
. 00	04300 NURSERY	43, 432	5, 453		20	0	43.
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	88, 868		2, 103, 803	103, 889	50.
	05200 DELIVERY ROOM & LABOR ROOM	0	7, 327		1, 252	31	52.
	05400 RADI OLOGY-DI AGNOSTI C	0	93, 824		3, 788	590, 939	54.
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	24, 734		1, 602, 375	46	59.
	06000 LABURATORY 06500 RESPI RATORY THERAPY	0	75, 595 24, 157		253, 529 1, 382	75 34, 427	60. 65.
	06600 PHYSI CAL THERAPY	0	81, 440		313	34, 427	66.
	06900 ELECTROCARDI OLOGY	0	14, 996		2	262, 186	69.
	07000 ELECTROENCEPHALOGRAPHY	0	4, 977		2	202, 100	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0	0	71.
. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	30, 637, 766	
. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.
	03950 ANCI LLARY - OTHER	0	C	0	0	0	76.
•	07697 CARDI AC REHABI LI TATI ON	0	3, 880	4, 540	0	0	76.
	OUTPATIENT SERVICE COST CENTERS		00.000	07.01-		01.00	
	09100 EMERGENCY	0	83, 098	97, 248	278	21, 204	91. 02
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	o	25, 056	0	~	13, 901	92. 93.
	OTHER REIMBURSABLE COST CENTERS	U	25,050			13, 901	93.
	09600 DURABLE MEDICAL EQUIP-RENTED	0	24, 930	0	250, 074	0	96.
	SPECIAL PURPOSE COST CENTERS		21,700	0	200,071		, 0.
	11300 I NTEREST EXPENSE						113.
	11600 HOSPI CE	0	20, 288	0	252	129, 174	
8. 00		1, 100, 292	1, 171, 343	874, 781	4, 228, 958	31, 805, 150	118.
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1	0	0		192.
	07950 RENTAL SPACE	0	0	0	0		194.
	07951 FOUNDATION	0	3, 786		0		194.
	07952 RETAIL SERVICES	0	3, 360		0		194. 104
	07953 REID CONTRACTED SERVICES	U	7, 797		140 242		194. 104
	07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	U	717, 653	0	149, 242	2, 596, 710	194. 194.
	07955 OTHER NRCC 07956 VACANT SPACE		0		0		194. 194.
	07958 CAMBRI DGE RHC	0	13, 170	0	0	56, 258	
4.08 0.00		U	13, 170		0		194. 200.
5.00		0	0	0	0		200.
1.00							

				F	rom 01/01/2016 0 12/31/2016 INTERNS &	Date/Time Pre 5/25/2017 3:1	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	EDUCATI ON	SERVI CES-SALAR Y & FRI NGES	PRGM. COSTS	
CENEDA		16.00	17.00	17.01	21.00	22.00	
	L SERVICE COST CENTERS	1	1				1 1
01 00101 00 00200 00 00400 02 00550 03 00560 04 00570 05 00580 06 00590 00 00700 00 00800 00 00900 0.00 01100 1.00 011300 4.00 01400 5.00 01500 5.00 01600 7.00 01700	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	5, 549, 420 0	3, 410, 757	2 024 020			1 1 2 4 5 5 5 5 5 5 7 8 9 10 11 13 14 15 16 17
	INSERVICE EDUCATION	0	0	3, 024, 028			17.
1 1	I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	396, 523	104.0//	21.
	I &R SERVICES-OTHER PRGM. COSTS APPRVD		0	0		124, 366	
	PARAMED ED PRGM ENT ROUTINE SERVICE COST CENTERS	0	0	19, 688			23
	ADULTS & PEDIATRICS	322, 187	1, 847, 682	674, 569	259, 231	81, 305	30
	INTENSIVE CARE UNIT	61,070		168, 868		01,000	
	SUBPROVIDER - IPF	82, 785		143, 376		0	40
. 00 04100	SUBPROVIDER - IRF	27, 412	0	41, 516	0	0	41
	NURSERY	15, 625	0	8, 895	0	0	43
	ARY SERVICE COST CENTERS	1 050 454		10 7/0	40.450	40.045	1 50
	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	1, 058, 156 46, 778		43, 768 14, 677	42, 452	13, 315 0	
1 1	RADI OLOGY-DI AGNOSTI C	860, 812		179, 926	3, 613	1, 133	
	CARDI AC CATHETERI ZATI ON	555, 780	1	44, 032		0	
0.00 06000	LABORATORY	568, 710	0	123, 203	0	0	60
	RESPI RATORY THERAPY	112, 712		60, 145		9, 632	
	PHYSI CAL THERAPY	126, 469		133, 753		0	
	ELECTROCARDI OLOGY	168, 001		27, 832	21, 678	6, 799	
1 1	ELECTROENCEPHALOGRAPHY	28, 056		4, 944 0		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 055 196, 429		0	0	0	
	DRUGS CHARGED TO PATIENTS	792, 056		0	0	0	
	RENAL DIALYSIS	5, 861		4, 061	0	0	
	ANCILLARY - OTHER	0	1	0	0	0	
	CARDIAC REHABILITATION	8, 577	0	6, 798	0	0	76
	TENT SERVICE COST CENTERS	004 504	4 404 007	4/0 /00	00.000	10, 100	1
.00 09100	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	391, 591	1, 106, 237	160, 680	38, 839	12, 182	91
	PATIENT CARE CENTER - OCC	36, 812	0	34, 498	0	0	
	REIMBURSABLE COST CENTERS	30,012	<u> </u>	54, 470	0	0	1 /3
	DURABLE MEDICAL EQUIP-RENTED	46, 412	0	11, 874	0	0	96
SPECI A	L PURPOSE COST CENTERS			•			
	INTEREST EXPENSE						113
6.0011600		36,074		28, 340			116
	SUBTOTALS (SUM OF LINES 1-117) MBURSABLE COST CENTERS	5, 549, 420	3, 410, 757	1, 935, 443	396, 523	124, 366	118
	GIFT, FLOWER, COFFEE SHOP & CANTEEN			0	0	0	190
	PHYSI CLANS' PRI VATE OFFICES	0	0	0			192
	RENTAL SPACE		Ő	0	0		194
4.0107951	FOUNDATION	0	0	795	0	0	194
	RETALL SERVICES	0	0	1, 611	0		194
	REID CONTRACTED SERVICES	0	0	0	0		194
	REID PHYSICIAN ASSOC.	0	0	814, 612	0		194
4.0507955		0	0	238, 173	0		194
	VACANT SPACE CAMBRIDGE RHC		0	0 33, 394	0		194. 194.
	CAMBRIDGE RHC Cross Foot Adjustments			33, 394	0		200.
					0		
	Negative Cost Centers			0	()	()	201.

Health Financial Systems REID COST ALLOCATION - GENERAL SERVICE COSTS REID	HOSPI TAL & HEAL		CN: 15-0048 Pe	ri od:	u of Form CMS-2552-10 Worksheet B
			Fr To	com 01/01/2016 12/31/2016	Part I Date/Time Prepared:
Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/25/2017 3:15 pm
	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES 5.04 00570 ADMITTING 5.05 00580 CASHI ERING/ACCOUNTS RECEIVABLE 5.06 00590 OTHER A&G 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 MEDICAL SERVICE 17.00 17.00 10701 INSERVICE 17.01 01701 INSERVICE 17.00 10700 SOCIAL SERVICE 17.00 10701	504.044				$\begin{array}{c} 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 5. \ 06\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 01\\ 21. \ 00\\ 22. \ 00\\ \end{array}$
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	594, 966				23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	30, 919, 311		30, 578, 775	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF	0	7, 983, 001 5, 615, 619		7, 983, 001 5, 615, 619	31.00 40.00
41.00 04100 SUBPROVIDER - IRF	0	2, 511, 049		2, 511, 049	41.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	749, 005	5 0	749, 005	43.00
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	33, 631, 727		33, 575, 960	50.00 52.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 594, 966	1, 558, 927 19, 469, 476		1, 558, 927 19, 464, 730	52.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	9, 884, 973		9, 884, 973	59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	13, 970, 972 2, 898, 745		13, 970, 972 2, 858, 403	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 898, 745		11, 785, 469	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 073, 886	-28, 477	3, 045, 409	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	933, 134		933, 134	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	21, 922 16, 758, 582		21, 922 16, 758, 582	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	33, 059, 192		33, 059, 192	73.00
74.00 07400 RENAL DIALYSIS	0	778, 406		778, 406	74.00
76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON	0	350, 843		0 350, 843	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS				,	
91.00 09100 EMERGENCY	0	10, 657, 737		10, 606, 716	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 PATIENT CARE CENTER - OCC	0	2, 348, 625	5 0	2, 348, 625	92.00 93.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	3, 129, 679	9 0	3, 129, 679	96.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	0	2, 808, 218		2, 808, 218	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	594, 966	214, 898, 498	-520, 889	214, 377, 609	118.00
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	(0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 310, 412	2 0	3, 310, 412	192.00
194. 00 07950 RENTAL SPACE	0	3, 555, 917		3, 555, 917	194.00
194. 01 07951 FOUNDATI ON 194. 02 07952 RETAI L_SERVI CES	0	424, 818 536, 004		424, 818 536, 004	194. 01 194. 02
194. 03 07953 REI D CONTRACTED SERVICES	0	390, 239		390, 239	194. 02
194. 04 07954 REID PHYSICIAN ASSOC.	0	142, 234, 903		142, 234, 903	194.04
194. 05 07955 OTHER NRCC 194. 06 07956 VACANT SPACE	0	244, 046 1, 465, 842		244, 046 1, 465, 842	194. 05 194. 06
194. 08 07958 CAMBRI DGE RHC	0	1, 465, 842		1, 583, 412	194.08
200.00 Cross Foot Adjustments	0	C	0 0	О	200.00
201.00 Negative Cost Centers	0	249 444 001		0	201.00
202.00 TOTAL (sum lines 118-201)	594, 966	368, 644, 091	-520, 889	368, 123, 202	202.00

		HUSPITAL & HEA				u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2016 To 12/31/2016		pared:
			CAP	TAL RELATED C	OSTS	5/25/2017 3:1	5 pm
	Cost Center Description	Directly Assigned New		NEW CAP BLDG & FIXT - OFFSITE		Subtotal	
		Capi tal	TIXI		LOUIT		
		Related Costs					
		0	1.00	1.01	2.00	2A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	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	14, 334	3, 234	27, 636	0	45, 204	4.00
5.01	00540 NONPATIENT TELEPHONES	488	4, 601	C	-	5, 089	5.01
5.02 5.03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	3, 544, 147	15, 166 18, 961	75, 653		3, 634, 966	5.02 5.03
5.03 5.04	00570 ADMITTING	14, 174 26, 065	174		, i	33, 135 156, 404	5.03
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	57,445	987	563, 772		622, 204	5.05
5.06	00590 OTHER A&G	82, 294	30, 395			600, 117	5.06
7.00	00700 OPERATION OF PLANT	123, 839	220, 709			631, 823	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	105, 571	14, 945			120, 516	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	9, 260 198, 431	8, 209 15, 227			17, 469 213, 658	9.00 10.00
10.00	01100 CAFETERI A	190, 431	11, 962		, i	11, 962	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 537	2, 369		-	4, 906	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	341, 858	10, 190	(C	0 0	352, 048	14.00
15.00	01500 PHARMACY	284, 813	8, 809			293, 622	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	38, 945	4, 249			449, 649	1
17. 00 17. 01	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	6, 001 37, 147	1, 504 12, 611			7, 505 49, 758	17.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	37,147	0			49,758	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	13, 218	0			13, 218	22.00
23.00	02300 PARAMED ED PRGM	5, 669	1, 285	185, 161	0	192, 115	23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			-	_		
30.00	03000 ADULTS & PEDIATRICS	405, 021	132, 358			537, 379	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	374, 907 40, 519	29, 746 27, 066			404, 653 67, 585	
41.00	04100 SUBPROVI DER – I RF	40, 499	21, 684		-	62, 183	
43.00	04300 NURSERY	8, 114	3, 248		0 0	11, 362	
	ANCI LLARY SERVI CE COST CENTERS				-		
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	850, 507 50, 532	58, 719 10, 075			1, 813, 680	50.00 52.00
52.00	05400 RADI OLOGY-DI AGNOSTI C	1, 031, 473	73, 638		-	60, 607 1, 215, 655	
59.00	05900 CARDI AC CATHETERI ZATI ON	305, 774	16, 452			322, 226	59.00
60.00	06000 LABORATORY	455, 670	16, 895	(C	0 0	472, 565	60.00
65.00	06500 RESPI RATORY THERAPY	51, 534	1, 995		0 0	53, 529	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	75, 708	9, 794			3, 009, 104	
70.00	07000 ELECTROCARDI OLOGI	138, 014 41, 775	8, 494 0			146, 508 310, 672	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	200,077		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(C	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
74.00 76.00	07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	3, 726	1, 805			5, 531 0	74.00
76.97	07697 CARDI AC REHABI LI TATI ON	26, 805	5, 480		-	32, 285	1
	OUTPATIENT SERVICE COST CENTERS				· · · ·		
91.00	09100 EMERGENCY	169, 409	27, 590	C	0 0	196, 999	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	07 5 (7	10.005	50 546		0	92.00
93.00	04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS	27, 567	10, 825	58, 519	0	96, 911	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	22, 321	2, 149	198, 426	0	222, 896	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	7,380	539		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	9, 033, 491	844, 139	6, 627, 987	0	16, 505, 617	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0) 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	91, 902	302	169, 684		261, 888	
	07950 RENTAL SPACE	217, 931	0	1, 314, 778	3 0	1, 532, 709	
	07951 FOUNDATION	1, 171	250		0		194.01
	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES	0 167	2, 835				194. 02 194. 03
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	1, 664, 268	41, 785	9, 732, 608		11, 438, 661	
	07955 OTHER NRCC	0	645				194.04
194.06	07956 VACANT SPACE	0	1, 678		3 0	1, 187, 811	194.06
	07958 CAMBRI DGE RHC	31, 413	0	(C	0 0	31, 413	194.08
200.00	5		~				200.00
201.00	Negative Cost Centers		0	(0 0	0	201.00

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2016	Worksheet B Part II	
				o 12/31/2016		
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	Directly Assigned New		NEW CAP BLDG & FIXT - OFFSITE		Subtotal	
	Capital Related Costs					
	0	1.00	1.01	2.00	2A	
202.00 TOTAL (sum lines 118-201)	11, 040, 343	891, 634	19, 031, 190	0	30, 963, 167	202.00

Heal th	Fi nanci	ial S	Syste	ems		
		CAD		DEL	ATED	C

<u>leal th Fin</u> ar	ncial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	<u>2552-1</u> 0
	OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0048	Period: From 01/01/2016 Fo 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 3:1	pared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	
CENED		4.00	5.01	5.02	5.03	5.04	
	AL SERVICE COST CENTERS						1 00
1.01 00101 2.00 00200 4.00 00400 5.01 00540 5.02 00550 5.03 00560 5.04 00570 5.05 00580 5.06 00590 7.00 00700 8.00 008000 9.00 009000 11.00 01100 13.00 01300 14.00 01400 15.00 01600 17.00 01700	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATI ENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE INSERVICE EDUCATION I&R SERVICES SALARY & FRINGES APPRVD	45, 204 72 1, 156 261 547 621 1, 942 639 94 437 135 590 119 174 1, 127 624 636 266 93	5, 161 424 56 158 208 208 102 11 11 155 0 32 18 76 120 60 81 0	3, 636, 544 379, 100 55, 75 23, 893 44, 60 (3, 186 4, 77 54, 156 (22, 300 19, 11 133, 80 44, 60 235, 74	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	213, 287 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 17.\ 01\\ 21.\ 01\\ 21.\ 01\\ \end{array}$
	I &R SERVICES-OTHER PRGM. COSTS APPRVD	11	0	(117	0	22.00
	PARAMED ED PRGM	62	5	15, 929	9 109	0	23.00
30.00 03000 31.00 03100 40.00 04000 41.00 04100 43.00 04300	I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY	4, 544 903 958 355 111	401 92 39 56 0	379, 100 55, 75 23, 89 44, 60	1 15, 466 3 4, 213	12, 385 2, 348 3, 182 1, 054 601	31. 00 40. 00
	LARY SERVICE COST CENTERS	400	222	120 50	1 (1 7/0	40 (25	
52.00 05200 54.00 05400 59.00 05900 50.00 06000 55.00 06600 66.00 06600 59.00 07000 70.00 07100 72.00 07200 74.00 07400 76.97 074700 76.97 074700	OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC CARDIAC CATHETERIZATION LABORATORY RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS RENAL DIALYSIS ANCILLARY - OTHER CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	490 150 1, 614 448 1, 001 401 1, 413 250 80 0 0 0 0 0 0 0 55	333 76 269 51 113 11 158 16 12 0 0 0 0 9 0 21	3, 186 (3, 186	2 4, 740 3 43, 208 9 50, 258 7 4, 091 5 11, 002 0 2, 004 1 5, 133 3 366 0 0 0 0 0 0 5 998 0 0 5 998 0 0 0 290	30, 448 225 0 330	65.00 66.00 70.00 71.00 72.00 73.00 74.00 76.00 76.97
91.00 09100		1, 344	144	119, 460	6 14, 136	15, 053	91.00
	OBSERVATION BEDS (NON-DISTINCT PART) PATIENT CARE CENTER - OCC	352	100	62, 122	2 2, 847	1, 415	92.00 93.00
	REIMBURSABLE COST CENTERS		100	02, 12.	2,047	1, 415	73. U
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	264	44	19, 11	5 13, 725	1, 784	96.00
113.0011300 116.0011600 118.00	SUBTOTALS (SUM OF LINES 1-117)	312 24, 651	23 3, 733	4, 779 2, 631, 443		1, 387 213, 287	113.00 116.00 118.00
190. 00 19000 192. 00 19200 194. 00 07950 194. 01 07951 194. 02 07952 194. 03 07953 194. 04 07954 194. 05 07955 194. 06 07956	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES RENTAL SPACE FOUNDATION RETAIL SERVICES REID CONTRACTED SERVICES REID PHYSICIAN ASSOC. OTHER NRCC VACANT SPACE CAMBRIDGE RHC Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118-201)	0 0 46 31 66 20, 120 0 0 290 0 45, 204	0 114 171 0 0 0 1,131 0 0 0 0 0 5,161	(1, 59; 9, 55 57, 34; (936, 60 (((3, 636, 54;	1,676 1 1 4 66 0 9 42,264 0	0 0 0 0 0 0 0 0 0	190.00 192.00 194.00 194.02 194.03 194.03 194.04 194.08 200.00 201.00

Heal th	Fi nar	nci al	Syste	ems		
				DEI	ATED	0

	Cost Center Description	CASHI ERI NG/ACC	OTHER A&G		rom 01/01/2016 o 12/31/2016	Part II Date/Time Pre 5/25/2017 3:1 HOUSEKEEPING	
	cost center bescription	OUNTS RECEI VABLE		PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.05	5.06	7.00	8.00	9.00	
I. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
l. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02 5.03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5.02 5.03
5.03 5.04	00570 ADMITTING						5.03
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	647, 594					5.05
5.06	00590 OTHER A&G	0	649, 531				5.06
7.00	00700 OPERATION OF PLANT	0	10, 701	647, 361			7.00
3.00	00800 LAUNDRY & LINEN SERVICE	0	1, 389	12, 857			8.00
9.00	00900 HOUSEKEEPI NG	0	4, 254	6, 765		39, 865	9.00
0.00	01000 DI ETARY	0	1, 672	11, 502		694	10.00
1.00		0	3, 208	10, 291		0	11.00
3.00 4.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	1, 320 7, 486	2, 038 8, 767		1, 659 55	13.00 14.00
14.00	01500 PHARMACY	0	60, 473	7, 338		0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	9, 618			246	16.00
7.00	01700 SOCIAL SERVICE	0	5, 985	457		152	17.00
7.01	01701 INSERVICE EDUCATION	0	5, 094	9, 717		387	17.01
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	689	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	217	0	-	0	22.00
23.00	02300 PARAMED ED PRGM	0	960	2, 926	0	0	23.00
0 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	27 501	42.070	110 710	24.004	11 700	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	37, 581 7, 123	43, 079 11, 677	112, 718 25, 591		11, 730 2, 607	30.00 31.00
10.00	04000 SUBPROVIDER - IPF	9,656	8, 158			1, 819	
11.00	04100 SUBPROVIDER - IRF	3, 197	3, 579	18, 656		1, 327	41.00
13.00	04300 NURSERY	1, 823	1, 057	2, 795		50	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	123, 714	51, 630	42, 344	24, 995	3, 350	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 456	2, 339	8, 668		860	
54.00	05400 RADI OLOGY-DI AGNOSTI C	100, 409	28, 935	45, 779		1, 938	54.00
59.00 50.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	64, 829 66, 337	13, 306 22, 284	4, 787 14, 149		514 1, 982	59.00 60.00
55.00	06500 RESPI RATORY THERAPY	13, 147	4, 518	1, 245		340	1
6.00	06600 PHYSI CAL THERAPY	14, 752	19, 285	50, 262		310	
69.00	06900 ELECTROCARDI OLOGY	19, 596	4, 447	581		688	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 273	1, 480	5, 629	327	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123	4	0	-	301	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	22, 912	29, 181	0		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	92, 389	2,828			395	
74.00 76.00	07400 RENAL DI ALYSI S 03950 ANCI LLARY – OTHER	684	1, 274	1, 553		495 0	74.00 76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1,000	560	0	-	147	76.97
0. 77	OUTPATIENT SERVICE COST CENTERS	1,000					/0. //
91.00	09100 EMERGENCY	45, 677	14, 380	23, 736	16, 688	4, 055	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040 PATIENT CARE CENTER - OCC	4, 294	3, 865	422	1, 464	500	93.00
	OTHER REIMBURSABLE COST CENTERS	5 44	4.050	0.011		0.0	
76.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	5, 414	4, 859	3, 911	0	28	96.00
12 00	11300 INTEREST EXPENSE	T T		[113.00
	11600 HOSPI CE	4, 208	4, 536	0	0	315	116.00
18. OC		647, 594	390, 327	459, 981	Ű	36, 944	
	NONREI MBURSABLE COST CENTERS						
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	5, 700	2, 560	7, 804		192.00
	07950 RENTAL SPACE	0	5, 879	23, 369			194.00
		0	731	215			194.01
94.02	07952 RETAIL SERVICES	0	924	713			194.02
	07953 REID CONTRACTED SERVICES	0	674 240 511	125 209	-		194.03
	07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	0	240, 511	135, 298			194. 04 194. 05
	07955 OTHER NRCC 07956 VACANT SPACE		2, 175	555 24, 670			194.05
	07958 CAMBRIDGE RHC		2, 175	24, 670	0		194.00
200. 00			2,009			0	200.00
		1		-	_		
201. 00	Negative Cost Centers	0	0	0	0	0	201.00

Heal th	Fina	nci	al	Syste	ems		
		OF	C۸		DEL	ATED	C

Heal th Finar	ncial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION (OF CAPITAL RELATED COSTS		Provider C		eriod: fom 01/01/2016 0 12/31/2016	Worksheet B Part II Date/Time Pre 5/25/2017 3:1	pared: 5 pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	AL SERVICE COST CENTERS			1			1 00
1.01 00101 2.00 00200 4.00 00400 5.01 00540 5.02 00550 5.03 00560 5.04 00570 5.05 00580 5.06 00590 7.00 00700 8.00 00800 11.00 01100 13.00 01300 14.00 01400 15.00 01500 16.00 01600 17.00 01700 17.00 01700 12.00 02100 22.00 02200 23.00 02300	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATI ENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE INSERVICE EDUCATION I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM	286, 075 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26, 051 47 282 833 865 0 234 77 16 35	32, 574 0	430, 315 506 0 14 0 0 14 0 0	459, 273 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 12.\ 00\\ 22.\ 00\\ 23.\ 00\end{array}$
30.00 03000 31.00 03100 40.00 04000 41.00 04100	I ENT ROUTI NE SERVICE COST CENTERS ADULTS & PEDIATRICS I NTENSI VE CARE UNI T SUBPROVI DER - I PF SUBPROVI DER - I RF NURSERY	169, 931 26, 246 58, 858 19, 748 11, 292	3, 715 719 925 296 74	2, 305 5 2, 968 5 948	259 390 0 0 2	59 75 12 8 0	30.00 31.00 40.00 41.00 43.00
50.00 05000 52.00 05200 54.00 05400 59.00 05900 60.00 06000 65.00 06500 66.00 06600 69.00 06900 70.00 07000 71.00 07100 73.00 07300 74.00 03950 76.07 07697	LARY SERVICE COST CENTERS OPERATING ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC CARDIAC CATHETERIZATION LABORATORY RESPIRATORY THERAPY PHYSICAL THERAPY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS RENAL DIALYSIS ANCILLARY - OTHER CARDIAC REHABILITATION TIENT SERVICE COST CENTERS		1, 208 100 1, 275 336 1, 027 328 1, 107 204 68 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	319 4,089 1,078 1,078 1,053 1,053 0 <	206, 769 123 372 157, 494 24, 919 136 31 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 385 0 7, 876 1 459 0 3, 495 0 3, 495 0 0 408, 351 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	70.00 71.00 72.00 73.00
91.00 09100 92.00 09200 93.00 04040		0	1, 129		27 0	283 185	92.00
96.00 09600 SPECI	DURABLE MEDICAL EQUIP-RENTED AL PURPOSE COST CENTERS	0	339		24, 579	0	
116. 00 11600 118. 00	I NTEREST EXPENSE HOSPI CE SUBTOTALS (SUM OF LINES 1-117) I MBURSABLE COST CENTERS	0 286, 075	276 15, 918		25 415, 646	1, 722 423, 912	113.00 116.00 118.00
190. 00 19000 192. 00 19200 194. 00 07950 194. 01 07951 194. 03 07953 194. 04 07954 194. 05 07955 194. 06 07955	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES RENTAL SPACE FOUNDATION RETAIL SERVICES REID CONTRACTED SERVICES REID PHYSICIAN ASSOC.	0 0 0 0 0 0 0 0 0 0 0 0 0 286, 075	0 51 46 106 9, 751 0 179 26, 051		0 0 0 0 14, 669 0 0 0 430, 315	0 0 0 34, 611 0 750	194. 05 194. 06 194. 08 200. 00 201. 00

Health Fi	nancial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	ON OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0048 P F	Period: From 01/01/2016 To 12/31/2016		pared: 5 pm
					INTERNS &	RESIDENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM.COSTS	
		16.00	17.00	17.01	21.00	22.00	
GE	NERAL SERVICE COST CENTERS						
1.01 00 ² 2.00 002 4.00 004	100 NEW CAP REL COSTS-BLDG & FIXT 101 NEW CAP BLDG & FIXT - OFFSITE 200 NEW CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 540 NONPATIENT TELEPHONES						1.00 1.01 2.00 4.00 5.01
. 03 00!	550 DATA PROCESSING 560 PURCHASING RECEIVING AND STORES 570 ADMITTING						5. 02 5. 03 5. 04
. 06 00!	580 CASHI ERI NG/ACCOUNTS RECEI VABLE 590 OTHER A&G 700 OPERATI ON OF PLANT						5.05 5.06 7.00
. 00 008 . 00 009	800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG						8. 00 9. 00
1.00 01	000 DI ETARY 100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON						10.00 11.00 13.00
4.00 014 5.00 01	400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY						14.00 15.00
7.00 01	600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 701 I NSERVI CE EDUCATI ON	596, 542 0 0	59, 685 0	301, 869			16.00 17.00 17.01
2.00 02	100 I&R SERVICES-SALARY & FRINGES APPRVD 200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 300 PARAMED ED PRGM	0		0 0 1, 965)	13, 579	21.00 22.00 23.00
	PATIENT ROUTINE SERVICE COST CENTERS	0	0	1, 703			20.00
1.00 03	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	34, 645 6, 567	7, 678	16, 857	7		30.00
1. 00 04 [.]	000 SUBPROVI DER – I PF 100 SUBPROVI DER – I RF 300 NURSERY	8, 902 2, 948 1, 680	0		Ļ		40.00 41.00 43.00
	CILLARY SERVICE COST CENTERS	440 507			,'		1 50 00
2.00 05	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	113, 597 5, 030 92, 563		1, 465	5		50.00 52.00 54.00
0. 00 060	900 CARDI AC CATHETERI ZATI ON 000 LABORATORY 500 RESPI RATORY THERAPY	59, 763 61, 153 12, 120	0	4, 395 12, 299 6, 004			59.00 60.00 65.00
6.00 06 9.00 06	600 PHYSI CAL_THERAPY 900 ELECTROCARDI OLOGY	12, 120 13, 599 18, 065	0 0	13, 352 2, 778	2		66. 00 69. 00
1.00 07	000 ELECTROENCEPHALOGRAPHY 100 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENT	3, 017 113 21, 122	0				70.00
3.00 073 4.00 074	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS	85, 170 630	0 0	0 405	5		73.00 74.00
6.97 07	950 ANCILLARY - OTHER 697 CARDIAC REHABILITATION TPATIENT SERVICE COST CENTERS	0 922	0	0 679		L	76.00 76.9
2.00 093	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART) 040 PATIENT CARE CENTER - OCC	42, 108 3, 958					91.00 92.00 93.00
0TH 6.00 090	HER REIMBURSABLE COST CENTERS 600 DURABLE MEDICAL EQUIP-RENTED	4, 991	0				96.00
13.00113 16.00110	ECIAL PURPOSE COST CENTERS 300 INTEREST EXPENSE 600 HOSPICE	3, 879		2, 829			113. 00 116. 00
	SUBTOTALS (SUM OF LINES 1-117) NREIMBURSABLE COST CENTERS 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	596, 542				0	118. 00
92. 00 192 94. 00 079	200 PHYSI CI ANS' PRI VATE OFFI CES 950 RENTAL SPACE	0	0	0			192.00 194.00
94.02079 94.03079	951 FOUNDATI ON 952 RETAI L SERVI CES 953 REI D CONTRACTED SERVI CES	0	0	79 161 0			194. 01 194. 02 194. 03
94. 05 07	954 REID PHYSICIAN ASSOC. 955 OTHER NRCC 956 VACANT SPACE	0	0	81, 317 23, 775 0	5		194. 04 194. 05 194. 06
74. UUU/	958 CAMBRIDGE RHC	0	0	3, 334			194.08
94.08079 200.00 201.00	Cross Foot Adjustments Negative Cost Centers				859		200.00

	cial Systems REID DF CAPITAL RELATED COSTS	HOSPI TAL & HEAL		CN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-255 Worksheet B Part II Date/Time Prepar 5/25/2017 3:15 p
	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	<u>- 572572017 5. 15 p</u>
		23.00	24.00	25.00	26.00	
.00 00100 .01 00100 .00 00200 .00 00400 .01 00540 .02 00550 .03 00560 .04 00570 .05 00580 .06 00700 .00 00700 .00 00400 .00 01000 1.00 01100 3.00 01300 4.00 01400 5.00 01500 6.00 01600 7.01 01700 7.01 01701 1.00 02100	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE INSERVICE SOLARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM	214, 110				1 1 2 2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
I NPAT	ENT ROUTINE SERVICE COST CENTERS	211,110		1		
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT		1, 522, 897 596, 074		0 1, 522, 897 0 596, 074	30
	SUBPROVIDER - IPF		236, 779		0 236, 779	40
	SUBPROVIDER - IRF		170, 152		0 170, 152	41
	NURSERY LARY SERVICE COST CENTERS		40, 108	3	0 40, 108	43
	OPERATI NG ROOM		2, 632, 721		0 2, 632, 721	50
	DELIVERY ROOM & LABOR ROOM		143, 019		0 143,019	52
	RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON		1, 846, 009 716, 780		0 1, 846, 009 0 716, 780	54
	LABORATORY		803, 234		0 803, 234	60
	RESPI RATORY THERAPY		127, 741		0 127, 741	65
	PHYSI CAL THERAPY		3, 296, 977		0 3, 296, 977	66
	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		286, 270 339, 240		0 286, 270 0 339, 240	69
	MEDICAL SUPPLIES CHARGED TO PATIENTS		582		0 582	71
	IMPL. DEV. CHARGED TO PATIENT		80, 766		0 80, 766	72
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS		619, 581 14, 590		0 619, 581 0 14, 590	73
	ANCILLARY - OTHER		(0 0	76
			39, 697	7	0 39, 697	76
	TIENT SERVICE COST CENTERS		534, 244	1	0 534, 244	91
	OBSERVATION BEDS (NON-DISTINCT PART)				0	92
	PATIENT CARE CENTER - OCC		182, 219	2	0 182, 219	93
	REI MBURSABLE COST CENTERS DURABLE MEDI CAL EQUI P-RENTED		303, 134	1	0 303, 134	96
	AL PURPOSE COST CENTERS		303, 13-	T	0 303, 134	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	INTEREST EXPENSE					113
16.0011600 18.00	SUBTOTALS (SUM OF LINES 1-117)	0	43, 948 14, 576, 762		0 43, 948 0 14, 576, 762	11 <i>6</i> 118
	IMBURSABLE COST CENTERS	<u> </u>	14, 370, 702	-	0 14, 370, 702	110
90.0019000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		(0 0	190
	PHYSICIANS' PRIVATE OFFICES		279, 868		0 279, 868	192
	RENTAL SPACE FOUNDATI ON		1, 563, 804 12, 178		0 1, 563, 804 0 12, 178	194 194
94.0207952	RETAIL SERVICES		62, 120		0 62, 120	194
94. 03 07953	REID CONTRACTED SERVICES		1, 013	3	0 1, 013	194
	REID PHYSICIAN ASSOC.		12, 959, 610		0 12, 959, 610	194
	OTHER NRCC VACANT SPACE		24, 976 1, 214, 656		0 24,976 0 1,214,656	194 194
	CAMBRI DGE RHC		39, 632		0 1, 214, 030	194
	Cross Foot Adjustments	214, 110	228, 548		0 228, 548	200
00. 00 01. 00	Negative Cost Centers				0 0	201

In Lieu	u of Form CMS-2552-10
riod:	Worksheet B-1
0m 01/01/2016 12/31/2016	Date/Time Prepared:

CUST ALLUCA	HIUN - STATISTICAL BASIS		Provider Co	1	From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description		TAL RELATED CO		EMPLOYEE	NONPATI ENT	
		FIXT (SQUARE FEET)	FIXT - OFFSITE	EQUI P (SQUARE FEET)		TELEPHONES (PHONES)	
		1.00	(SQUARE FEET)		(GROSS SALARI ES)	5.01	
GENER	RAL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	5.01	
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	735, 942					1.00
	1 NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP	0	275, 456		D		1.01 2.00
	EMPLOYEE BENEFITS DEPARTMENT	2, 669 3, 798	400		0 152, 468, 514 243, 262		4.00 5.01
5.02 00550	DATA PROCESSING	12, 518	1, 095		3, 904, 861	2, 733	5. 02
	D PURCHASING RECEIVING AND STORES	15, 650 144	0 1, 884		0 882, 963 0 1, 846, 331	32	•
5.05 00580	CASHI ERI NG/ACCOUNTS RECEI VABLE	815	8, 160		2, 098, 759		5.05
	O OTHER A&G O OPERATI ON OF PLANT	25, 088 182, 168	7, 055 4, 158		0 6, 560, 962 0 2, 159, 339		•
	LAUNDRY & LINEN SERVICE HOUSEKEEPING	12, 335 6, 776	0		0 317, 181 0 1, 474, 789	6	
10.00 01000	D DI ETARY	12, 568	0		0 454, 501	88	10.00
	D CAFETERIA D NURSI NG ADMI NI STRATI ON	9, 873 1, 955	0		0 1, 992, 897 0 402, 656	0	
14.00 01400	CENTRAL SERVICES & SUPPLY	8, 411	0		588, 438	10	14.00
) PHARMACY MEDICAL RECORDS & LIBRARY	7, 271 3, 507	0 5, 883		0 3, 808, 036 0 2, 107, 005		
	SOCIAL SERVICE	1, 241 10, 409	0		2, 148, 342 899, 005		
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		314, 039	0	21.00
	I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM	0 1, 061	0 2, 680		0 38, 332 0 210, 364		
I NPAT	FIENT ROUTINE SERVICE COST CENTERS						
	DADULTS & PEDIATRICS DINTENSIVE CARE UNIT	109, 246 24, 552	0 0		0 15, 350, 822 0 3, 052, 332		
	SUBPROVI DER – I PF SUBPROVI DER – I RF	22, 340 17, 898	0		0 3, 235, 157 0 1, 199, 857		•
43.00 04300	NURSERY	2, 681	0		0 1, 199, 857 0 375, 865		
	LARY SERVICE COST CENTERS	48, 466	13, 091		0 1, 655, 346	189	50.00
	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	8, 316	0		505, 975	43	•
59.00 05900	CARDI AC CATHETERI ZATI ON	60, 780 13, 579	1, 600 0		0 5, 451, 506 0 1, 512, 286		
) LABORATORY D RESPI RATORY THERAPY	13, 945 1, 647	0		0 3, 380, 403 0 1, 354, 264	64	
66.00 06600	PHYSI CAL THERAPY	8, 084	42, 316		0 4, 773, 665	90	66.00
	D ELECTROCARDI OLOGY D ELECTROENCEPHALOGRAPHY	7, 011 0	0 3, 892		0 843, 272 0 271, 168		•
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0			0	73.00
	DRENAL DIALYSIS DANCILLARY - OTHER	1, 490	0			5	
76.97 07693	7 CARDI AC REHABI LI TATI ON	4, 523	0		185, 409		
91.00 09100	ATLENT SERVICE COST CENTERS	22, 772	0		0 4, 540, 138	82	91.00
	OBSERVATION BEDS (NON-DISTINCT PART) PATIENT CARE CENTER - OCC	8, 935	847		0 1, 188, 146	57	92.00 93.00
OTHER	R REIMBURSABLE COST CENTERS						
	DURABLE MEDICAL EQUIP-RENTED AL PURPOSE COST CENTERS	1, 774	2, 872		0 892, 767	25	96.00
113.00 11300	INTEREST EXPENSE	445	0		1 050 770	10	113.00
116. 00 11600 118. 00	SUBTOTALS (SUM OF LINES 1-117)	445 696, 741	0 95, 933		0 1, 052, 772 0 83, 273, 212		116. 00 118. 00
	IMBURSABLE COST CENTERS	0	0		0 0	0	190. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	249	2, 456		0	65	192.00
	D RENTAL SPACE 1 FOUNDATI ON	0 206	19, 030 0		0 0 0 154,627		194. 00 194. 01
194.0207952	2 RETALL SERVICES	2, 340	0		0 104, 987	0	194. 02 194. 03
194.04 07954	3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC.	0 34, 489	0 140, 869		223, 291 67, 731, 467	644	194.04
	5 OTHER NRCC 5 VACANT SPACE	532 1, 385	0 17, 168				194. 05 194. 06
194.0807958	B CAMBRI DGE RHC	0	0		980, 930		194. 08
200.00	Cross Foot Adjustments						200.00

Heal th F	inancial Systems RELD	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		CAP	ITAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG &	NEW CAP BLDG &	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		FLXT	FIXT - OFFSITE	EQUI P	BENEFI TS	TELEPHONES	
		(SQUARE FEET)		(SQUARE FEET)) DEPARTMENT	(PHONES)	
			(SQUARE FEET)		(GROSS		
					SALARI ES)		
		1.00	1.01	2.00	4.00	5. 01	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	891, 634	19, 031, 190		0 19, 560, 662	299, 545	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 211555	69. 089764	0. 00000	0 0. 128293	102. 129219	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				45, 204	5, 161	204.00
205.00	Unit cost multiplier (Wkst. B, Part				0. 000296	1. 759632	205.00

	HOSPI TAL & HEA	ALTH CARE SERVIC			u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	paro 5 pi
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/ACC		
	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	
GENERAL SERVICE COST CENTERS	1	1		1		4
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						
1.01 00101 NEW CAP BLDG & FIXT - OFFSITE						
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						:
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						
5. 01 00540 NONPATI ENT TELEPHONES	2 202					
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASING RECEIVING AND STORES	2, 283					
			01 700 227	0		
5. 04 00570 ADMI TTI NG 5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	35		733, 037, 48			
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06 00590 OTHER A&G	28			0 733, 037, 489	-13, 909, 499	
7.00 00700 OPERATION OF PLANT	20			0 0 0 0	-13, 909, 499	
8.00 00800 LAUNDRY & LINEN SERVICE	0	94, 018 2, 673		0 0	0	
9. 00 00900 HOUSEKEEPING	2	141, 160		0 0	0	
10. 00 01000 DI ETARY	34			0 0	0	
11. 00 01100 CAFETERIA	0				0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	14	-		0 0	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	14			0 0	0	
15. 00 01500 PHARMACY	40				0	
16. 00 01600 MEDICAL RECORDS & LIBRARY	84			0 0	0	
17. 00 01700 SOCIAL SERVICE	28			0 0	0	
17. 01 01701 I NSERVI CE EDUCATI ON	148			0 0	0	
21. 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			0 0	0	1
22. 00 02200 I & SERVICES-OTHER PRGM. COSTS APPRVD	0			0 0	0	
23. 00 02300 PARAMED ED PRGM	10	_,		0 0	0	
INPATIENT ROUTINE SERVICE COST CENTERS	1	_,				1
30. 00 03000 ADULTS & PEDI ATRI CS	238	614, 761	42, 561, 08	1 42, 561, 081	0	3
31.00 03100 I NTENSI VE CARE UNI T	35		8,067,31		0	
40. 00 04000 SUBPROVIDER - IPF	15	96, 698	10, 935, 90	0 10, 935, 900	0	4
41. 00 04100 SUBPROVIDER - IRF	28		3, 621, 10		0	4
43. 00 04300 NURSERY	0		2,064,02		0	4
ANCILLARY SERVICE COST CENTERS			· · ·			1
50. 00 05000 OPERATI NG ROOM	87	1, 417, 628	139, 739, 61	6 139, 739, 616	0	5
52.00 05200 DELIVERY ROOM & LABOR ROOM	32	108, 781	6, 179, 40	6, 179, 408	0	5
54. 00 05400 RADI OLOGY-DI AGNOSTI C	152	991, 682	113, 713, 55	2 113, 713, 552	0	5
59. 00 05900 CARDI AC CATHETERI ZATI ON	10	1, 153, 503	73, 418, 81	2 73, 418, 812	0	5
60. 00 06000 LABORATORY	58	93, 897	75, 126, 86	7 75, 126, 867	0	6
65. 00 06500 RESPI RATORY THERAPY	12		14, 889, 33		0	
66. 00 06600 PHYSI CAL THERAPY	104	46, 006	16, 706, 62		0	6
69. 00 06900 ELECTROCARDI OLOGY	49		22, 193, 02		0	1 ~
70. 00 07000 ELECTROENCEPHALOGRAPHY	8		3, 706, 27		0	1 .
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	139 30	7 139 307	0	17

516 408 552 812 867 333 624 021 273 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 139, 307 139, 307 0 0 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 2 0 25, 948, 285 25, 948, 285 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 C 104, 630, 900 104, 630, 900 74.00 07400 RENAL DIALYSIS 13, 734 774, 296 774, 296 76.00 03950 ANCI LLARY - OTHER 0 C 0 07697 CARDI AC REHABI LI TATI ON 2 6, 659 1, 133, 033 76.97 1, 133, 033 OUTPATIENT SERVICE COST CENTERS 91.00 75 09100 EMERGENCY 324, 447 51, 729, 372 51, 729, 372 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC 93.00 39 65, 346 4,862,916 4,862,916 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 12 315, 021 6, 131, 063 6, 131, 063 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 3 269, 410 4, 765, 392 4, 765, 392 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 733, 037, 489 733, 037, 489 118.00 1,652 8, 429, 521 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 Ω 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 1 4,808 0 0 0 0 0 0 0 0 38, 475 0 194.00 07950 RENTAL SPACE 0 0 194. 01 07951 FOUNDATI ON 6 257 0 194. 02 07952 RETAIL SERVICES 36 1, 522 194.03 07953 REID CONTRACTED SERVICES 0 0 0 194.04 07954 REID PHYSICIAN ASSOC. 588 970, 020

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24, 262

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Cross Foot Adjustments

Negative Cost Centers

194.05 07955 OTHER NRCC

200.00

201.00

194.06 07956 VACANT SPACE

194.08 07958 CAMBRI DGE RHC

0 71.00

0 72.00

0 73.00

0 74.00

0 76.00

0 76.97

0

0 93.00

0 96.00

-13, 909, 499 118.00

91.00

92.00

113.00

0 116.00

0 190.00

0 192.00

0 194.00

0 194.01

0 194.02

0 194.03

0 194.04

0 194.05

0 194.06

0 194.08

200.00

201.00

		HOSPITAL & HEA			-	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	5/25/2017 3:1	5 pm
	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	
202.00	Cost to be allocated (per Wkst. B,	23, 394, 318	3, 834, 869	3, 799, 25	6 7, 019, 846		202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	10, 247. 182654	0. 404998	0.00518	3 0.009576		203.00
204.00	Cost to be allocated (per Wkst. B,	3, 636, 546	412, 558	213, 28	7 647, 594		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1, 592. 880420	0. 043570	0. 00029	1 0. 000883		205.00
	11)						

Heal th	Fi nanci al	Systems	
COST A			

<u>Heal th</u>	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016 o 12/31/2016		
	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		5.06	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1	1	1	1	1	
13.00 14.00 15.00 16.00 17.00 17.01 21.00 22.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFTERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01700 I& SERVICES-SALARY & FRINGES APPRVD 02200 I& SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	354, 734, 592 5, 844, 403 758, 796 2, 323, 566 913, 432 1, 751, 867 720, 848 4, 088, 275 33, 027, 372 5, 253, 117 3, 268, 848 2, 782, 321 376, 104 118, 509 524, 431	8, 411 7, 040 1, 162	1, 931, 816 0 0 0 49, 171 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 422 251 0 20 0 89 55 140 0 0	51, 326 0 0 0 0 0 0 0 0 0 0 0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00
31.00 40.00 41.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	23, 527, 577 6, 377, 400 4, 455, 437 1, 954, 572 577, 532	108, 140 24, 552 22, 340 17, 898 2, 681	126, 204 112, 029	943 658	4, 709 10, 560 3, 543	31.00 40.00 41.00
$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 59.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 00\\ \end{array}$	ANCI LLARY SERVI CE COST CENTERS 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 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER 07607 CARDI AC REHABI LI TATI ON	28, 197, 810 1, 277, 368 15, 802, 793 7, 267, 228 12, 170, 222 2, 467, 736 10, 532, 608 2, 428, 919 808, 492 2, 056 15, 937, 238 1, 544, 247 695, 869 0 305, 945	8, 316 43, 920 4, 593 13, 574 1, 194 48, 220 557 5, 400 0	0 123, 835 0 98, 769 0 15, 067 0 4, 578 0 0 0 0	311 701 186 717 123 112 249 0 0 109		$\begin{array}{c} 52.\ 00\\ 54.\ 00\\ 59.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ \end{array}$
92.00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 PATIENT CARE CENTER - OCC	7, 853, 845			1, 467		92.00
	OF OF OF ATTENT CARE CENTER - OCC OTHER REI MBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	2, 653, 916			1	1	1
	11300 I NTEREST EXPENSE 11600 HOSPI CE	2, 477, 361 213, 178, 956	0 441, 296	0 1, 797, 512	114 13, 365		113. 00 116. 00 118. 00
192.00 194.00 194.02 194.03 194.04 194.05 194.06 194.08	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC 07955 VACANT SPACE 07958 CAMBRIDGE RHC	0 3, 112, 977 3, 210, 769 399, 135 504, 560 368, 012 131, 347, 002 645 1, 187, 811 1, 424, 725	0 2, 456 22, 420 206 684 0 129, 804 532 23, 668 0	109, 115 0 0 0 0 25, 189 0	0 0 20 0 0	0 0 0 0 0 0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 08
200. 00 201. 00 202. 00	Negative Cost Centers	13, 909, 499	6, 073, 568	909, 176	2, 478, 142	1, 100, 292	200. 00 201. 00 202. 00

Health Financial Systems	REI D	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CO		Period: From 01/01/2016	Worksheet B-1	
					o 12/31/2016		
Cost Center Description		OTHER A&G	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
			(SQUARE FEET)	(POUNDS OF	SERVI CE)		
				LAUNDRY)			
		5.06	7.00	8.00	9.00	10.00	
203.00 Unit cost multiplier (Wkst.	B, Part I)	0. 039211	9. 779263	0. 470633	171. 830675	21. 437322	203.00
204.00 Cost to be allocated (per W Part II)	kst. B,	649, 531	647, 361	138, 169	39, 865	286, 075	204.00
205.00 Unit cost multiplier (Wkst.	B, Part	0. 001831	1. 042338	0. 071523	2. 764180	5. 573686	205. 00

Heal th	Fi nanci al	Systems	
COST A			

alth Financial Systems REID DST ALLOCATION - STATISTICAL BASIS	HUSPITAL & HEF	ALTH CARE SERVI Provider C	CN: 15-0048 F	Period:	u of Form CMS- Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
Cost Center Description	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (MED SUPPLI ES)	PHARMACY (DRUGS)	MEDI CAL RECORDS & LI BRARY (TOTAL	
	11.00	NURSING HRS)	14.00	15.00	REVENUE)	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS 00 00100 NEW CAP REL COSTS-BLDG & FIXT 0 01 00101 NEW CAP REL COSTS-BLDG & FIXT 0 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT 01 00540 NONPATI ENT TELEPHONES 02 00550 DATA PROCESSING 03 00560 PURCHASING RECEIVING AND STORES 04 00570 ADMITTING 05 00580 CASHI ERING/ACCOUNTS RECEIVABLE 06 00590 OTHER A&G 00 00700 OPERATION OF PLANT 00 00500 LAUNDRY & LINEN SERVICE 0 00 00500 HERING/ACCOUNTS RECEIVABLE 00 001000 DIETARY 0 0 00 01400 CAFETERIA 8 00 01400 <t< td=""><td>3, 780, 745 6, 808 40, 998 121, 714 125, 540 0 33, 974 11, 186 2, 386 5, 589</td><td>1,474,148 0</td><td>20, 399, 326 23, 975 (672 (0 (0 (0 (0 (0)</td><td>5 29, 749, 872 7 0 2 17 0 0 0 0 0 0</td><td>733, 037, 489 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>) 17. () 17. () 21. () 22. (</td></t<>	3, 780, 745 6, 808 40, 998 121, 714 125, 540 0 33, 974 11, 186 2, 386 5, 589	1,474,148 0	20, 399, 326 23, 975 (672 (0 (0 (0 (0 (0)	5 29, 749, 872 7 0 2 17 0 0 0 0 0 0	733, 037, 489 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0) 17. () 17. () 21. () 22. (
INPATI ENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0.00 03100 INTENSIVE CARE UNIT 0.00 04000 SUBPROVIDER - IPF 0.00 04100 SUBPROVIDER - IRF 0.00 04300 NURSERY	539, 189 104, 296 134, 302 42, 922 10, 753	2 104, 296 2 134, 302 2 42, 922	18, 487 (7 4, 840 0 763 0 500	42, 561, 081 8, 067, 312 10, 935, 900 3, 621, 102 2, 064, 024	2 31. (40. (41. (
ANCI LLARY SERVICE COST CENTERS	175, 257 14, 449 185, 031 48, 778 149, 082 47, 641 160, 609 29, 574 9, 816 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 449 185, 031 48, 778 0 48, 778 0 47, 641 0	5, 835 17, 650 7, 465, 927 1, 181, 267 6, 44 1, 459 8 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5 27 510, 195 7 40 7 65 9 0 8 29, 723 9 0 8 226, 362 0 0 0 0 0 0 0 26, 451, 519 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	139, 739, 616 6, 179, 408 113, 713, 552 73, 418, 812 75, 126, 867 14, 889, 333 16, 706, 624 22, 193, 021 3, 706, 273 139, 307 25, 948, 285 104, 630, 900 774, 296 0 1, 133, 033	52.0 54.0 55.0 59.0 60.0 65.0 65.0 66.0 69.0 70.0 71.0 72.0 73.0 74.0 76.0
OO 09100 EMERGENCY OO 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) O0 04040 PATIENT CARE CENTER - OCC OTHER REIMBURSABLE COST CENTERS	163, 879 49, 414				51, 729, 372 4, 862, 916	92.
00 09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	49, 165	0	1, 165, 166	5 O	6, 131, 063	
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 HOSPI CE 8. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	40, 010 2, 310, 013		1, 176 19, 703, 966		4, 765, 392 733, 037, 489	
NUME INDUCES CONTEND 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 02 00 19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 02 00 7950 RENTAL SPACE 04 01 07951 FOUNDATION 04 02 07952 RETAL SERVICES 04 02 07953 REID CONTRACTED SERVICES 04 04 07954 REID PHYSICIAN ASSOC. 04 06 07955 OTHER NRCC 04 06 07958 CAMBRIDGE RHC 04 08 07958 CAMBRIDGE RHC 00 00 Cross Foot Adjustments 01 00 Negative Cost Centers	C 2 2 7, 466 6, 626 15, 376 1, 415, 289 C C 25, 973		695, 360 () () () () () () () () () () () () ()	0 0 0 0 0 0 0 0 0 2, 241, 904 0 0		190. 192. 194. 194. 194. 194. 194. 194. 194. 194

Heal th Fi	nancial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016		
		1			To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
	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	
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 917, 110	874, 781	4, 378, 20	0 34, 458, 118	5, 549, 420	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 507072	0. 593415	0. 21462	1. 158261	0.007570	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	26, 051	32, 574	430, 31	5 459, 273	596, 542	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 006890	0. 022097	0. 02109	0. 015438	0. 000814	205.00

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

HTTPME Part 2012/2026 Electric Prepared (Display 2012) Electric Prepared (Display 2012) Dest Center Reserviption SCIAL SPRICE (THE SPFUT) HTRENG A RESIGNES (Display 2012) Paskact PF (Display 2012) 0 00001 http: Coll Cathles (Display 2012) 77.00 17.01 21.00 22.00 20.00 1 00001 http: Coll Education (Display 2012) 0.01	COST ALLOCATION - STATISTICAL BASIS		Provider C	Provi der CCN: 15-0048 Peri od:		Worksheet B-1	
Cost Center Description SOCIAL SERVEC (THE SERVE) LINEGRICE (SECOND SECONDS - ACCOUNTS - ONLY THE SERVED PARAMELED (SECONDS - ONLY SECONDS - ONLY THE SERVED PARAMELED (SECONDS - ONLY SECONDS - ONLY SE					From 01/01/2016 To 12/31/2016		
Intervention Intervention PARK (CSF) PRAK (CSF) PRA				I NTERNS 8	RESI DENTS	572572017 3:1	5 pm
Intervention Intervention PARK (CSF) PRAK (CSF) PRA	Cost Center Description	SOCIAL SERVICE	I NSERVI CE	SERVI CES-SALA	RISERVI CES-OTHER	PARAMED ED	
Low Little Little <thlittle< th=""> <thlittle< th=""></thlittle<></thlittle<>			EDUCATI ON	Y & FRINGES	PRGM. COSTS	PRGM	
EBBORL SERVICE COST CENTERS 1.00 100 00100 MER AP REL COST CENTERS FERTING 1.00 100 00100 MER AP REL COST CENTERS 5.01 100 00100 MER AP REL COST CENTERS 5.02 100 00100 MER AP REL COST CENTERS 6.040 100 00100 MER AP REL COST CENTERS 6.040 100 00100 MER AP REL COST CENTERS 5.02		(TIME SPENT)	(IN HOUSE ED)			(TIME SPENT)	
1.00 DOTOD NAR CAP HELD AS IT NATE 1.00 1.00 DOTOD NAR CAP HELD AS IT NATE 1.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 2.00 DOTOD NAR CAP HELD AS IT NATE 0.01 3.00 DIADON NARS HELD AS IT NATE 0.01 3.00 DIADON NARS HELD AS IT NATE 0.01 3.00 DIADON NARS HELD AS IT NARES SUPPA 3.00 DIADON NARS HELD AS IT NARES SUPPA 3.00 DIADON NARS HELD AS IT NARES SUPPA 3.00 DIADON NARES HELD AS IT N	CENEDAL SEDVICE COST CENTEDS	17.00	17.01	21.00	22.00	23.00	
2 00 00200 RPL APA REL COSTS-JMOLE COUP 2 00 00200 RPL ALS DEPARTMENT 5 00 00200 RPL ALS OUTS A SUPPLY 5 00 0000 RPL ALS OUTS A SUPPLY 5 00 0000 RPL ALS OUTS A SUPPLY 5 00 00 00 00 00 00 00 00 00 00 00 00 0	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00000 EPRLPYCE ENERFITS DEPARTMENT 4.00 5.01 00040 MAX PROCESSING 5.01 5.02 000540 MAX PROCESSING 5.01 5.03 000540 MAX PROCESSING 5.01 5.04 000540 MAX PROCESSING 5.00 5.05 000540 MAX PROCESSING 5.00 5.05 000540 MAX PROCESSING 5.00 5.05 000540 MAX PROCESSING 7.00 5.00 000540 MAX PROCESSING 11.00 11.00 5.00 000540 MAX PROCESSING 11.00 11.00 11.00 11.00 5.00 0100540 MAX PROCESSING 6.040 137.011 1.00 11.00 11.00 5.00 0100540 MAX PROCESSING 6.040 137.011 1.00 1.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
5.02 00050 DATA PROCESSING 5.03 5.03 00050 DATA PROCESSING 5.03 5.04 00051 ALMATTING 5.04 5.05 00050 DESCIPALIZATION IN INFORMATION RECEIVABLE 5.03 5.04 00050 DEFARTING OF PLANT 5.06 5.05 00050 DEFARTING OF PLANT 5.06 5.06 00050 DEFARTING OF PLANT 5.06 5.00 00050 DEFARTING OF PLANT 5.06 5.00 00050 DEFARTING OF PLANT 5.06 5.00 01300 DEFARTING SERVER 0.00 5.00 01300 DEFARTING SERVER 0.00 5.00 01300 DEFARTING SERVER 0.00 7.00 01300 DEFARTING SERVER 0.00 7.00 01300 DEFARTING SERVER SERVER 7.00 01300 DEFARTING SERVER DEFARTING 7.00 0 0 DEFARTING DEFARTING 7.00 DEFARTING SERVER S	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02 00500 PARCMASH & FECELVING AND STORES 5.0.00500 (ASHEER NEGAZACOUNTS RECEIVABLE 5.00 00500 (ASHEER NEGAZACOUNTS RECEIVABLE 5.00 00500 (ASHEER NEGAZACOUNTS RECEIVABLE 5.00 00500 (AURIN KA AGA CAUNTS RECEIVABLE 5.00 0000 (AURIN KA AGA CAUNTS RECEIVABLE 5.00 000 (AURIN KA AGA CAUNTS RECEIV							
5.06 00580 CASHIE FRINC/ACCOUNTS RECEIVABLE 5.06 5.07 00 000000 CONTRO DUPLANT (IN GUE PLANT 5.06 7.00 000000 CONTRO DUPLANT (IN GUE PLANT 5.06 0.00 00000 CONTRO DUPLANT (IN GUE PLANT 5.06 10.00 010000 CONTRO DUPLANT (IN GUE PLANT 5.06 10.00 01000 COLAR SERVICES-OTHER PREAL 5.020 10.00 00000 ALW SERVICES-OTHER PREAL 5.027 10.00 00000 ALW SERVICES-OTHER PREAL 5.027 10.00 00000 ALW SERVICES-OTHER PREAL 5.027 10.00 000000 ALW SERVICES-OTHER PREAL 5.027 10.00 000000 ALW SERVICES-OTHER PREAL 5.020 10.00	5. 03 00560 PURCHASING RECEIVING AND STORES						5.03
5.06 000500 DHER AGG 5.06 5.06 5.06 5.06 5.06 5.06 5.06 6.00 7.00							
8.00 00000 00000 010000 010000 01000 <t< td=""><td>5.06 00590 OTHER A&G</td><td></td><td></td><td></td><td></td><td></td><td>5.06</td></t<>	5.06 00590 OTHER A&G						5.06
9.00 09900 0005EVELEPING 9.00 01005 0ET ARY 9.00 01100 CARTERIN A 11.00 01100 CARTERIN A 11.00 01100 CARTERIN A 11.00 1130 01100 CARTERIN A 11.00 1137 011 7 11.00 01200 TRANKOV 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
11.00 01100 CAFETERIA 11.00	9.00 00900 HOUSEKEEPI NG						9.00
13.00 01300_NURSING ADMINISTRATION 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 PARMACY 15.00							
15:00 01500 PHARMACY 15:00 16:00	13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
16.00 01000 [MEDICAL, RECORDS & LIBRARY 6,00 17,01 6,700 17,00 10,00 17,00 10,00 17,00 10,00							
17. 01 101701 INSERVICE EDUCATION 0 137. 011 137. 011 17. 01 00 02. 00 00 00 17. 01	16. 00 01600 MEDICAL RECORDS & LIBRARY	(16.00
21.00 02100 [AR SERVICES-SALARY & FRINCES APPRVD 0 0 439 439 23.00 23.00 02300 PARAMED ED PRGM. COSTS APPRVD 0 892 100 23.00 10.00 03000 ADULTS A PEDIATRICS 3.727 30.563 287 0.80 0 31.00 10.00 03000 ADULTS A PEDIATRICS 3.727 7.651 0 0 0.00 0 0 0 0.00 0 0 0 0 0 0 0 0.00 0 <td< td=""><td></td><td></td><td>137, 011</td><td></td><td></td><td></td><td></td></td<>			137, 011				
23. 00 02300 PARAMED ED PRGM 0 892 100 23. 00 INNAT LENT ROUTINE SERVICE COST CENTERS 3,722 30,563 287 287 0 30. 00 10. 00 03000 AUULTS & PEDIATRICS 3,727 30,563 287 287 0 30. 00 10. 00 04000 SUBPROVIDER - IPF 0 6,496 0 0 40. 00 13. 00 04300 NURSERV 0 433 0 0 0 43. 00 MILLARY SERVICE COST CENTERS	21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	-	O	43			21.00
INPATI FNT ROUTINE SERVICE COST CENTERS 287 287 287 0 30.00 0 000000000000000000000000000000000000		-	-		439		
31.00 03100 INTENSIVE CARE UNIT 777 7, 651 0	INPATIENT ROUTINE SERVICE COST CENTERS	0.070	20 5 (2				
11.00 Gut 200 Server 2 0 1, 881 0 0 0 41, 00 AND 04300 NURSERV 0 0, 00 0							
43.00 0 <td></td> <td>-</td> <td></td> <td></td> <td>-</td> <td>-</td> <td></td>		-			-	-	
50. 00 0 0 1,983 47 47 0 50. 00 52. 00 05200 DELIVERY ROM & LABOR ROM 32 665 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI ACROSTI C 0 8, 152 4 4 100 54. 00 59. 00 05900 CARDI AC CATHETERIZATI ON 0 1, 995 0 0 0 59. 00 66. 00 Debotio LABORATORY 0 2, 725 34 34 0 65. 00 66. 00 Debotio LECTROCARDI OLOGY 0 1, 261 24 24 0							
52:00 DELIVERY ROM & LABOR ROM 32 665 0 0 52:00 60:00 59:00 59:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 71:00 70:00 71:00 70:00 71:00 70:00 71:00 70:00 72:00 72:00 72:00			1 002		7 47		50.00
59:00 0 0 1,995 0 0 59:00 0 0 59:00 0 0 59:00 0		-					
60:00 0000 LABORATORY 0 5.582 0 0 66:00 66:00 65:00 06500 RESP RATORY THERAPY 0 2.725 34 34 0 65:00 66:00 06600 PHYSICAL THERAPY 0 2.725 34 34 0 65:00 66:00 0 0 0 0 0 0 0 0 0 0 0 0 66:00 0 66:00 0					4 4		
66:00 06:00 0 0 0 66:00 0 0 0 66:00 0							
69:00 06900 ELECTROCARDIOLOGY 0 1,261 24 24 0 69.00 70:00 07000 ELECTROENCEPHALOGRAPHY 0 224 0 0 0 0 70.00 71:00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 71.00 72:00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73:00 07300 RUSAGRED TO PATIENTS 0 0 0 0 73.00 74:00 07400 RENAL DIALYSIS 0 184 0 0 0 74.00 76:00 07697 CARDIA C REHABILITATION 0 308 0 0 0 76.00 00 09100 MEREKI MEDICARCA COST CENTERS		0					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 <td< td=""><td></td><td>0</td><td></td><td></td><td></td><td>-</td><td></td></td<>		0				-	
72.00 O7200 INPL_DEV. CHARGED TO PATIENT 0 0 0 0 0 72.00 73.00 O7300 RUGS CHARGED TO PATIENTS 0		-					
74.00 07400 RENAL DIALYSIS 0 184 0 0 0 74.00 76.00 03950 ANCI LLARY - OTHER 0 0 0 0 0 0 0 0 76.00 97 76.00 97 <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td>-</td> <td></td>		0	-			-	
76.00 03950 ANCI LLARY - OTHER 0 0 0 0 0 0 76.00 76.97 70.07697 CARDI AC REHABILITATION 0 308 0 0 0 76.97 91.00 OP100 EMERGENCY 1,959 7,280 43 43 0 91.00 92.00 OP200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 1,563 0 0 0 92.00 93.00 4040 PATI ENT CARE CENTER - OCC 0 1,563 0 0 0 92.00 93.00 0400 PATI ENT CARE CENTER - OCC 0 1,563 0 0 0 92.00 93.00 OPGOLURABLE MEDI CAL EQUI P-RENTED 0 538 0		0	-				
OUTPATI ENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY 1,959 7,280 43 43 0 91.00 92.00 92.00 00SERVATI ON BEDS (NON-DI STI NCT PART) 1,959 7,280 43 43 0 91.00 92.00 92.00 00SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 93.00 04040 (PATI ENT CARE CENTER - OCC 0 1,563 0 0 0 92.00 93.00 0 0 0 1,563 0 0 0 92.00 93.00 0 0 0 538 0 0 0 0 93.00 0 0 0 538 0 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 0 0 1.284 0 0 0 113.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 192.00 0 0 0 0 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>•</td> <td></td> <td></td>		0	0		•		
91.00 09100 EMERGENCY 1,959 7,280 43 43 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 1,959 7,280 43 43 0 92.00 93.00 0d400 PATI ENT CARE CENTER - OCC 0 1,563 0 0 0 93.00 07HER REI MBURSABLE COST CENTERS 0 538 0 0 0 96.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 538 0 0 0 96.00 91.00 113.00 INTEREST EXPENSE 0 1,284 0 0 0 116.00 113.00 INTERSABLE COST CENTERS 0 1,284 0 0 116.00 116.00 118.00 NORREI MBURSABLE COST CENTERS 0 0 0 0 118.00 190.00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 194.00 07950 RENTAL SPACE 0 0 0 0 0 194.00 <td></td> <td>0</td> <td>308</td> <td></td> <td>0 0</td> <td>0</td> <td>76.97</td>		0	308		0 0	0	76.97
93. 00 04040 PATI ENT CARE CENTER - OCC 0 1,563 0 0 0 93. 00 OTHER REIMBURSABLE COST CENTERS	91.00 09100 EMERGENCY	1, 959	7, 280	4	3 43	0	•
OTHER REI MBURSABLE COST CENTERS 96.00 96.00 DORABLE MEDI CAL EQUIP-RENTED 0 538 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 96.00 96.00 SPECIAL PURPOSE COST CENTERS 96.00 <td></td> <td>0</td> <td>1 563</td> <td></td> <td>0</td> <td>0</td> <td>•</td>		0	1 563		0	0	•
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 116.00 HOSPI CE 0 1,284 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 6,040 87,690 439 439 100 118.00 NORREI MBURSABLE COST CENTERS 0 0 0 0 118.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 0 0 0 194.00 194.02 07952 RENTAL SPACE 0 0 0 194.02 194.02 07953 REI D CONTRACTED SERVICES 0 73 0 0 194.02 194.02 07954 REI D PHYSI CLAN ASSOC. 0 36,908 0 0 194.02 194.04 07954 REI D PHYSI CLAN ASSOC. 0	OTHER REIMBURSABLE COST CENTERS						
113.00 INTEREST EXPENSE 0 1, 284 0 0 113.00 116.00 11600 HOSPI CE 0 1, 284 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 6, 040 87, 690 439 439 100 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 0 0 0 194.00 194.01 07951 FOUNDATI ON 0 36 0 0 194.02 194.02 07952 RETAI L SERVI CES 0 73 0 0 194.02 194.03 07953 REI D CONTRACTED SERVI CES 0 73 0 0 194.02 194.04 07954 REI D PHYSI CI AN ASSOC. 0 36, 908 0 0 194.04 194.06 <t< td=""><td></td><td>0</td><td>538</td><td>3</td><td>0 0</td><td>0</td><td>96.00</td></t<>		0	538	3	0 0	0	96.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 6,040 87,690 439 439 100 118.00 NORREI MBURSABLE COST CENTERS NORREI MBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.00 192.00 192.00 0 192.00 0 192.00 0 0 192.00 192.00 0 0 192.00 194.02 0 0 0 192.00 194.02 192.00 194.01 194.02 194.01 0 0 0 194.01 194.02 1952 RETAI L SERVICES 0 73 0 0 0 194.02 194.02 1952 REI D CONTRACTED SERVICES 0 0 0 0 194.03 194.04 194.05 194.04 194.04 194.04 194.04 194.04 194.05 194.05 0 0	113.00 11300 I NTEREST EXPENSE	_					
NOREI MBURSABLE COST CENTERS 190.00 197.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 0 0 194.00 194.01 07951 FOUNDATI ON 0 36 0 0 194.01 194.02 07952 RETAI L SERVI CES 0 73 0 0 194.02 194.03 07953 REI D CONTRACTED SERVI CES 0 73 0 0 194.02 194.03 07953 REI D CONTRACTED SERVI CES 0 73 0 0 194.02 194.04 07954 REI D PHYSI CI AN ASSOC. 0 36, 908 0 0 194.03 194.04 07955 OTHER NRCC 0 10, 791 0 0 194.05 194.06 07956 VACANT SPACE 0 0 0 194.06 <					-		
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 0 0 0 194.00 194.01 07951 FOUNDATI ON 0 36 0 0 194.01 194.02 07952 RETAL SERVI CES 0 73 0 0 194.02 194.03 07953 REI D CONTRACTED SERVI CES 0 73 0 0 194.03 194.04 07954 REI D PHYSI CI AN ASSOC. 0 36,908 0 0 194.04 194.05 07955 OTHER NRCC 0 10,791 0 0 194.05 194.06 07956 VACANT SPACE 0 0 0 194.06 0 0 194.05 194.06 07956 VACANT SPACE 0 0 0 0 194.06 0 0 194.06 0 0 0 194.06 0 0 194.06 0 0 0 194.06 194.06 194.06 194.06 200.00	NONREI MBURSABLE COST CENTERS			1			
194.00 07950 RENTAL SPACE 0 0 0 194.00 194.01 07951 FOUNDATION 0 36 0 0 194.01 194.02 07952 RETAL SERVICES 0 73 0 0 194.02 194.03 07953 REID CONTRACTED SERVICES 0 73 0 0 194.03 194.04 07954 REID PHYSICIAN ASSOC. 0 36,908 0 0 194.04 194.05 07955 OTHER NRCC 0 10,791 0 0 194.05 194.06 07956 VACANT SPACE 0 0 0 194.05 194.05 194.08 07958 CAMBRIDGE RHC 0 10,791 0 0 194.05 194.08 07958 CAMBRIDGE RHC 0 0 0 194.05 194.05 194.08 07958 Cross Foot Adjustments 0 1,513 0 0 194.08		-					•
194. 02 07952 RETAIL SERVICES 0 73 0 0 194. 02 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 0 194. 03 194. 04 07954 REID DHYSICIAN ASSOC. 0 36, 908 0 0 194. 04 194. 05 07955 OTHER NRCC 0 10, 791 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 194. 05 194. 08 07958 CAMBRI DGE RHC 0 1, 513 0 0 194. 08 200. 00 Cross Foot Adjustments 0 1, 513 0 0 200. 00	194.00 07950 RENTAL SPACE	0	C		0 0	0	194.00
194. 03 07953 REI D CONTRACTED SERVICES 0 0 0 194. 03 194. 04 07954 REI D PHYSICI AN ASSOC. 0 36, 908 0 0 194. 04 194. 05 07955 OTHER NRCC 0 10, 791 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 194. 05 194. 08 07958 CAMBRI DGE RHC 0 0 0 194. 08 200. 00 Cross Foot Adjustments 0 1, 513 0 200. 00		0					
194. 05 07955 OTHER NRCC 0 10, 791 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 0 194. 06 194. 08 07958 CAMBRI DGE RHC 0 1, 513 0 0 194. 08 200. 00 Cross Foot Adjustments 0 1, 513 0 200. 00 200. 00	194.0307953 REID CONTRACTED SERVICES	0	C			0	194. 03
194.06 07956 VACANT SPACE 0 0 0 194.06 194.08 07958 CAMBRI DGE RHC 0 1,513 0 0 194.08 200.00 Cross Foot Adjustments 0 1,513 0 200.00 200.00		0			0 lc		•
200.00 Cross Foot Adjustments 200.00	194.0607956 VACANT SPACE	0	C			0	194.06
		0	1, 513	5 (0 0		

Health Fin	ancial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	i	Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
				INTERNS 8	RESI DENTS		
	Cost Center Description	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVICES-SALAI Y&FRINGES	RSERVICES-OTHER PRGM.COSTS	PARAMED ED PRGM	
		(TIME SPENT)	(IN HOUSE ED)	(ASSI GNED TI ME)	(ASSI GNED TI ME)	(TIME SPENT)	
		17.00	17.01	21.00	22.00	23.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 410, 757	3, 024, 028	396, 52	3 124, 366	594, 966	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	564. 694868	22. 071425	903.24145	8 283. 293850	5, 949. 660000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	59, 685	301, 869	85	9 13, 579	214, 110	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	9. 881623	2. 203246	1. 956720	30. 931663	2, 141. 100000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0048	Period: From 01/01/2016 Fo 12/31/2016	Date/Time Pre 5/25/2017 3:1	pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		2.00	0.00	11 00	0100	
30. 00 03000 ADULTS & PEDIATRICS	30, 578, 775		30, 578, 77	5 0	30, 578, 775	30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 983, 001		7, 983, 00		7, 983, 001	
40. 00 04000 SUBPROVI DER – I PF	5, 615, 619		5, 615, 61		5, 615, 619	
41. 00 04100 SUBPROVI DER – I RF	2, 511, 049		2, 511, 04		2, 511, 049	
43. 00 04300 NURSERY	749,005		749, 00		749,005	
ANCI LLARY SERVI CE COST CENTERS	747,003		747,00		747,003	43.00
50. 00 05000 OPERATING ROOM	33, 575, 960		33, 575, 96	0 0	33, 575, 960	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 558, 927		1, 558, 92		1, 558, 927	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 464, 730		19, 464, 73		19, 464, 730	
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 884, 973		9, 884, 97		9, 884, 973	
60. 00 06000 LABORATORY	13, 970, 972		13, 970, 97		13, 970, 972	
65. 00 06500 RESPIRATORY THERAPY	2, 858, 403				2, 858, 403	
66. 00 06600 PHYSI CAL THERAPY	11, 785, 469		11, 785, 46			
69. 00 06900 ELECTROCARDI OLOGY	3, 045, 409		3, 045, 40		11, 785, 469 3, 045, 409	
	933, 134		933, 13		933, 134	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	21, 922		21, 92		21, 922	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	16, 758, 582		16, 758, 58		16, 758, 582	
73. 00 07300 DRUGS CHARGED TO PATIENTS	33, 059, 192		33, 059, 19		33, 059, 192	
74.00 07400 RENAL DIALYSIS	778, 406		778, 40		778, 406	
76.00 03950 ANCI LLARY - 0THER	0			0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	350, 843		350, 84	3 0	350, 843	76.97
OUTPATIENT SERVICE COST CENTERS				-		
91.00 09100 EMERGENCY	10, 606, 716		10, 606, 71			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 653, 984		2, 653, 98		2, 653, 984	
93.00 04040 PATIENT CARE CENTER - OCC	2, 348, 625		2, 348, 62	5 0	2, 348, 625	93.00
OTHER REIMBURSABLE COST CENTERS	1		r			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	3, 129, 679		3, 129, 67	9 0	3, 129, 679	96.00
SPECIAL PURPOSE COST CENTERS	1					
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	2, 808, 218		2, 808, 21		2, 808, 218	
200.00 Subtotal (see instructions)	217, 031, 593					
201.00 Less Observation Beds	2, 653, 984		2, 653, 98		2, 653, 984	
202.00 Total (see instructions)	214, 377, 609	0	214, 377, 60	9 0	214, 377, 609	202.00

Health Financial S		HUSPITAL & HEAL			III LIE	u of Form CMS-2	2552-1
COMPUTATION OF RAT	10 OF COSTS TO CHARGES		Provider CC		Peri od:	Worksheet C	
					From 01/01/2016	Part I	
					To 12/31/2016		pared:
				XVIII	lloonitol	5/25/2017 3:1 PPS	5 pm
			Charges	AVIII	Hospi tal	PP5	
Cost	Center Description	I npati ent	Outpati ent	Total (col	6 Cost or Other	TEFRA	
0031 0	Senter Description	inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
				+ cor. 7)	Ratio	Ratio	
		6,00	7.00	8.00	9.00	10.00	
INPATIENT RO	DUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	S & PEDI ATRI CS	38, 619, 287		38, 619, 28	7		30.00
	SIVE CARE UNIT	8,067,312		8, 067, 31		1	31.00
40. 00 04000 SUBPRO		10, 935, 900		10, 935, 90		l	40.00
41.00 04100 SUBPRO		3, 621, 102		3, 621, 10		1	41.00
43.00 04300 NURSER		2,064,024		2,064,02		1	43.00
	ERVICE COST CENTERS	2,004,024		2,004,02	т.		
50. 00 05000 OPERAT		49, 614, 340	90, 125, 276	139, 739, 61	6 0. 240275	0.00000	50.00
	RY ROOM & LABOR ROOM	5, 259, 248	920, 160				
	LOGY-DI AGNOSTI C	15, 255, 169	98, 458, 383				
	AC CATHETERIZATION	20, 306, 596	53, 112, 216				
60. 00 06000 LABORA		25, 229, 831	49, 897, 036			0. 000000	
	ATORY THERAPY	12, 316, 472	2, 572, 861	14, 889, 33		0, 000000	
66. 00 06600 PHYSI C		6, 083, 093	10, 623, 531	16, 706, 62		0. 000000	
69.00 06900 ELECTR		3, 070, 101	19, 122, 920			0. 000000	
	ROENCEPHALOGRAPHY	7, 259	3, 699, 014	3, 706, 27		0, 000000	
	AL SUPPLIES CHARGED TO PATIENTS	126, 775	12, 532			0. 000000	
	DEV. CHARGED TO PATIENT	14, 886, 071	11, 062, 214			0. 000000	
	CHARGED TO PATIENTS	33, 996, 003	70, 634, 897	104, 630, 90		0, 000000	
74.00 07400 RENAL		733, 145	41, 151	774, 29		0. 000000	
76.00 03950 ANCI LL		0	0		0 0.000000	0. 000000	
	AC REHABILITATION	2,962	1, 130, 071	1, 133, 03		0, 000000	
	SERVICE COST CENTERS						
91.00 09100 EMERGE		8, 048, 168	43, 681, 204	51, 729, 37	2 0. 205042	0.00000	91.0
2. 00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART)	727,613	3, 214, 181	3, 941, 79	4 0. 673293	0.000000	92.0
93.00 04040 PATIEN	IT CARE CENTER - OCC	122, 958	4, 739, 958	4, 862, 91	6 0. 482966	0.000000	93.0
	JRSABLE COST CENTERS						
96.00 09600 DURABL	E MEDICAL EQUIP-RENTED	0	6, 131, 063	6, 131, 06	0. 510463	0.00000	96.0
	POSE COST CENTERS						
113. 00 11300 I NTERE							113.0
116. 00 11600 HOSPI C	E	1, 683, 584	3, 081, 808	4, 765, 39	2		116.0
200.00 Subtot	al (see instructions)	260, 777, 013	472, 260, 476	733, 037, 48	9		200. 0
201.00 Less 0	Observation Beds						201.00
	(see instructions)	260, 777, 013		733, 037, 48			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Period: From 01/01/2016 Worksheet C Part I Date/Time Prepared: Title XVIII Worksheet C Part I Date/Time Prepared: 26/202017 3:15 pm 0:000 03000 ADULTS & PEDIATRICS 30:00 Title XVIII Hospital 9PS 30:00 03000 ADULTS & PEDIATRICS 30:00 Title XVIII Hospital 30:00 30:00 03000 ADULTS & PEDIATRICS 30:00 Title XVIII Hospital 9PS 30:00 03000 ADULTS & PEDIATRICS 30:00 Title XVIII Hospital 9PS 30:00 03000 ADULTS & PEDIATRICS 30:00 Title XVIII Hospital 30:00 40:00 NEXILARY SERVICE COST CENTERS 50:00 06200 PERATING ROM 0.240275 52:00 50:00 50:00 05200 CARULCEY ROM 0.1314638 50:00 52:00 50:00 05200 CARULCEY ROM 0.134638 50:00 50:00 60:00 06000 PHYSICAL THERAPY 0.137224 60:00 60:00 70:00 07000 RUCS CHARGED TO PATIENTS 0.315960 71:00 70:00 70:00 07000 RUCS CHARGED TO PATIENTS 0.315960 <th>2</th> <th>HOSITIAL & HEALT</th> <th></th> <th></th> <th></th>	2	HOSITIAL & HEALT			
Cost Center Description PPS Inpatient Ratio Title XVIII Hospital PPS IMPATIENT ROUTINE SERVICE COST CENTERS 30.00	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048		Date/Time Prepared:
Ratio 11.00 10.00 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 40.00 04000 SUBPROVIDER - IPF 41.00 41.00 42.00 42.00 43.00 043.00 SUBPROVIDER - IPF 43.00 43.00 04300 NURSERY 50.00 52.00 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.252278 52.00 52.00 50.00 05400 RADICLOGY-DIAGNOSTIC 0.171173 54.00 59.00 59.00 05900 CARDIA CATHETERIZATION 0.134638 59.00 59.00 66.00 06600 PHYSICAL HERAPY 0.191977 65.00 65.00 67.00 05900 PHYSICAL HERAPY 0.131224 69.00 69.00 71.00 013224 0.9000 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00			Title XVIII	Hospi tal	PPS
11.00 11.00 10.01 INFATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDI ATRICS 31.00 31.00 04100 SUBPROVIDER - 1PF 41.00 41.00 04100 SUBPROVIDER - 1 RF 41.00 30.00 0600 ONURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05200 OPERATING ROM 0.240275 51.00 05000 OPERATING ROM 0.240275 52.00 05200 DELIVERY ROMA & LABOR ROM 0.252278 54.00 54.00 59.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.134638 65.00 065000 RESPI RATORY THERAPY 0.191977 65.00 06000 RESPI RATORY THERAPY 0.191977 66.00 0.00 OPELCETROEADERDERDIDLOGY 0.337224 70.00 07000 ELECTROEADERDERDIDLOGY 0.31290 71.00 0.1400 RESPI RATORY 0.251772 70.00 07000 DELOCTROEADERDERDIDLOGY 0.31960 73.00 07300 DRUGS CHARGED TO PATIENT 0.454845 73.00	Cost Center Description	PPS Inpatient			
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74.00 07400 RENAL DI ALYSI S 1.005308 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 76.00 76.01 07697 CARDI AC REHABI LI TATI ON 0.309649 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0.205042 91.00 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.673293 91.00 93.00 04040 PATI ENT CARE CENTER - OCC 0.482966 93.00 07HER REI MBURSABLE COST CENTERS 96.00 9600 DURABLE MEDI CAL EQUI P-RENTED 0.510463 96.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 11300 106 HOSPI CE 116.00 11600 1020.00 200.00 200.00 201.00 Less Observati on Beds 201.00 201.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 645845			72.00
76.00 03950 ANCI LLARY - OTHER 0.000000 76.00 76.97 07697 CARDI AC_REHABI LI TATI ON 0.309649 76.97 0UTPATI ENT SERVICE COST CENTERS 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.673293 91.00 93.00 04040 PATI ENT CARE CENTER - OCC 0.482966 93.00 0THER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.510463 96.00 95.01 113.00 1NTEREST EXPENSE 113.00 1NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 200.00 200.00 200.00 200.00 200.00 Less Observati on Beds 200.00 201.00 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 315960			73.00
76. 97 07697 CARDI AC REHABILITATION 0. 309649 76. 97 0UTPATI ENT SERVICE COST CENTERS 91. 00 91. 00 09100 EMERGENCY 0. 205042 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 673293 92. 00 93. 00 0440 PATI ENT CARE CENTER - OCC 0. 482966 93. 00 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 510463 96. 00 SPECIAL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE Subtotal (see instructions) 200. 00 201. 00 201. 00 201. 00	74.00 07400 RENAL DIALYSIS	1.005308			74.00
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.205042 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.673293 92.00 93.00 04040 PATI ENT CARE CENTER - 0CC 0.482966 93.00 0THER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUIP-RENTED 0.510463 96.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 116.00 116.00 11600 HOSPI CE 116.00 200.00 201.00 Less Observation Beds 201.00	76.00 03950 ANCI LLARY - OTHER	0. 000000			76.00
91.00 09100 EMERGENCY 0.205042 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.673293 92.00 93.00 04040 PATIENT CARE CENTER - OCC 0.482966 93.00 0THER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.510463 96.00 SPECIAL PURPOSE COST CENTERS 96.00 113.00 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 116.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 309649			76.9
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.673293 92.00 93.00 04040 PATIENT CARE CENTER - OCC 0.482966 93.00 0THER REIMBURSABLE COST CENTERS 096.00 DURABLE MEDICAL EQUIP-RENTED 0.510463 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 1600 HOSPICE 116.00 116.00 200.00 201.00 Less Observation Beds 201.00 201.00 201.00 201.00	OUTPATIENT SERVICE COST CENTERS				
93.00 04040 PATI ENT CARE CENTER - OCC 0.482966 93.00 OTHER REI MBURSABLE COST CENTERS 096.00 DURABLE MEDI CAL EQUI P-RENTED 0.510463 96.00 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 116.00 1060HOSPICE Subtotal (see instructions) 116.00 1000 200.00 201.00 Less Observation Beds 201.00	91.00 09100 EMERGENCY	0. 205042			91.00
OTHER REI MBURSABLE COST CENTERS 96.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 673293			92.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 510463 96.00 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 113.00 116.00 1060 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 </td <td>93.00 04040 PATIENT CARE CENTER - OCC</td> <td>0. 482966</td> <td></td> <td></td> <td>93.00</td>	93.00 04040 PATIENT CARE CENTER - OCC	0. 482966			93.00
SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00	OTHER REIMBURSABLE COST CENTERS	· · ·			
SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00	96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 510463			96.00
116.00 11600 H0SPICE 116.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 Less Observation Beds 201.00		· ·			
200.00 Subtotal (see instructions) 200.00 201.00 <td>113.00 11300 INTEREST EXPENSE</td> <td></td> <td></td> <td></td> <td>113.00</td>	113.00 11300 INTEREST EXPENSE				113.00
201.00 Less Observation Beds 201.00	116.00 11600 HOSPI CE				116.00
	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201.00
	202.00 Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/25/2017 3:1	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description		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	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	30, 578, 775		30, 578, 77		30, 578, 775	
31.00 03100 INTENSIVE CARE UNIT	7, 983, 001		7, 983, 00		7, 983, 001	31.00
40. 00 04000 SUBPROVI DER – I PF	5, 615, 619		5, 615, 61		5, 615, 619	
41. 00 04100 SUBPROVI DER – I RF	2, 511, 049		2, 511, 04		2, 511, 049	
43. 00 04300 NURSERY	749,005		749, 00	05 0	749, 005	43.00
ANCI LLARY SERVICE COST CENTERS	1 1			1		
50.00 OPERATING ROOM	33, 575, 960		33, 575, 96		33, 575, 960	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 558, 927		1, 558, 92		1, 558, 927	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	19, 464, 730		19, 464, 73		19, 464, 730	
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 884, 973		9, 884, 97		9, 884, 973	
60. 00 06000 LABORATORY	13, 970, 972		13, 970, 97		13, 970, 972	
65. 00 06500 RESPI RATORY THERAPY	2, 858, 403	0	2, 858, 40	03 0	2, 858, 403	65.00
66. 00 06600 PHYSI CAL THERAPY	11, 785, 469	0	11, 785, 46	09 0	11, 785, 469	66.00
69. 00 06900 ELECTROCARDI OLOGY	3, 045, 409		3, 045, 40	09 0	3, 045, 409	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	933, 134		933, 13	4 0	933, 134	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 922		21, 92	2 0	21, 922	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	16, 758, 582		16, 758, 58	0	16, 758, 582	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 059, 192		33, 059, 19	02 0	33, 059, 192	73.00
74.00 07400 RENAL DIALYSIS	778, 406		778, 40	06 0	778, 406	74.00
76. 00 03950 ANCI LLARY – OTHER	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	350, 843		350, 84	3 0	350, 843	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	10, 606, 716		10, 606, 71	6 0	10, 606, 716	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 653, 984		2, 653, 98	34	2, 653, 984	92.00
93.00 04040 PATIENT CARE CENTER - OCC	2, 348, 625		2, 348, 62	.5 0	2, 348, 625	93.00
OTHER REIMBURSABLE COST CENTERS			•			1
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	3, 129, 679		3, 129, 67	'9 0	3, 129, 679	96.00
SPECIAL PURPOSE COST CENTERS			•			1
113.0011300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	2, 808, 218		2, 808, 21	8	2, 808, 218	116.00
200.00 Subtotal (see instructions)	217, 031, 593	0	217, 031, 59	03 0		
201.00 Less Observation Beds	2, 653, 984		2, 653, 98		2, 653, 984	201.00
202.00 Total (see instructions)	214, 377, 609	0	214, 377, 60	09 0	214, 377, 609	202.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	pared: 5 pm
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	38, 619, 287		38, 619, 28	37		30.00
31.00	03100 INTENSIVE CARE UNIT	8,067,312		8,067,3	12		31.00
40.00	04000 SUBPROVIDER - IPF	10, 935, 900		10, 935, 90	00		40.00
41.00	04100 SUBPROVIDER - IRF	3, 621, 102		3, 621, 10			41.00
43.00	04300 NURSERY	2,064,024		2,064,02			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	49, 614, 340	90, 125, 276	139, 739, 6	0. 240275	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 259, 248	920, 160	6, 179, 40	0. 252278	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 255, 169	98, 458, 383			0.000000	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 306, 596	53, 112, 216	73, 418, 81	0. 134638	0.000000	59.00
60.00	06000 LABORATORY	25, 229, 831	49, 897, 036	75, 126, 86	0. 185965	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	12, 316, 472	2, 572, 861	14, 889, 33	0. 191977	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	6, 083, 093	10, 623, 531	16, 706, 62	0. 705437	0. 000000	66.00
69.00	06900 ELECTROCARDI OLOGY	3, 070, 101	19, 122, 920	22, 193, 02	0. 137224	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	7, 259	3, 699, 014	3, 706, 27	0. 251772	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126, 775	12, 532			0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	14, 886, 071	11, 062, 214	25, 948, 28	0. 645845	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33, 996, 003	70, 634, 897	104, 630, 90	0. 315960	0.000000	73.00
	07400 RENAL DIALYSIS	733, 145	41, 151	774, 29	1. 005308	0.000000	
	03950 ANCI LLARY - OTHER	0	0		0 0.000000	0.000000	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	2, 962	1, 130, 071	1, 133, 03	0. 309649	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	8, 048, 168	43, 681, 204			0.00000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	727, 613	3, 214, 181				
93.00	04040 PATIENT CARE CENTER - OCC	122, 958	4, 739, 958	4, 862, 91	0. 482966	0.00000	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	6, 131, 063	6, 131, 06	0. 510463	0.00000	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	1, 683, 584	3, 081, 808				116.00
200.00		260, 777, 013	472, 260, 476	733, 037, 48	39		200.00
201.00							201.00
202.00	Total (see instructions)	260, 777, 013	472, 260, 476	733, 037, 48	39		202.00

Health Financial Systems REID	HUSPITAL & HEALT	H CARE SERVICES	In Lieu	U OT FORM CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Peri od:	Worksheet C	
			From 01/01/2016	Part I	
			To 12/31/2016	Date/Time Prep 5/25/2017 3:15	
		Title XIX	Hospi tal	Cost	рш
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41.00 04100 SUBPROVIDER - IRF					41.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 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 I MPL. 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 ANCI LLARY - OTHER	0. 000000				76.00
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				1	113.00
116. 00 11600 HOSPI CE				1	116.00
200.00 Subtotal (see instructions)				2	200.00
201.00 Less Observation Beds				2	201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Period: From 01/01/2016 To 12/31/2016		pared: 5 pm
		Title	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	1, 522, 897	0	1, 522, 89	7 32, 653	46.64	30.00
31.00 INTENSIVE CARE UNIT	596,074		596, 07	4 4, 709	126.58	31.00
40. 00 SUBPROVIDER - IPF	236, 779	0	236, 77	9 10, 560	22.42	40.00
41.00 SUBPROVIDER - IRF	170, 152	0	170, 15	2 3, 517	48.38	41.00
43.00 NURSERY	40, 108		40, 10	8 2,026	19.80	43.00
200.00 Total (lines 30-199)	2, 566, 010		2, 566, 01	0 53, 465		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	18, 255	851, 413				30.00
31.00 INTENSIVE CARE UNIT	2,007	254, 046				31.00
40.00 SUBPROVIDER - IPF	7, 681	172, 208				40.00
41.00 SUBPROVIDER - IRF	2, 326	112, 532				41.00
43.00 NURSERY	0					43.00
200.00 Total (lines 30-199)	30, 269	1, 390, 199				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 ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 632, 721	139, 739, 616	0. 01884	0 35, 472, 156	668, 295	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	143, 019	6, 179, 408	0. 02314	4 49, 344	1, 142	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 846, 009	113, 713, 552	0. 01623	4 13, 657, 158	221, 710	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	716, 780	73, 418, 812	0. 00976	3 12, 948, 074	126, 412	59.00
60. 00 06000 LABORATORY	803, 234	75, 126, 867	0. 01069	2 16, 870, 983	180, 385	60.00
65. 00 06500 RESPI RATORY THERAPY	127, 741	14, 889, 333	0. 00857	9 8, 541, 537	73, 278	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 296, 977	16, 706, 624	0. 19734	5 2, 120, 648	418, 499	66.00
69. 00 06900 ELECTROCARDI OLOGY	286, 270	22, 193, 021	0. 01289	9 2, 404, 361	31, 014	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	339, 240	3, 706, 273	0. 09153	1 7, 259	664	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	582	139, 307	0. 00417	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	80, 766	25, 948, 285	0. 00311	3 9, 463, 070	29, 459	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	619, 581	104, 630, 900	0. 00592	2 20, 244, 061	119, 885	73.00
74.00 07400 RENAL DI ALYSI S	14, 590	774, 296	0. 01884	3 546, 573	10, 299	74.00
76. 00 03950 ANCI LLARY – OTHER	0	0	0. 00000	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	39, 697	1, 133, 033	0. 03503	6 2,962	104	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	534, 244	51, 729, 372	0. 01032	8 7, 214, 588	74, 512	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	132, 174	3, 941, 794	0. 03353	1 727, 613	24, 398	92.00
93.00 04040 PATIENT CARE CENTER - OCC	182, 219	4, 862, 916	0. 03747	1 121,082	4, 537	93.00
OTHER REIMBURSABLE COST CENTERS						1
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	303, 134	6, 131, 063	0. 04944	2 0	0	96.00
200.00 Total (lines 50-199)	12, 098, 978	664, 964, 472		130, 391, 469	1, 984, 593	200. 00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	pared: 5 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School			Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	l				-
30. 00 03000 ADULTS & PEDI ATRI CS	0	C)	0 0	0	
31.00 03100 INTENSIVE CARE UNIT	0	C)	0	0	
40. 00 04000 SUBPROVIDER - IPF	0	C		0 0	0	101.00
41. 00 04100 SUBPROVIDER – IRF	0	C		0 0	0	
43. 00 04300 NURSERY	0	C		0	0	43.00
200.00 Total (lines 30-199)	0	C)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	s Program		
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	32, 653					30.00
31.00 03100 INTENSIVE CARE UNIT	4, 709					31.00
40. 00 04000 SUBPROVIDER - IPF	10, 560					40.00
41. 00 04100 SUBPROVIDER - IRF	3, 517	0.00	2, 32	26 0		41.00
43. 00 04300 NURSERY	2, 026	0.00		0 0		43.00
200.00 Total (lines 30-199)	53, 465		30, 26	09 0		200. 00

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PASS	Provider CC		Period: From 01/01/2016 Fo 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician N Anesthetist Cost	3		Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	-			-	-	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	504.04	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	594, 96	6 0	594, 966	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0			0	73.00
74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCI LLARY - OTHER	0	0			0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			0	76.97
OUTPATIENT SERVICE COST CENTERS	U	0	l'	<u> </u>	0	10.91
91. 00 09100 EMERGENCY	0	0			0	91.00
92. 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	0	0		5 0	0	73.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
200.00 Total (lines 50-199)	0	0		-	-	

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 C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016		
				Го 12/31/2016	Date/Time Pre 5/25/2017 3:1	pared: 5 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 O5000 OPERATING ROOM	0					1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	594, 966					
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY	0	75, 126, 867				60.00
65. 00 06500 RESPI RATORY THERAPY	0	14, 889, 333				65.00
66. 00 06600 PHYSI CAL THERAPY	0	16, 706, 624				
69. 00 06900 ELECTROCARDI OLOGY	0	22, 193, 021				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	3, 706, 273				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139, 307	0.00000	0. 000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	25, 948, 285	0.00000	0. 000000	9, 463, 070	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	104, 630, 900	0.00000	0. 000000	20, 244, 061	73.00
74.00 07400 RENAL DIALYSIS	0	774, 296	0.00000	0. 000000	546, 573	74.00
76. 00 03950 ANCI LLARY - OTHER	0	0	0.00000	0. 000000	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 133, 033	0.00000	0. 000000	2, 962	76.97
OUTPATIENT SERVICE COST CENTERS	_					
91.00 09100 EMERGENCY	0	51, 729, 372	0.00000	0. 000000	7, 214, 588	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 941, 794	0.00000	0. 000000	727, 613	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	4, 862, 916	0.00000	0. 000000	121, 082	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	6, 131, 063	0.00000	0. 000000		96.00
200.00 Total (lines 50-199)	594, 966	664, 964, 472			130, 391, 469	200.00

Health Financial Systems REID	HOSPI TAL & HEAI	_TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	VICE OTHER PASS	Provider CO	CN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016		epared:
			XVIII	Hospi tal	5/25/2017 3: ² PPS	15 pm
Cost Center Description	Inpati ent	Outpatient	Outpatient	HOSPItal	PP5	
cost center bescription	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	charges	Costs (col.			
	x col. 10)		x col. 12)	7		
	11.00	12.00	13.00	-		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATING ROOM	0	30, 909, 376		0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	470		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	71, 454	37, 570, 384		58		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	26, 419, 220		0		59.00
60, 00 06000 LABORATORY	0	8, 525, 522		0		60,00
65. 00 06500 RESPI RATORY THERAPY	0	854,093		0		65.00
66.00 06600 PHYSI CAL THERAPY	0	35, 571		0		66.00
69. 00 06900 ELECTROCARDI OLOGY	0	10, 507, 096		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 632, 728		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 186, 083		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	21, 334, 989		0		73.00
74, 00 07400 RENAL DI ALYSI S	0	25,007		0		74.00
76.00 03950 ANCI LLARY - OTHER	0	0		0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	554, 944		0		76.97
OUTPATIENT SERVICE COST CENTERS				-		
91. 00 09100 EMERGENCY	0	11, 810, 558		0		7 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	931, 965		0		92.00
93.00 04040 PATIENT CARE CENTER - OCC	0	3, 048, 922		0		93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
200.00 Total (lines 50-199)	71, 454	159, 346, 928	196, 50	58		200.00
				•		•

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	VACCINE COST	Provider CO		Period: From 01/01/2016 Fo 12/31/2016	Worksheet D Part V Date/Time Pre 5/25/2017 3:1	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 240275			0 0	7, 426, 750	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 252278	470		0 0	119	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171173	37, 570, 384		0 0	6, 431, 035	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 134638	26, 419, 220		0 0	3, 557, 031	59.00
60. 00 06000 LABORATORY	0. 185965	8, 525, 522	2, 47	0 0	1, 585, 449	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 191977	854, 093		0 0	163, 966	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 705437	35, 571		0 0	25, 093	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 137224	10, 507, 096		0 0	1, 441, 826	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 251772	1, 632, 728		0 0	411, 075	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157365	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 645845	5, 186, 083		0 0	3, 349, 406	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 315960	21, 334, 989	64	5 87, 000	6, 741, 003	73.00
74.00 07400 RENAL DIALYSIS	1.005308	25, 007		0 0	25, 140	74.00
76. 00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 309649	554, 944		0 0	171, 838	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0. 205042	11, 810, 558		0 0	2, 421, 660	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 673293	931, 965		0 0	627, 486	92.00
93.00 04040 PATIENT CARE CENTER - OCC	0. 482966	3, 048, 922		0 0	1, 472, 526	93.00
OTHER REIMBURSABLE COST CENTERS			•			1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 510463	0		0 0	0	96.00
200.00 Subtotal (see instructions)		159, 346, 928	3, 11	5 87,000	35, 851, 403	200.00
201.00 Less PBP Clinic Lab. Services-Program			,	0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		159, 346, 928	3, 11	5 87,000	35, 851, 403	202.00

	HOSPITAL & HEA			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/25/2017 3:1	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	-	-	1			
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 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	459	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 MEDI CAL 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	204		1			73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 ANCI LLARY - OTHER	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	-	-	1			
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	, i i i i i i i i i i i i i i i i i i i				96.00
200.00 Subtotal (see instructions)	663	27, 489				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		07.000				
202.00 Net Charges (line 200 +/- line 201)	663	27, 489				202.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0048	Period:	Worksheet D	
		Component	CCN: 15-S048	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	narodi
		Component	CCN. 13-3046	10 12/31/2010	5/25/2017 3:1	pareu. 5 pm
		Title	e XVIII	Subprovider -	PPS	<u> </u>
	L	-		I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0 (00 704	100 700 (1)	0.0100			
50. 00 05000 OPERATI NG ROOM	2, 632, 721					
52.00 05200 DELIVERY ROOM & LABOR ROOM	143, 019				0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 846, 009				6, 948	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	716, 780					59.00
60. 00 06000 LABORATORY	803, 234					60.00
65. 00 06500 RESPI RATORY THERAPY	127, 741					65.00
66. 00 06600 PHYSI CAL THERAPY	3, 296, 977					66.00
69. 00 06900 ELECTROCARDI OLOGY	286, 270					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	339, 240				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	582				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	80, 766					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	619, 581					73.00
74. 00 07400 RENAL DI ALYSI S	14, 590	774, 296			108	74.00
76. 00 03950 ANCI LLARY – OTHER	0	-	0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	39, 697	1, 133, 033	0. 03503	36 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		-	- 1		
91. 00 09100 EMERGENCY	534, 244				5, 524	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-,,			0	92.00
93.00 04040 PATIENT CARE CENTER - OCC	182, 219	4, 862, 916	0. 03747	1, 564	59	93.00
OTHER REIMBURSABLE COST CENTERS	-	1				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	303, 134				0	
200.00 Total (lines 50-199)	11, 966, 804	664, 964, 472	1	3, 823, 019	92, 380	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 C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S048	From 01/01/2016 To 12/31/2016		narad
		Component	UCN. 15-3046	10 12/31/2010	5/25/2017 3:1	
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	<u>4)</u> 5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	594, 96	6 0	594, 966	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 ANCI LLARY - OTHER	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		1	1		
91.00 09100 EMERGENCY	0	0		0 0	0	
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	1	1			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	-		0 0		
200.00 Total (lines 50-199)	0	0	594, 96	06 0	594, 966	200. 00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016	Part IV Date/Time Pre	narod
		Component	UCN. 15-3040	10 12/31/2010	5/25/2017 3:1	
		Title	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	0	120 720 (1(0,00000	0 0.000000	22,059	50.00
	0					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	594, 966				428, 014	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	73, 418, 812			13, 767	59.00
	0	75, 126, 867			720, 976	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	14, 889, 333			397, 292	65.00 66.00
69. 00 06900 ELECTROCARDI OLOGY	0	16, 706, 624			301, 938	
70. 00 07000 ELECTROCARDI OLOGY	0	22, 193, 021			33, 180	70.00
	0	3, 706, 273			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	139, 307			•	71.00 72.00
72.00 07200 TMPL. DEV. CHARGED TO PATTENT 73.00 07300 DRUGS CHARGED TO PATTENTS	0	25, 948, 285 104, 630, 900			5, 260 1, 358, 385	
73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DIALYSIS	0	774, 296			1, 358, 385	73.00
76. 00 03950 ANCI LLARY - OTHER	0	174,290			5,747	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	-			0	76.97
OUTPATIENT SERVICE COST CENTERS	0	1, 155, 055	0.00000	0 0.000000	0	/0.9/
91. 00 09100 EMERGENCY	0	51, 729, 372	0,00000	0 0. 000000	534, 837	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0 0 0 0 0 0	91.00
93. 00 04040 PATIENT CARE CENTER - OCC	0	4, 862, 916			1, 564	93.00
OTHER REIMBURSABLE COST CENTERS	0	4,002,910	0.0000	0.00000	1, 304	73.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	6, 131, 063	0.00000	0 0. 000000	0	96.00
200.00 Total (lines 50-199)	594, 966			0.00000	3, 823, 019	
	1 574, 900	1 307, 707, 472	I	1	5, 025, 017	200.00

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CO	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-SO48	From 01/01/2016 To 12/31/2016		narod.
		component (JUN. 15-3046	10 12/31/2010	5/25/2017 3:1	
		Title	XVIII	Subprovider -	PPS	
				I PF		
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)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG 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	2, 239	0		0		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	64		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	105		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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76. 00 03950 ANCI LLARY – OTHER	0	0		0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
OUTPATIENT SERVICE COST CENTERS			-			
91. 00 09100 EMERGENCY	0	4, 718		0		91.00
92.00 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						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
200.00 Total (lines 50-199)	2, 239	4, 887		0		200. 00

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0048	Peri od:	Worksheet D	
		Component (CCN: 15-S048	From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
		component (CN. 15-5040	10 12/31/2010	5/25/2017 3:1	5 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to Charge		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			
	1.00	2.00	(see inst.)	(see inst.)	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 240275	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 240275	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 252278	0		0 0	0	52.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 134638	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 134030	64		0 0	12	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 185985	105		0 0	20	
66. 00 06600 PHYSI CAL THERAPY	0. 191977	105		0 0	20	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 137224	0		0 0	0	69.00
		0		0 0	0	
	0. 251772	0		0 0		70.00
	0. 157365	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 645845	0		0 5, 427	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0. 315960	0		0 5,427	0	73.00
	1.005308	0		0 0	0	74.00
76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000 0. 309649	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0. 309649	0		0 0	0	/0.9/
91. 00 09100 EMERGENCY	0. 205042	4, 718		0 0	967	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 203042	4,718		0 0	907	91.00
		-		0 0	-	
93. 00 04040 PATI ENT_CARE_CENTER - OCC OTHER_REI MBURSABLE_COST_CENTERS	0. 482966	0		0 0	0	93.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 510463	0		0 0	0	96.00
200.00 Subtotal (see instructions)	0. 510463	4, 887		0 5, 427	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		4, 887		0 5,427	999	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 +/- line 201)		4, 887		0 5, 427	999	202.00
	1 1	1,007	I	5, 427	,,,,	1-02.00

Health Financial Systems	REID HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICE	S AND VACCINE COST	Provider CO	CN: 15-0048	Peri od:	Worksheet D	
		Company	CON 15 CO40	From 01/01/2016	Part V	
		component (CCN: 15-SO48	To 12/31/2016	Date/Time Pr 5/25/2017 3:	epared: 15 nm
		Title	XVIII	Subprovider -	PPS	
				. I PF		
	Cost					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
		Services Not				
	Subject To	Subject To				
		ed. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
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				54.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
60. 00 06000 LABORATORY	0	0				60.0
65. 00 06500 RESPI RATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	ITS 0	0				71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 715				73.0
74.00 07400 RENAL DIALYSIS	0	0				74.0
76.00 03950 ANCI LLARY - OTHER	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	CT) (T	0				92.0
93.00 04040 PATIENT CARE CENTER - OCC	0	0				93.0
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.0
200.00 Subtotal (see instructions)	0	1, 715				200.0
201.00 Less PBP Clinic Lab. Services-Proc	uram 0	.,,,,				201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201) 0	1, 715				202.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0048	Period:	Worksheet D	
		Component	CCN: 15-T048	From 01/01/2016 To 12/31/2016	Part II Date/Time Pre	narad
		Component	CCN. 13-1046	10 12/31/2010	5/25/2017 3:1	pareu. 5 pm
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0 (00 704	400 700 (4)	0.0100	0 0 101	(0	50.00
50. 00 05000 OPERATING ROOM	2, 632, 721				60	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	143,019				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,846,009				1, 155	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	716, 780					59.00
60. 00 06000 LABORATORY	803, 234					60.00
65. 00 06500 RESPIRATORY THERAPY	127, 741					
66.00 06600 PHYSI CAL THERAPY	3, 296, 977					66.00
69. 00 06900 ELECTROCARDI OLOGY	286, 270				26	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	339, 240				0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	582				0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	80, 766				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	619, 581				2, 307	73.00
74.00 07400 RENAL DIALYSIS	14, 590					74.00
76. 00 03950 ANCI LLARY - OTHER	0	-	0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	39, 697	1, 133, 033	0. 03503	36 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	504.044	54 700 070			10	
91.00 09100 EMERGENCY	534, 244				19	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	-,,			0	92.00
93. 00 04040 PATIENT CARE CENTER - OCC	182, 219	4, 862, 916	0.03747	312	12	93.00
OTHER REI MBURSABLE COST CENTERS	000.404	(101 0/0	0.0404			04 00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	303, 134				0	
200.00 Total (lines 50-199)	11, 966, 804	664, 964, 472		2, 604, 210	352, 316	1200. OO

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	RVICE OTHER PASS	S Provider C	CN: 15-0048	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T048	From 01/01/2016 To 12/31/2016		narod
		component	JCN. 13-1046	10 12/31/2010	5/25/2017 3:1	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	594, 96	6 0	594, 966	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0,1,,00	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 ANCI LLARY – OTHER	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1		1			
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 REI MBURSABLE COST CENTERS				0	0	0/ 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0		96.00
200.00 Total (lines 50-199)	I U	0	594, 96	0	594, 966	200.00

Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2016 To 12/31/2016		narod
		component	CCN. 15-1046	10 12/31/2010	5/25/2017 3:1	
		Title	e XVIII	Subprovider -	PPS	
	L			I RF		
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	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	0	100 700 (1)	0.00000		2 101	
	0					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	594, 966				71, 129	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	73, 418, 812			488	59.00 60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	75, 126, 867 14, 889, 333			196, 883 175, 216	
66. 00 06600 PHYSI CAL THERAPY	0				1, 747, 290	
69. 00 06900 ELECTROCARDI OLOGY	0	16, 706, 624 22, 193, 021				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	3, 706, 273			2,051	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	139, 307			-	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	25, 948, 285				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	104, 630, 900				73.00
74. 00 07400 RENAL DI ALYSI S	0	774, 296			16, 195	
76. 00 03950 ANCI LLARY - OTHER	0	,,,4,2,0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	-				76.97
OUTPATIENT SERVICE COST CENTERS	0	1, 133, 033	0.00000	0 0.000000	0	10. 11
91. 00 09100 EMERGENCY	0	51, 729, 372	0, 00000	0 0. 000000	1, 851	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93. 00 04040 PATIENT CARE CENTER - OCC	0	4, 862, 916				93.00
OTHER REIMBURSABLE COST CENTERS	. 0	1,002,710	0.0000	0.00000	512	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	6, 131, 063	0.00000	0 0.000000	0	96.00
200.00 Total (lines 50-199)	594, 966			51 000000	2, 604, 210	
		1	1	1		

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T048	From 01/01/2016 To 12/31/2016		narod
		Component	JUN. 15-1046	10 12/31/2010	5/25/2017 3:1	
		Title	XVIII	Subprovider -	PPS	
				I RF		
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)	10.00	x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS		0	1	0		50.00
	0	0		0		50.00
	372	0		0		52.00
	3/2	0		0		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74. 00 07400 RENAL DIALYSIS	0	0		0		74.00
76. 00 03950 ANCI LLARY - OTHER	0	0		0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
OUTPATIENT SERVICE COST CENTERS	<u>Ч</u>	0	I	0		/0. //
91. 00 09100 EMERGENCY	0	160		0		91.00
92. 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						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
200.00 Total (lines 50-199)	372	160		0		200.00
						•

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0048	Peri od:	Worksheet D	
			Component	CCN: 15-T048	From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
			component	CCN. 13-1046	10 12/31/2010	5/25/2017 3:1	5 pm
			Title	× XVIII	Subprovider -	PPS	<u> </u>
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS	,				1	-
50.00	05000 OPERATING ROOM	0. 240275	0		0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 252278	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 171173	0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 134638	0		0 0	0	
60.00	06000 LABORATORY	0. 185965	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 191977	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0. 705437	0		0 0	0	00.00
69.00	06900 ELECTROCARDI OLOGY	0. 137224	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 251772	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157365	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 645845	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 315960	0		0 0	0	73.00
74.00	07400 RENAL DIALYSIS	1.005308	0		0 0	0	74.00
76.00	03950 ANCILLARY - OTHER	0. 000000	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 309649	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
91.00	09100 EMERGENCY	0. 205042	160		0 187	33	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 673293	0		0 0	0	92.00
93.00	04040 PATIENT CARE CENTER - OCC	0. 482966	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS			•			1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 510463	0		0 0	0	96.00
200.00	Subtotal (see instructions)		160		0 187	33	200.00
201.00					0 0		201.00
	Only Charges						
202.00			160	1	0 187	33	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-0048 Period: To 12/31/2016 Period: Deriver Period: Deriver Period: Deriver Period: Deriver Period: Deriver Period: Deriver Worksheet D Period: Deriver Period: Deriver Worksheet D Period: Deriver Period: Deriver Worksheet D Deriver Period: Deriver Period: Deriver Worksheet D Deriver Period: Deriver Deriver Deriver Deriver	Health Financial Systems REID	HOSPI TAL & HEALT	H CARE SERVI	CES	In Lie	u of Form CMS-	-2552-10
ANCI LLARY SERVICE COST CENTERS Cost					Peri od:	Worksheet D	
Cost Center Description Cost Cost Center Description 50:00 0 0 0			Component (CN. 15 TO49			oporod
Cost Center Description Costs Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 50.00			component c	CN: 15-1048	10 12/31/2016		epareu: 15 pm
Cost Center Description Costs Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0			Title	XVIII	Subprovider -		
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92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 9 <td></td> <td>0</td> <td>38</td> <td></td> <td></td> <td></td> <td>91.00</td>		0	38				91.00
93.0004040PATI ENT CARE CENTER - OCC0093.00OTHER REI MBURSABLE COST CENTERS96.0009600DURABLE MEDI CAL EQUI P-RENTED0096.00200.00Subtotal (see instructions)038200.00201.00Less PBP Clinic Lab. Services-Program0201.00201.00		0					
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200.00Subtotal (see instructions)038200.00201.00Less PBP Clinic Lab. Services-Program0201.00201.00Only Charges0000		0	0				96.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0		0					
Only Charges		0					
202.00 Net Charges (line 200 +/- line 201) 0 38 202.00	202.00 Net Charges (line 200 +/- line 201)	0	38				202.00

Health Fina	ancial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
APPORTI ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
					From 01/01/2016 To 12/31/2016		narodi
					10 12/31/2010	5/25/2017 3:1	pareu. 5 pm
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		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	
	LLARY SERVICE COST CENTERS	0.040075		0.070.70			
	DO OPERATING ROOM	0. 240275		2, 070, 73			00.00
	DO DELIVERY ROOM & LABOR ROOM	0. 252278		, , , , , ,		u u	
	DO RADI OLOGY-DI AGNOSTI C	0. 171173		2, 792, 20		0	
	DO CARDI AC CATHETERI ZATI ON	0. 134638		883, 17		0	
	DO LABORATORY	0. 185965		1, 459, 78		0	
	DO RESPI RATORY THERAPY	0. 191977		70, 54		0	00.00
	DO PHYSI CAL THERAPY	0. 705437		610, 38		0	66.00
	DO ELECTROCARDI OLOGY	0. 137224		302, 90		0	07.00
	DO ELECTROENCEPHALOGRAPHY	0. 251772		40, 66		0	1 0.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157365			3 0	0	
	DO IMPL. DEV. CHARGED TO PATIENT	0. 645845		210, 57		0	1 2.00
	DO DRUGS CHARGED TO PATIENTS	0. 315960		1, 726, 22		0	
	DO RENAL DI ALYSI S	1.005308		52	2 0	0	1 1 100
	50 ANCI LLARY - OTHER	0. 000000			0 0	0	76.00
	97 CARDI AC REHABI LI TATI ON	0. 309649	0	9, 53	2 0	0	76.97
	PATIENT SERVICE COST CENTERS		I	I			
	DO EMERGENCY	0. 205042		2, 528, 01		0	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	0. 673293		2, 1, 10		-	1 12:00
	40 PATIENT CARE CENTER - OCC	0. 482966	0	123, 46	6 0	0	93.00
	ER REIMBURSABLE COST CENTERS	1		1	-		
	DO DURABLE MEDICAL EQUIP-RENTED	0. 510463	0		0 0	0	1 20.00
200.00	Subtotal (see instructions)		0	13, 174, 42	0 0		200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0	1	201.00
	Only Charges					1	
202.00	Net Charges (line 200 +/- line 201)		0	13, 174, 42	0 0	0	202.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pro 5/25/2017 3:	epared: 15 pm
		Titl	e 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 OPERATI NG ROOM	497, 545					50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 946					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	477, 950					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	118, 908					59.00
60. 00 06000 LABORATORY	271, 469	0				60.00
65. 00 06500 RESPI RATORY THERAPY	13, 544					65.00
66. 00 06600 PHYSI CAL THERAPY	430, 587	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	41, 566	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	10, 238	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	135, 998	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	545, 419	0				73.00
74.00 07400 RENAL DIALYSIS	525	0				74.00
76.00 03950 ANCI LLARY - OTHER	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 952	0				76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	518, 350	0	1			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	184, 806	0				92.00
93.00 04040 PATIENT CARE CENTER - OCC	59, 630	0				93.00
OTHER REIMBURSABLE COST CENTERS		•				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	3, 327, 443	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 327, 443	0				202.00

REID HOSPITAL	&	HEALTH	CARE	SERVI CES

	Financial Systems REID HOSPITAL & HEALT			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016		pare
		Title XVIII	Hospi tal	5/25/2017 3: 1 PPS	5 pili
	Cost Center Description		noopi tui		
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		32, 653	1.
. 00	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			32, 653	
. 00	Private room days (excluding swing-bed and observation bed da		rivate room davs	0	
. 00	do not complete this line.		rvate room days,	Ū	0.
. 00	Semi-private room days (excluding swing-bed and observation b	bed days)		29, 819	4.
.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	7
	reporting period			_	_
. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Dreaman (avaluating	a owing had and	10 255	9.
. 00	newborn days)	to the Program (excruding	g swing-bed and	18, 255	9
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	com days)	0	10
0.00	through December 31 of the cost reporting period (see instruc		oom days)	0	1 '0
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e			-	
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	te room days)	0	12
	through December 31 of the cost reporting period		-		
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y		,		
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only)			0	16
7 00 7	SWING BED ADJUSTMENT	and through December 21 (of the cost	0.00	1 1 7
7.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through becember 31 c	on the cost	0.00	17
8. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
0.00	reporting period			0.00	'0
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
	reporting period	5			
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			30, 578, 775	
2.00	Swing-bed cost applicable to SNF type services through Decemb	ber 31 of the cost report	ting period (line	0	22
2 00	5 x line 17)	n 21 of the east reporting	a posted (line (0	1 22
3.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ig period (Time 6	0	23
4.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
4.00	7 x line 19)	el 31 01 the cost report	ng period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
6.00	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		30, 578, 775	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	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 mi	inus line 32)(soo instru	rtions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		500157	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	30, 578, 775	
	27 minus line 36)			00, 070, 770	"
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
		JUSTMENTS			1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			936.48	38
		e instructions)		936. 48 17, 095, 442	
9.00	Adjusted general inpatient routine service cost per diem (see	e instructions) e 38)			39

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	
				rom 01/01/2016		
			1	o 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
· · · · · · · · · · · · · · · · · · ·		Inpatient Days			(col. 3 x col.	
			col. 2)		4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0 0	0	42.00
Intensive Care Type Inpatient Hospital U	nits					
43.00 INTENSIVE CARE UNIT	7, 983, 001	4, 709	1, 695. 26	2,007	3, 402, 387	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	40.00
48.00 Program inpatient ancillary service cost	•				34, 307, 549	
49.00 Total Program inpatient costs (sum of li	nes 41 through 48)(see instructio	ns)		54, 805, 378	49.00
PASS THROUGH COST ADJUSTMENTS			Whet D arm	af Danta I and	1 105 450	50.00
50.00 Pass through costs applicable to Program	i inpatient routine	services (Tron	WKST. D, SUM	or Parts I and	1, 105, 459	50.00
51.00 Pass through costs applicable to Program	inpationt ancillar	sy sorvicos (fr	om What D a	m of Parts II	2, 056, 047	51.00
and IV)	i inpatrent anci i al	y services (II	UIII WKSt. D, St		2,030,047	51.00
52.00 Total Program excludable cost (sum of li	nes 50 and 51)				3, 161, 506	52.00
53.00 Total Program inpatient operating cost e	,	lated non-phy	sician anesthe	tist and	51, 643, 872	
medical education costs (line 49 minus l		, acoa, non piŋ		and and	01,010,072	00100
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program di scharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient op	erating cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cos	st reporting period	ending 1996, u	pdated and com	pounded by the	0.00	59.00
market basket						
60.00 Lesser of lines 53/54 or 55 from prior y					0.00	
61.00 If line 53/54 is less than the lower of					0	61.00
which operating costs (line 53) are less		ts (lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (see instructions)					1
62.00 Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive		ictions)			0	63.00
64.00 PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine		mbor 21 of the	cost roportir	a pariod (Soo	0	64.00
instructions) (title XVIII only)	costs through bece		cost reportin	ig per lou (see	0	04.00
65.00 Medicare swing-bed SNF inpatient routine	costs after Decemb	per 31 of the c	ost reporting	neriod (See	0	65.00
instructions) (title XVIII only)			ost reporting		, o	00.00
66.00 Total Medicare swing-bed SNF inpatient r	outine costs (line	64 plus line 6	5)(title XVIII	onlv). For	0	66.00
CAH (see instructions)				57		
67.00 Title V or XIX swing-bed NF inpatient ro	outine costs through	n December 31 d	f the cost rep	orting period	0	67.00
(line 12 x line 19)						
68.00 Title V or XIX swing-bed NF inpatient ro	outine costs after D	December 31 of	the cost repor	ting period	0	68.00
(line 13 x line 20)					_	
69.00 Total title V or XIX swing-bed NF inpati					0	69.00
PART III - SKILLED NURSING FACILITY, OTH						70.00
70.00 Skilled nursing facility/other nursing f 71.00 Adjusted general inpatient routine servi	5					70.00
71.00 Adjusted general inpatient routine servi 72.00 Program routine service cost (line 9 x l		The 70 - The	2)			72.00
5	· ·	line 14 v li	ng 35)			73.00
73.00 Medically necessary private room cost ap 74.00 Total Program general inpatient routine						74.00
75.00 Capital -related cost allocated to inpati				int II column		75.00
26, line 45)	Sine roatine service	(110m W	S. KSHOOL D, FC			, 5. 00
76.00 Per diem capital-related costs (line 75	÷line 2)					76.00
77.00 Program capital -related costs (line 9 x						77.00
78.00 Inpatient routine service cost (line 74						78.00
79.00 Aggregate charges to beneficiaries for e		provider record	s)			79.00
80.00 Total Program routine service costs for			· · · ·	ıs line 79)		80.00
81.00 Inpatient routine service cost per diem	limitation					81.00
82.00 Inpatient routine service cost limitatio	on (line 9 x line 81)				82.00
83.00 Reasonable inpatient routine service cos	sts (see instruction	ıs)				83.00
84.00 Program inpatient ancillary services (se	e instructions)					84.00
85.00 Utilization review - physician compensat						85.00
	(sum of lines 83 th	rough 85)				86.00
86.00 Total Program inpatient operating costs		n eugn ee)				
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST	i odgir ooy				
PART IV - COMPUTATION OF OBSERVATION BED 87.00 Total observation bed days (see instruct	PASS THROUGH COST i ons)				2, 834	
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST ions) per diem (line 27 ÷	line 2)			2, 834 936. 48 2, 653, 984	88.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lieu of Form CMS-2			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1		
				To 12/31/2016			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	1, 522, 897	30, 578, 775	0. 04980	2 2, 653, 984	132, 174	90.00	
91.00 Nursing School cost	0	30, 578, 775	0.00000	0 2, 653, 984	0	91.00	
92.00 Allied health cost	0	30, 578, 775	0.00000	0 2, 653, 984	0	92.00	
93.00 All other Medical Education	0	30, 578, 775	0.00000			93.00	

	Financial Systems REID HOSPITAL & HEALTH ATION OF INPATIENT OPERATING COST	CARE SERVICES Provider CCN: 15-0048	In Lie Period:	u of Form CMS-2 Worksheet D-1		
		Component CCN: 15-S048	From 01/01/2016 To 12/31/2016		pared:	
		Title XVIII	Subprovider -	PPS		
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			10, 560	1.00	
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day	10, 560 0	2.00 3.00			
	do not complete this line.		rvate room days,			
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		ar 31 of the cost	10, 560 0	4.00 5.00	
	reporting period			0	5.00	
6.00	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	
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	- 31 of the cost	0	7.00	
8.00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	81 of the cost	0	8.00	
	reporting period (if calendar year, enter 0 on this line)	-		-		
9.00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	7, 681	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00	
11.00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		coom dave) after	0	11.00	
11.00	December 31 of the cost reporting period (if calendar year, en		com days) arter	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	K only (including privat	te room days)	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	K only (including privat	te room days)	0	13.00	
14.00	after December 31 of the cost reporting period (if calendar ye			0	14.00	
14.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	0				
16.00	Nursery days (title V or XIX only)			0	16.00	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.00	
10.00	reporting period	0.00	10.00			
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	0.00	18.00			
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	f the cost	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to service: reporting period	s after December 31 of 1	the cost	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions			5, 615, 619		
22.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost report	ting period (line	0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00	
24.00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00	
25 00	7 x line 19)			0	25.00	
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reporting	j period (iine 8	0	25.00	
26.00	Total swing-bed cost (see instructions)			0		
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 615, 619	27.00	
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0		
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0		
31.00	General inpatient routine service cost/charge ratio (line 27 -	+ line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)				32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00 34.00			
34.00 35.00						
36.00	51					
37.00	00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5,615,619					
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
	Adjusted general inpatient routine service cost per diem (see			531.78 4,084,602	38.00 39.00	
39.00 40.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			4, 084, 602		
	Total Program general inpatient routine service cost (line 39	. ,		4, 084, 602	41.00	

leal th	Financial Systems REID	HOSPITAL & HEALT	TH CARE SERVI	CES	In Lie	eu of Form CMS-	2552
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	
			Component		From 01/01/2016 To 12/31/2016		
			Title	e XVIII	Subprovider -	PPS	J pi
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Costlr				(col. 3 x col.	
				col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0 0	0	42
. 00	INTENSIVE CARE UNIT	0	C	0.0	0 0	0	43
. 00	CORONARY CARE UNIT	0	C	0.0	0		44
5.00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
7.00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)			1, 057, 105	48
. 00	Total Program inpatient costs (sum of lines			ons)		5, 141, 707	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from	n Wkst. D, sum	of Parts I and	172, 208	50
	111)						
1.00	Pass through costs applicable to Program inp	batient ancillary	services (fr	om Wkst. D, s	um of Parts II	94, 619	51
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				266, 827	52
3.00	Total Program inpatient operating cost exclu	,	ated non-phy	vsician anesth	etist and	4, 874, 880	
	medical education costs (line 49 minus line						
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
1.00	Program di scharges					0	
5.00	Target amount per discharge					0.00	
o. 00 7. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	act amount (1	ino E4 minus	Lino E2)	0	
. 00 3. 00	Bonus payment (see instructions)	ing cost and tary	get anount (i	The 50 million	TTHE 55)	0	
9.00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	ndina 1996. u	updated and co	mpounded by the		
	market basket	5 1 5 1 5 1	5		p		
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
1.00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(TINES 54 X	60), or 1% or	the target		
2.00	Relief payment (see instructions)	Thistructions)				0	62
3.00	Allowable Inpatient cost plus incentive pay	nent (see instruc [.]	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•					
1.00	Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	e cost reporti	ng period (See	0	64
- 00	instructions)(title XVIII only)	the effect Described	- 01 -6 +6				
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after December	r 31 of the C	cost reporting	period (See	0	65
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVII	lonly) For	0	66
5.00	CAH (see instructions)						
7.00	Title V or XIX swing-bed NF inpatient routir	ne costs through [December 31 d	of the cost re	porting period	0	67
	(line 12 x line 19)						
8.00	Title V or XIX swing-bed NF inpatient routir	ne costs after Dec	cember 31 of	the cost repo	rting period	0	68
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ine 67 ± line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ine service d	cost (line 37)			70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71
2.00	Program routine service cost (line 9 x line			25)			72
3.00	Medically necessary private room cost applic						73
. 00 5. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74
. 00	26, line 45)	I JULINE SELVICE (IN KONCEL D, P	artir, curumn		'
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital-related costs (line 9 x line						7
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces						79
00 .	Total Program routine service costs for comp		st limitation	ı (IINE /8 min	us line /9)		80
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						8
3. 00	Reasonable inpatient routine service cost ()				83
. 00	Program inpatient ancillary services (see in	•	/				84
5. 00	Utilization review - physician compensation		s)				8
b. 00	Total Program inpatient operating costs (sum						86
_	PART IV - COMPUTATION OF OBSERVATION BED PAS					1	
	3 .					0	
			rine 2)				
87.00 88.00 89.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	diem (line 27 ÷ l	line 2)				0 0. 00 0

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
		Component (CCN: 15-S048	To 12/31/2016		
	_	Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	236, 779	5, 615, 619	0. 04216	04 0	0	90.00
91.00 Nursing School cost	0	5, 615, 619	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 615, 619	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 615, 619			0	93.00

alth Financial Systems REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-2	2552-
MPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet D-1	
	Component CCN: 15-T048	To 12/31/2016		
	Title XVIII	Subprovider -	5/25/2017 3: 15 PPS	5 pm
	n tre XVIII	I RF	FF3	_
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS			1.00	
I NPATI ENT DAYS				
00 Inpatient days (including private room days and swing-bed day 00 Inpatient days (including private room days, excluding swing-	s, excluding newborn)		3, 517 3, 517	1. (2. (
00 Private room days (excluding swing-bed and observation bed da		ivate room davs.	3, 517	
do not complete this line.				
00 Semi-private room days (excluding swing-bed and observation b			3, 517	4.
00 Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	er 31 of the cost	0	5.
00 Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
reporting period (if calendar year, enter 0 on this line)		01 - C + h +	0	-
00 Total swing-bed NF type inpatient days (including private roo reporting period	in days) through becember	31 OF the Cost	0	7.
00 Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 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	a the Dreaman (avaluding	owing had and	2, 326	9.
00 Total inpatient days including private room days applicable to newborn days)	o the Program (excruding	swing-bed and	2, 320	9.
0.00 Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.
through December 31 of the cost reporting period (see instruc .00 Swing-bed SNF type inpatient days applicable to title XVIII o		com dave) after	0	11.
December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11.
2.00 Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	12.
through December 31 of the cost reporting period 8.00 Swing-bed NF type inpatient days applicable to titles V or XI.	V only (including privat	o room dave)	0	13.
after December 31 of the cost reporting period (if calendar y			0	13.
.00 Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
.00 Total nursery days (title V or XIX only) .00 Nursery days (title V or XIX only)			0	
SWING BED ADJUSTMENT			0	10.
0. 00 Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17.
reporting period B.OO Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
reporting period			0.00	10.
0.00 Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.
reporting period 0.00 Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.
reporting period				
.00 Total general inpatient routine service cost (see instruction 2.00 Swing-bed cost applicable to SNF type services through Decemb	2	ing ported (line	2, 511, 049	21. 22.
5 x line 17)	er 31 of the cost report	ing period (inne	0	22.
8.00 Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.
x line 18) . OO Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost reporti	ng period (line	0	24.
7 x line 19)	a si oi the cost reporti	ng period (inne	0	24.
5.00 Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.
x line 20) 0.00 Total swing-bed cost (see instructions)			0	26.
General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 511, 049	
PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	d and abcomuction had ab		0	1 20
8.00 General inpatient routine service charges (excluding swing-be 9.00 Private room charges (excluding swing-bed charges)	and observation bed ch	lar ges)	0	
0.00 Semi-private room charges (excluding swing-bed charges)			0	
.00 General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
2.00 Average private room per diem charge (line 29 ÷ line 3) 2.00 Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
.00 Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
00 Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
 D. 00 Private room cost differential adjustment (line 3 x line 35) C. 00 General inpatient routine service cost net of swing-bed cost 	and private room cost di	fferential (line	0 2, 511, 049	36. 37.
27 minus line 36)			2, 311, 049	37.
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			713.97	38.
0.00 Program general inpatient routine service cost per drem (see			1, 660, 694	
0.00 Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40.
.00 Total Program general inpatient routine service cost (line 39	+ line 40)		1, 660, 694	1 41

		HOSPITAL & HEALT				u of Form CMS-	
OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0048	Period: From 01/01/2016	Worksheet D-1	1
			Component	CCN: 15-T048	To 12/31/2016		
			Title	e XVIII	Subprovider -	5/25/2017 3: 1 PPS	15 pr
					I RF		
	Cost Center Description	Total Inpatient CostIr	Total	Average Per		Program Cost (col. 3 x col.	
			ipatient bays	col. 2)	-	4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	0	0.0	0 00	0) 42
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0	0 00	C	43
. 00	CORONARY CARE UNIT	0	U	0.0	0		43
	BURN I NTENSI VE CARE UNI T						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			1, 456, 053	3 48
. 00	Total Program inpatient costs (sum of lines			ns)		3, 116, 747	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from	Wkst. D, sun	n of Parts I and	112, 532	2 50
. 00) Pass through costs applicable to Program inpa	ationt ancillary	sorvicos (fr	om What D	sum of Parts II	352, 688	3 51
. 00	and IV)	Then t and that y	Services (II	UNI WKSt. D, 3		332,000	
2. 00	Total Program excludable cost (sum of lines !	,				465, 220	
3.00	Total Program inpatient operating cost exclud		ated, non-phy	sician anestr	netist, and	2, 651, 527	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					C	54
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	5
. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)	conting portiod o	ading 100(indated and a	manundad by the		
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	Jorting period er	nui ng 1996, t	puated and co	hipounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year (cost report, upd;	ated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 ei	nter the less	er of 50% of		0	61
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	f the target		
. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				l c	62
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST					<u> </u>	
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	C	64
00	instructions)(title XVIII only)	to often Decembe	a 21 of the a	act conceting	n partial (Cas	C	
6.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	s arter December	i si oi the c	ost reporting	g period (see		65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6 [,]	4 plus line 6	5)(title XVII	I only). For	C	66
	CAH (see instructions)				•		
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through I	December 31 c	f the cost re	eporting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	a costs after De	combor 31 of	the cost ren	orting period	C	68
5. 00	(line 13 x line 20)			the cost rept	bitting period		
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (li	ine 67 + line	: 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU						
0. 00	Skilled nursing facility/other nursing facili	5		• •			70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne vo ÷ i i ne	<i>∠)</i>			71
. 00	Medically necessary private room cost applica	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	ce costs (line i	72 + line 73)				74
. 00	Capital-related cost allocated to inpatient i	routine service (costs (from W	orksheet B, F	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital -related costs (line 9 x line						7
00	Inpatient routine service cost (line 74 minus	s line 77)					78
	Aggregate charges to beneficiaries for excess						79
	Total Program routine service costs for compa		st limitatior	(line 78 mir	nus line 79)		80
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						8
. 00	Reasonable inpatient routine service cost inmitation (in	· · · · · · · · · · · · · · · · · · ·)				83
. 00	Program inpatient ancillary services (see ins		<i>,</i>				84
	Utilization review - physician compensation		s)				85
. 00	Total Program inpatient operating costs (sum		ough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					^	- -
	Total observation bed days (see instructions)					0	
	Adjusted general inpatient routine cost per o	diem (line 27 ∸)	line 2)			0.00) X>

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-T048	From 01/01/2016 To 12/31/2016		
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	170, 152	2, 511, 049	0.06776	0 0	0	90.00
91.00 Nursing School cost	0	2, 511, 049	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 511, 049	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 511, 049	0.00000	0 0	0	93.00

REI D	HOSPI TAL	&	HEALTH	CARE	SERVI CE	S

	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES	In Lie	u of Form CMS-2	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	Worksheet D-1	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
			10 12/01/2010	5/25/2017 3:1	
		Title XIX	Hospi tal	Cost	
	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	s, excluding newborn)		32, 653	1.0
	Inpatient days (including private room days, excluding swing-			32, 653	2.0
. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	rivate room days,	0	3. C
	do not complete this line.				
. 00	Semi-private room days (excluding swing-bed and observation be			29, 819	
. 00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decembe	er 31 of the cost	0	5.0
. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)			0	
. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	- 31 of the cost	0	7.0
	reporting period				
. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	31 of the cost	0	8.0
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	a the Brogram (oveluding	swing bod and	713	9.0
. 00	newborn days)		j swing-bed and	/13	7.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private m	room days)	0	10. C
	through December 31 of the cost reporting period (see instruct				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11.0
2.00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		to room days)	0	12.0
2.00	through December 31 of the cost reporting period		te room uays)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI)	K only (including privat	te room days)	0	13.0
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lir	ne)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			2,026	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			49	16.0
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost	0.00	17.0
	reporting period			0100	
8.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. C
0.00	reporting period			0.00	10.0
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. C
0. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of 1	the cost	0.00	20.0
	reporting period				
	Total general inpatient routine service cost (see instructions			30, 578, 775	
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.0
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 4	0	23. C
3.00	x line 18)	ST OF THE COST TEPOLITY	ig period (Title o	0	23.0
4.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.0
6. 00	x line 20) Total swing-bed cost (see instructions)			0	26. C
7.00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		30, 578, 775	
7.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			00,010,110	27.0
8.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28. C
	Private room charges (excluding swing-bed charges)			0	
0.00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27 -	÷ line 28)		0.000000	
2.00 3.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
4.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	ctions)	0.00	
5. 00	Average per diem private room cost differential (line 34 x lin		/	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
7.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	30, 578, 775	37.0
	27 minus line 36)				-
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			-
	Adjusted general inpatient routine service cost per diem (see			936.48	38 0
	Program general inpatient routine service cost (line 9 x line	-		667, 710	
	Medically necessary private room cost applicable to the Progra			0	
	Total Program general inpatient routine service cost (line 39	1		667, 710	

	Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
					rom 01/01/2016		
				1	o 12/31/2016	Date/Time Pre 5/25/2017 3:1	
			Ti +1	e XIX	Hospi tal	Cost	5 pili
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	cost center bescription		Inpatient Days			(col. 3 x col.	
		Inpatrent Cost	Inpatrent Days	col. 2)	- -	4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	749,005					12.00
42.00			2,020		49	10, 115	42.00
42.00	Intensive Care Type Inpatient Hospital Unit		4 700	1 (05.2)	114	102.2(0	42.00
43.00	INTENSIVE CARE UNIT	7, 983, 001	4, 709	1, 695. 26	5 114	193, 260	
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.OC
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (W					1, 461, 403	
49.00	Total Program inpatient costs (sum of lines	s 41 through 48)((see instructio	ns)		2, 340, 488	49. OC
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program in	npatient routine	services (from	Wkst. D, sum	of Parts I and	0	50. OC
	111)						
51.00	Pass through costs applicable to Program in	npatient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51.OC
	and IV)						
52.00	Total Program excludable cost (sum of lines	s 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excl	uding capital re	elated, non-phy	si ci an anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line	e 52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient opera	ating cost and ta	arget amount (L	ine 56 minus l	ine 53)	0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost r	eporting period	ending 1996 u	undated and com	nounded by the	0.00	
57.00	market basket	epor tring period	chunng 1770, u	puatea ana com	ipounded by the	0.00	37.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the m	arket hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of lin				he amount by	0.00	61.00
01.00	which operating costs (line 53) are less th					0	
	amount (line 56), otherwise enter zero (see		L3 (111163 54 X		the target		
62.00	Relief payment (see instructions)	instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive pay	mont (coo instru	(ctions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
(1 00	Medicare swing-bed SNF inpatient routine co	ata through Door	mbor 21 of the		a pariad (See	0	64.00
64.00		Sts through Dece		cost reportin	ig per l'ou (see	0	04.00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	ote ofter Decemb	or 21 of the e	oct roporting	noriad (Soo	0	65.00
05.00				ost reporting	perrou (see	0	05.00
((00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ina anata (lina	(1 plug ling (E) (+; + ~ V)/	only) For	0	66.00
66.00	CAH (see instructions)	The costs (The	o4 prus rifie o	5)(title xviii	UTTY). FUT	0	00.00
67.00	Title V or XIX swing-bed NF inpatient routi	no costs through	December 21 o	f the cost ror	orting pariod	0	67.00
07.00	(line 12 x line 19)	The costs thirough	i December 31 0	i the cost rep	or tring period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routi	no costs ofter F	locombor 21 of	the cost repor	ting poriod	0	68.00
00.00	s .		becember 31 01	the cost repor	ting period	0	00.00
40.00	(line 13 x line 20)	routino costa ((lino 47 , lino	40)		0	40.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	69.00
70 00			•				70 00
70.00 71.00	Skilled nursing facility/other nursing faci	3					70.00
	Adjusted general inpatient routine service		ine /u ÷ line	۷)			71.00
72.00	Program routine service cost (line 9 x line		(line 14	no 2E)			72.00
73.00	Medically necessary private room cost appli	U U	•	,			73.00
74.00	Total Program general inpatient routine ser						74.00
75.00	Capital -related cost allocated to inpatient	routine service	e costs (from W	orksheet B, Pa	ιτι, column		75.00
	26, line 45)						
76.00	Per diem capital-related costs (line 75 ÷ 1						76.00
77.00	Program capital -related costs (line 9 x lir	· · · · ·					77.00
78.00	Inpatient routine service cost (line 74 mir						78.00
79.00	Aggregate charges to beneficiaries for exce			· · ·			79.00
80.00	Total Program routine service costs for con		cost limitation	(line 78 minu	ıs line 79)		80.0
81.00	Inpatient routine service cost per diem lin						81.00
82.00	Inpatient routine service cost limitation ([line 9 x line 81	1)				82.0
83.00	Reasonable inpatient routine service costs	(see instruction	ıs)				83.00
05.00	Program inpatient ancillary services (see i						84.00
	Utilization review - physician compensation		ons)				85.0
84.00							86.00
84. 00 85. 00	llotal Program inpatient operating costs (su					1	1 - 5. 50
84.00 85.00 86.00	Total Program inpatient operating costs (su PART LV - COMPUTATION OF OBSERVATION BED PA		<u> </u>				
84.00 85.00 86.00	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST	<u>v</u> ,			2 834	87 0
84. 00 85. 00 86. 00 87. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction	SS THROUGH COST				2, 834 936, 48	
84.00 85.00 86.00 87.00 88.00	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST ns) diem (line 27 ÷	÷line 2)			2, 834 936. 48 2, 653, 984	88.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		pared: 5 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 522, 897	30, 578, 775	0. 04980	2 2, 653, 984	132, 174	90.00
91.00 Nursing School cost	0	30, 578, 775	0.00000	0 2, 653, 984	0	91.00
92.00 Allied health cost	0	30, 578, 775	0.00000	0 2, 653, 984	0	92.00
93.00 All other Medical Education	0	30, 578, 775	0. 00000	0 2, 653, 984	0	93.00

lealth Financial Systems	REID HOSP	ITAL & HEALTH	CARE SERVICES	In Lie	u of Form CMS-2	2552-
COMPUTATION OF INPATIENT	OPERATING COST		Provider CCN: 15-0048	Peri od:	Worksheet D-1	
			Component CCN: 15-SO48	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	parec 5 pm
			Title XIX	Subprovider -	Cost	<u>o p</u>
Cost Center	Description				1.00	
PART I - ALL PROVI	DER COMPONENTS				1.00	-
.00 Inpatient days (in	ncluding private room days and s	wing-bed days	excluding newborn)		10, 560	1 1.0
	ncluding private room days, excl	0 5	5		10, 560	
	(excluding swing-bed and observ	ation bed day	s). If you have only pr	ivate room days,	0	3.0
.00 do not complete t .00 Semi-private room	nis line. days (excluding swing-bed and o	bearvation ba	d dave)		10, 560	4.
	VF type inpatient days (includin		5 7	r 31 of the cost	10, 500	
reporting period						
	NF type inpatient days (includin (if calendar year, enter O on th		m days) after December	31 of the cost	0	6.
	f type inpatient days (including		davs) through December	31 of the cost	0	7.
reporting period			5			
	type inpatient days (including (if colordar your option 0 op the		days) after December 3	1 of the cost	0	8.
	(if calendar year, enter O on th ays including private room days		the Program (excluding	swing-bed and	0	9.
newborn days)				g	-	
	e inpatient days applicable to t			oom days)	0	10.
	31 of the cost reporting period e inpatient days applicable to t			oom davs) after	0	11.
December 31 of the	e cost reporting period (if cale	ndar year, en	ter 0 on this line)	5,	-	
	inpatient days applicable to ti	tles V or XIX	only (including privat	e room days)	0	12.
	31 of the cost reporting period inpatient days applicable to ti	tles V or XIX	only (including privat	e room days)	0	13.
after December 31	of the cost reporting period (i	f cal endar ye	ar, enter O on this lin	e)	Ū	
	ry private room days applicable	to the Progra	m (excluding swing-bed	days)	-	14.
5.00 Total nursery days 5.00 Nursery days (tit	s (title V or XIX only)				2, 026	15.
SWING BED ADJUSTME					47	1 10.
	swing-bed SNF services applicab	le to service	s through December 31 c	f the cost	0.00	17.
reporting period 8.00 Medicare rate for	swing-bed SNF services applicab	la ta sorvica	s after December 21 of	the cost	0.00	10
reporting period	swillig-bed swill services applicab	ie to service	saiter beceniber 51 01	the cost	0.00	10.
9.00 Medicaid rate for reporting period	swing-bed NF services applicabl	e to services	through December 31 of	the cost	0.00	19.
0.00 Medicaid rate for	swing-bed NF services applicabl	e to services	after December 31 of t	he cost	0.00	20.
reporting period 1.00 Total general inp	atient routine service cost (see	instructions)		5, 615, 619	21
5	blicable to SNF type services th		·	ing period (line	0,013,017	
5 x line 17)		0		.		
3.00 Swing-bed cost ap x line 18)	blicable to SNF type services af	ter December	31 of the cost reportin	g period (line 6	0	23.
-	plicable to NF type services thr	ough December	31 of the cost reporti	ng period (line	0	24.
7 x line 19)		C				
5.00 Swing-bed cost ap x line 20)	blicable to NF type services aft	er December 3	1 of the cost reporting	period (line 8	0	25.
	ost (see instructions)				0	26.
	routine service cost net of swi	ng-bed cost (line 21 minus line 26)		5, 615, 619	27.
	RENTIAL ADJUSTMENT routine service charges (exclud	ing swing-bod	and observation bed ch	arges)	0	28.
	ges (excluding swing-bed charges		and observation bed ci	ai ges)	0	
0.00 Semi-private room	charges (excluding swing-bed ch	arges)			0	
	routine service cost/charge rat	•	line 28)		0.000000	
<u> </u>	oom per diem charge (line 29 ÷ l ate room per diem charge (line 3				0.00 0.00	
	private room charge differential		us line 33)(see instruc	tions)	0.00	
	private room cost differential (e 31)		0.00	35.
1	differential adjustment (line 3		nd private room cost di	fforential (line	0 5 615 619	36.
27 minus line 36)	routine service cost net of swi	ng-bed cost a	nu private room cost di	inerential (IThe	5, 615, 619	37.
PART II – HOSPITÁL	AND SUBPROVIDERS ONLY					1
	OPERATING COST BEFORE PASS THRO				F04 70	1 20
3	npatient routine service cost p npatient routine service cost (l		-		531. 78 0	
0 0	ry private room cost applicable		-		0	
3	eral inpatient routine service c	0	. ,		0	41.

	<u> </u>	HOSPI TAL & HEA				eu of Form CMS-	
OMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-0048	Period: From 01/01/2016	Worksheet D-1	1
			Component	CCN: 15-S048	To 12/31/2016	Date/Time Pre	
			Tit	le XIX	Subprovider -	5/25/2017 3: Cost	15 pm
					I PF		
	Cost Center Description	Total Inpatient Cost	Total	Average Per		Program Cost (col. 3 x col.	
			inpatrent bay	col . 2)	•	4)	
	1	1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0		0 0.	0 00	C) 42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0 0.	0 00	C	43.
4.00	CORONARY CARE UNIT	0		0.	0		44.
5.00	BURN INTENSIVE CARE UNIT						45.
5.00	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	cost center bescription					1.00	+
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			97	/ 48.
9.00	Total Program inpatient costs (sum of lines			ons)		97	49.
	PASS THROUGH COST ADJUSTMENTS						1 50
0. 00	Pass through costs applicable to Program inp	atient routine	services (Tro	M WKST. D, SU	n of Parts I and	C	50
1.00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	0	51.
	and IV)		,				
2.00	Total Program excludable cost (sum of lines	,				0	
3. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		lated, non-ph	nysician anest	netist, and	C	53
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
I. 00	Program discharges					0	54
5.00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)		
9.00 9.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996.	updated and c	ompounded by the		
	market basket	p=::::					
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (TTHES 54)	(00), 01 1% 0	the target		
2.00	Relief payment (see instructions)	,				C	62
3.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			C) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST	to through Doos	mbor 21 of th	a agat napant	ng pariod (Saa	0	
1.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece		le cost report	ng period (see		64
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	g period (See	C	65
	instructions)(title XVIII only)						
6.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	l only). For	C) 66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	C	67
	(line 12 x line 19)	e coste til ough	200011201 01		sporting porrod		
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	f the cost rep	orting period	C	68 (
- <u></u>	(line 13 x line 20)	routino posto (va (0)			
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					C) 69
0. 00	Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service c	ost per diem (l	ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line	,	(1) 44				72
. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient	•			Part II. column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00 . 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der i recor	ds)			79
. 00	Total Program routine service costs for comp				nus line 79)		80
. 00	Inpatient routine service cost per diem limi	tation			,		81
. 00	Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs (s)				83
. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84
5.00 5.00	Total Program inpatient operating costs (sum	•					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS					·	
7.00	Total observation bed days (see instructions					0	
3.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)) 88.) 89.
. 00							

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component (CCN: 15-S048	From 01/01/2016 To 12/31/2016		pared: 5 pm
	_	Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	236, 779	5, 615, 619	0. 04216	04 0	0	90.00
91.00 Nursing School cost	0	5, 615, 619	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 615, 619	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 615, 619	0.00000	0 0	0	93.00

	Financial Systems REID HOSPITAL & HEALTH		In Lie	u of Form CMS-2	
MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	Worksheet D-1	
		Component CCN: 15-T048	From 01/01/2016 To 12/31/2016	Date/Time Pre	nare
			10 12/31/2010	5/25/2017 3:1	
		Title XIX	Subprovider -	Cost	
	Cost Center Description		IRF		
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		3, 517	1
00	Inpatient days (including private room days, excluding swing-b	bed and newborn days)		3, 517	2
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	rivate room days,	0	3
	do not complete this line.			0.547	
00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 21 of the cost	3, 517 0	45
0	reporting period	on days) thi ough becenbe	a si ui the cust	0	
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7
	reporting period	n dave) ofter December 2	1 of the east	0	
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	i days) after December 3	an of the cost	0	8
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	0	9
	newborn days)		, s g s s s s		
00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10
~~	through December 31 of the cost reporting period (see instruct			0	1.1
00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		com days) arter	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room davs)	0	12
	through December 31 of the cost reporting period			-	
00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13
~ ~	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0 2, 026	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2,028	
	SWING BED ADJUSTMENT				
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
. 00	reporting period	s through becomen of or		0.00	
. 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	<i>,</i>		2, 511, 049	
. 00	Swing-bed cost applicable to SNF type services through December 5×1 (ine 17)	er 31 of the cost report	ing period (iine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line 6	0	23
	x line 18)		5 1 2 2 2 2		
. 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)				0.5
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		2, 511, 049	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges)			0	29
00 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	Eline 28)		0 0. 000000	30 31
	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
	Average semi-private room per diem charge (line 20 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mir		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)	and antivata area and "	fforontial (1)	0	36
00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	iterential (line	2, 511, 049	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		713.97	
	Program general inpatient routine service cost (line 9 x line			0	
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	. ,		0	40 41

MPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	
			Component		To 12/31/2016	Date/Time Pre	pare
			Ti tl	e XIX	Subprovider -	5/25/2017 3:1 Cost	5 pii
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center beschiption	Inpatient Cost				(col. 3 x col.	
		•	· · ·	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42
00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43
00	CORONARY CARE UNIT	0	0	0.0	0	l v	44
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			0	48
00	Total Program inpatient costs (sum of lines 4	1 through 48)(s	ee instructio	ns)		0	
	PASS THROUGH COST ADJUSTMENTS						
00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50
.00) Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst D s	um of Parts II	0	51
. 00	and IV)	in one unor rung	301 11 003 (11			Ŭ	
00	Total Program excludable cost (sum of lines !	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesth	etist, and	0	53
	medical education costs (line 49 minus line 5	52)					1
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	
00	Bonus payment (see instructions)	5	5		,	0	58
00	Lesser of lines 53/54 or 55 from the cost rep	orting period e	nding 1996, u	pdated and co	mpounded by the	0.00	59
~ ~	market basket						
00	Lesser of lines 53/54 or 55 from prior year of				4 h a	0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than	5 55, 59 OF 60 6	enter the less (lines 54 v	er or 50% or 60) or 1% of	the target	0	61
	amount (line 56), otherwise enter zero (see i		(111e3 54 X	00), 01 1/0 01	the target		
00	Relief payment (see instructions)					0	62
00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	١.
00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Decem	iber 31 of the	cost reporti	ng period (See	0	64
00	Medicare swing-bed SNF inpatient routine cost	s after Decembe	er 31 of the c	ost reporting	period (See	0	65
00	instructions) (title XVIII only)			oot ropor tring	poi i ou (000	Ĵ	
00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66
~ ~	CAH (see instructions)			e			
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	t the cost re	porting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)				5 1 1 1		
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co	5					71
00	Program routine service cost (line 9 x line 3			,			72
00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
00	Total Program general inpatient routine servi	5	•	,			74
00	Capital-related cost allocated to inpatient i	routine service	costs (from W	orksheet B, P	art II, column		75
00	26, line 45) Por diam capital related costs (line 75 · lin	2)					-,
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		ovider record	is)			79
00	Total Program routine service costs for compa				us line 79)		80
00	Inpatient routine service cost per diem limit						8
00	Inpatient routine service cost limitation (li						82
00	Reasonable inpatient routine service costs (s		5)				83
00	Program inpatient ancillary services (see ins						84
00	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougii ob)				86
						0	87
. 00	Total observation bed davs (see instructions)						
00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-T048	From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	170, 152	2, 511, 049	0.06776	0 0	0	90.00
91.00 Nursing School cost	0	2, 511, 049	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 511, 049	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 511, 049	0.00000	0 0	0	93.00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CES CN: 15-0048	Peri od:	ieu of Form CMS- Worksheet D-3	
INIAL	ENT ANOTEEART SERVICE COST ATTORTONIMENT		CN. 15 0040	From 01/01/20		,
				To 12/31/20 ⁻	6 Date/Time Pre 5/25/2017 3:1	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			20, 911, 5		30.00
31.00	03100 I NTENSI VE CARE UNI T			6, 124, 5		31.00
40.00	04000 SUBPROVI DER - I PF			505, 0	24	40.00
41.00	04100 SUBPROVI DER – I RF				0	41.00
43.00						43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		0.0400			50.00
50.00	05000 OPERATING ROOM		0. 2402			
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2522			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1711			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1346			
60.00			0. 1859			
65.00	06500 RESPIRATORY THERAPY		0. 1919			
66.00	06600 PHYSI CAL THERAPY		0.7054			
69.00 70.00	06900 ELECTROCARDI OLOGY		0. 1372			
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2517 0. 1573		59 1,828 0 0	
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1573			
	07200 TMPL. DEV. CHARGED TO PATIENT		0. 8458			
74.00	07400 RENAL DIALYSIS		1. 0053			
76.00	03950 ANCI LLARY - OTHER		0.0000		0 0 0	
	07697 CARDI AC REHABI LI TATI ON		0.3096		-	
/0.9/	OUTPATIENT SERVICE COST CENTERS		0.3090	2,9	917	10.97
01 00	09100 EMERGENCY		0.2050	42 7, 214, 5	38 1, 479, 294	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6732			
	04040 PATIENT CARE CENTER - OCC		0. 4829			
/0.00	OTHER REIMBURSABLE COST CENTERS		0.4029	121,0	50,470	1 / 00
96 00	09600 DURABLE MEDICAL EQUI P-RENTED		0.5104	63	0 0	96.00
200.00			0.0104	130, 391, 4		
200.00		v charges (line 61)		100,071,4	0	201.00
-01.00	Net Charges (line 200 minus line 201)	, s.a. ges (1110 01)	1	130, 391, 4	~	202.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SEF	RVICES	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONN	ENT Provider	CCN: 15-0048	Period:	Worksheet D-3	
			From 01/01/2016		
	Componer	nt CCN: 15-SO48	To 12/31/2016		
		tle XVIII	Subprovider -	5/25/2017 3:1 PPS	<u>5 pm</u>
	11		IPF	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		TO Charges	Charges	(col. 1 x col.	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	25	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 SUBPROVIDER - I PF			7, 932, 491		40.00
41. 00 04100 SUBPROVIDER - IRF			0		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					40.00
50. 00 05000 OPERATI NG ROOM		0.2402	22, 059	5, 300	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2522		0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1711		73, 264	•
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13463		1, 854	•
60. 00 06000 LABORATORY		0. 18596			
65. 00 06500 RESPIRATORY THERAPY		0. 1919			
66. 00 06600 PHYSI CAL THERAPY		0. 70543			
69. 00 06900 ELECTROCARDI OLOGY		0. 1372			•
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2517		4, 555 0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	TENTS	0. 15736		0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	TENTS	0. 64584		-	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 31596			
74. 00 07400 RENAL DI ALYSI S		1.00530		5, 778	•
76. 00 03950 ANCI LLARY - OTHER		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 30964		0	•
OUTPATIENT SERVICE COST CENTERS		0.0070	., .	<u> </u>	/0. //
91. 00 09100 EMERGENCY		0. 20504	12 534, 837	109, 664	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)	0.6732		0	92.00
93. 00 04040 PATIENT CARE CENTER - OCC		0. 48296		755	
OTHER REIMBURSABLE COST CENTERS		0.1027	1,001	,,,,,	/0.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 51040	0	0	96.00
200.00 Total (sum of lines 50-94 and 9	6-98)		3, 823, 019		
	vices-Program only charges (line 61)	0,020,017	.,,	201.00
202.00 Net Charges (line 200 minus lin		<i>`</i>	3, 823, 019		202.00
		1	-,,01,	I	

Health Financial Systems REID HOSPITAL & HEALTH	CARE SERVICE	ES	In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0048		Peri od:	Worksheet D-3	
			From 01/01/2016		
	Component CC	CN: 15-T048	To 12/31/2016		
	Title XVIII		Subprovider -	5/25/2017 3:1	5 pm
			IRF	PPS	
Cost Center Description	l r	Ratio of Cos		Inpati ent	
	ľ	To Charges	Program	Program Costs	
		to charges		(col. 1 x col.	
			charges	2)	
	-	1.00	2.00	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 SUBPROVI DER - I RF			2, 397, 969		41.00
43. 00 04300 NURSERY			2, 377, 707		43.00
ANCI LLARY SERVI CE COST CENTERS					40.00
50. 00 05000 OPERATI NG ROOM		0. 24027	75 3, 181	764	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 25227		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23227		12, 175	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 13463		66	1
60. 00 06000 LABORATORY		0. 18596		36, 613	
65. 00 06500 RESPI RATORY THERAPY		0. 19197		33, 637	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 70543		1, 232, 603	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 13722		281	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 25177		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 15736		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 64584		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 31596		123, 102	
74. 00 07400 RENAL DIALYSIS		1.00530		16, 281	
76. 00 03950 ANCI LLARY - OTHER		0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 30964		0	76.97
OUTPATI ENT SERVICE COST CENTERS	I	0. 30704	0	0	/0. //
91. 00 09100 EMERGENCY		0. 20504	2 1, 851	380	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.67329		0	92.00
93. 00 04040 PATIENT CARE CENTER - OCC		0. 48296		151	93.00
OTHER REIMBURSABLE COST CENTERS	I	0. 40270	512	151	/0.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 51046	3 0	0	96.00
200.00 Total (sum of lines 50-94 and 96-98)		0.01040	2, 604, 210		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		2,001,210	1, 100, 000	201.00
202.00 Net Charges (line 200 minus line 201)			2, 604, 210		202.00
	I		2,000,7210	I	

	nanci al Systems REID HOSPI TAL & HEA ANCI LLARY SERVI CE COST APPORTI ONMENT			Peri od:	_ieu of Form CMS- Worksheet D-3	
	ANCIELARI SERVICE COST AFFORTIONWENT	Provider CCN: 15-00		From 01/01/20		5
				To 12/31/20	16 Date/Time Pro	
			e XIX	Hospi tal	5/25/2017 3: Cost	ro pili
	Cost Center Description		Ratio of Cos			
		To Charges		Program Costs		
			10 onarges	Charges	(col . 1 x col .	
				ondriges	2)	
		1.00	2.00	3.00		
I NF	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	000 ADULTS & PEDI ATRI CS			1, 539, 2	276	30. 00
31.00 03 [.]	100 I NTENSI VE CARE UNI T			319, 0	081	31.00
40.00 040	000 SUBPROVIDER - IPF			502, 4	45	40.00
41.00 04 [.]	100 SUBPROVIDER - IRF			44, 2	273	41.00
43.00 04:	300 NURSERY			397, 1		43.00
ANG	CILLARY SERVICE COST CENTERS					
50.00 050	000 OPERATING ROOM		0. 2402	75 1, 041, 9	250, 358	3 50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM		0. 2522	78 454, 7	96 114, 735	5 52.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C		0. 1711	73 474, 0	16 81, 139	9 54.00
59.00 054	900 CARDI AC CATHETERI ZATI ON		0. 1346	38 451, 4	60, 788	3 59.00
60. 00 060	000 LABORATORY		0. 1859	65 955, 1	81 177, 630	60. 00
65.00 06!	500 RESPI RATORY THERAPY		0. 1919	77 345, 5	66, 33	1 65.00
66.00 060	600 PHYSI CAL THERAPY		0.7054	37 126, 0	88, 918	3 66. 00
69.00 069	900 ELECTROCARDI OLOGY		0. 1372	24 91, 2		
70.00 070	000 ELECTROENCEPHALOGRAPHY		0. 2517		0 0	
71.00 07 [.]	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1573	65 7, 1	16 1, 120	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENT		0. 6458			5 72.00
73.00 07:	300 DRUGS CHARGED TO PATIENTS		0. 3159			2 73.00
74.00 074	400 RENAL DIALYSIS		1.0053	08 17, 2	23 17, 314	4 74.00
76.00 039	950 ANCI LLARY - OTHER		0.0000	00	0 0	76.00
76.97 070	697 CARDI AC REHABI LI TATI ON		0. 3096	49	0 0	76. 9
OUT	TPATIENT SERVICE COST CENTERS				!	
91.00 09	100 EMERGENCY		0. 2050	42 1, 8	351 380	0 91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)		0.6732		0 (92.00
	040 PATIENT CARE CENTER - OCC		0. 4829			93.00
	HER REIMBURSABLE COST CENTERS					
96.00 090	600 DURABLE MEDI CAL EQUI P-RENTED		0. 5104	63	0 (96.0
200.00	Total (sum of lines 50-94 and 96-98)			5, 581, 4	65 1, 461, 403	3 200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)			0	201.00
202.00	Net Charges (line 200 minus line 201)	/		5, 581, 4	65	202.00

	INCI AL SYSTEMS REID HOSPITAL & HEALTH ANCI LLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2016		
		Component	CCN: 15-SO48	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Ti tl	e XIX	Subprovider - IPF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS		1			
	0 ADULTS & PEDIATRICS			0		30.00
				1 041 400		31.0
	0 SUBPROVIDER - I PF			1, 041, 489		40.0
	0 SUBPROVIDER - IRF			0		41.0
	ONURSERY			0		43.0
	O OPERATI NG ROOM		0. 2402	75 0	0	50.0
	0 DELIVERY ROOM & LABOR ROOM		0. 2402		0	
	0 RADI OLOGY-DI AGNOSTI C		0. 2522		0	54.0
	0 CARDI AC CATHETERI ZATI ON		0. 1711		0	
	0 LABORATORY		0. 1340		0	60.0
	0 RESPI RATORY THERAPY		0. 1037		0	65.0
	0 PHYSI CAL THERAPY		0.7054		0	
	0 ELECTROCARDI OLOGY		0. 1372		0	
	0 ELECTROENCEPHALOGRAPHY		0. 2517		0	70.0
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1573		0	
	0 I MPL. DEV. CHARGED TO PATI ENT		0. 6458		0	1
	0 DRUGS CHARGED TO PATIENTS		0. 3159		0	
	0 RENAL DI ALYSI S		1.0053		0	74.0
	0 ANCI LLARY - OTHER		0.0000		0	
	7 CARDI AC REHABI LI TATI ON		0. 3096		0	
	ATIENT SERVICE COST CENTERS					
	0 EMERGENCY		0. 2050	42 473	97	91.0
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)		0. 6732	93 0	0	92.0
93.00 0404	O PATIENT CARE CENTER - OCC		0. 4829	66 0	0	93.0
	R REIMBURSABLE COST CENTERS					
	O DURABLE MEDICAL EQUIP-RENTED		0. 5104		0	
200. 00	Total (sum of lines 50-94 and 96-98)			473	97	200. 0
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.0
202.00	Net Charges (line 200 minus line 201)			473		202.00

Health Financial Syst INPATIENT ANCILLARY S	ems REID HOSPITAL ERVICE COST APPORTIONMENT		CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2016		
		Component	CCN: 15-T048	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Titl	le XIX	Subprovider - IRF	Cost	•
Cost Cen	er Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	NE SERVICE COST CENTERS		1			
30.00 03000 ADULTS &				0		30.0
31.00 03100 I NTENSI VE				0		31.0
40. 00 04000 SUBPROVI [0		40.0
41.00 04100 SUBPROVI [ER - IRF			277, 992		41.0
43.00 04300 NURSERY	CE COST CENTERS			0		43.0
50. 00 05000 OPERATI NO			0. 2402	75 0	0	50.0
	ROOM & LABOR ROOM		0. 2402		0	
54. 00 05400 RADI OLOG			0. 2322		0	
59.00 05900 CARDI AC (0. 1711		0	
60. 00 06000 LABORATO			0. 1340		0	
65. 00 06500 RESPI RATO			0. 1037		0	65.0
66. 00 06600 PHYSI CAL			0.7054		0	
69.00 06900 ELECTROCA			0. 1372		0	
70.00 07000 ELECTROE			0. 2517		0	
	UPPLIES CHARGED TO PATIENTS		0. 1573		0	
72.00 07200 IMPL. DEV			0. 6458		0	
	RGED TO PATIENTS		0. 3159		0	
74.00 07400 RENAL DI			1.0053		0	74.0
76.00 03950 ANCI LLAR	- OTHER		0.0000	00 0	0	76.0
76. 97 07697 CARDI AC I	EHABI LI TATI ON		0. 3096	49 0	0	76.9
OUTPATIENT SER	ICE COST CENTERS					
91.00 09100 EMERGENC			0. 2050	42 0	0	91.0
	ON BEDS (NON-DISTINCT PART)		0. 6732		0	
	ARE CENTER - OCC		0. 4829	66 0	0	93.0
	BLE COST CENTERS					
96.00 09600 DURABLE M			0. 5104		0	
	m of lines 50-94 and 96-98)			0	0	200. 0
	Clinic Laboratory Services-Program onl	y charges (line 61)		0		201.0
202.00 Net Charg	es (line 200 minus line 201)			0		202.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/25/2017 3:1	
		Title XVIII	Hospi tal	PPS	
			-	1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00	DRG Amounts Other than Outlier Payments		(0	
. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to Uctober i	(see	36, 227, 860	1.0
. 02	DRG amounts other than outlier payments for discharges occurr	ring on or after October	1 (see	12, 022, 772	1.0
	instructions)	-			
. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for discharges occurring	prior to October	0	1.0
. 04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1.0
	October 1 (see instructions)				
2.00 2.01	Outlier payments for discharges. (see instructions)			571, 534 0	1
2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	
. 00	Managed Care Simulated Payments			6, 779, 210	
. 00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	157.26	4.0
. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.0
. 00	or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs which meet	the criteria for an add	-on to the cap	0.00	6.0
	for new programs in accordance with 42 CFR 413.79(e)		(1)(1)(1)(1)	0.00	
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified			0.00 0.00	
	If the cost report straddles July 1, 2011 then see instruction		()()()()()()()	0.00	
. 00	Adjustment (increase or decrease) to the FTE count for allopa			0.00	8.
	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	79(c)(2)(iv), 64 FR 263	40 (May 12,		
. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under section 5503	of the ACA. If	0.00	8.
	the cost report straddles July 1, 2011, see instructions.				
8. 02	The amount of increase if the hospital was awarded FTE cap sl	ots from a closed teach	ing hospital	0.00	8.
. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir	ues (8 8 01 and 8 02)	(see	0.00	9.1
. 00	instructions)		(300	0.00	
	FTE count for allopathic and osteopathic programs in the curr	rent year from your reco	rds	0.00	
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00	
3.00	Total allowable FTE count for the prior year.			0.00	
4.00	Total allowable FTE count for the penultimate year if that ye	ear ended on or after Se	ptember 30, 1997,	0.00	14.
F 00	otherwise enter zero.			0.00	15
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 4.39	
	Adjustment for residents displaced by program or hospital clo	osure		0.00	
8. 00	Adjusted rolling average FTE count			4.39	
	Current year resident to bed ratio (line 18 divided by line 4	4).		0.027916	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 027965 0. 027916	
2.00	IME payment adjustment (see instructions)			730, 418	
2. 01	IME payment adjustment - Managed Care (see instructions)			102, 624	22.
3. 00	Indirect Medical Education Adjustment for the Add-on for Sect Number of additional allopathic and osteopathic IME FTE resid		Sec /12 105	0.00	23.
5.00	(f)(1)(iv)(C).		566. 412.105	0.00	23.
4.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
5.00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	25.
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
7.00	IME payments adjustment factor. (see instructions)			0. 000000	
8.00	IME add-on adjustment amount (see instructions)			0	1
8.01	IME add-on adjustment amount - Managed Care (see instructions	5)		0 720 419	1
9.00	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0)1)		730, 418 102, 624	
	Di sproporti onate Share Adjustment	···,		102, 024	2.
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	oatient days (see instru	ctions)	4.90	
1.00	Percentage of Medicaid patient days (see instructions)			20.50	
2.00 3.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	3)		25. 40 10. 17	
5.00	Disproportionate share adjustment (see instructions)	- /		1, 226, 772	

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Heal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147	35.00
35.01	Factor 3 (see instructions)		0. 000227066		
35.02	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line)	1, 454, 619	1, 286, 719	35.02
25 02	(see instructions)	at (and instructions)	1 000 077	224 224	25 02
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amoun Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1, 088, 977 1, 413, 301		35.03 36.00
50.00	Additional payment for high percentage of ESRD beneficiary disc				50.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding di		0		40.00
101.00	652, 682, 683, 684 and 685 (see instructions)	Solidi goo i oi illo bitos	0		10100
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	3, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DF	RGs 652, 682, 683, 684	0		41.01
10.00	an 685. (see instructions)		0.00		40.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, instructions)	683, 684 all 685. (See	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by	vline 41 divided by 7	0. 000000		44.00
	days)	,			
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.0	01)	0		46.00
47.00	Subtotal (see instructions)		52, 192, 657		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural hospitals	64, 165, 708		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			64, 268, 332	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt. II, as applicable)		4, 029, 200	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I	II, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		164, 067	52.00
53.00	Nursing and Allied Health Managed Care payment			26, 422	
54.00	Special add-on payments for new technologies			3, 107	
54.01	Islet isolation add-on payment			0	
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see intruc			0	55.00 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III		rough 35)	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV		ough boy.	71, 454	
59.00	Total (sum of amounts on lines 49 through 58)			68, 562, 582	
60.00	Primary payer payments			21, 241	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus l	ine 60)		68, 541, 341	61.00
62.00	Deductibles billed to program beneficiaries			5, 051, 746	
63.00	Coinsurance billed to program beneficiaries			41, 216	
64.00	Allowable bad debts (see instructions)			824, 696	
65.00	Adjusted reimbursable bad debts (see instructions)	unti ana)		536, 052	
66.00 67.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (line 61 plus line 65 minus lines 62 and 63)	uctions)		346, 510 63, 984, 431	
68.00	Credits received from manufacturers for replaced devices for ap	onlicable to MS-DRGs (see	≥ instructions)	03, 704, 431	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F			0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		, ,	0	1
70.50	RURAL DEMONSTRATION PROJECT			0	1
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 217, 798	
70.93 70.94	HRR adjustment amount (see instructions)			-272, 656	
	Recovery of accel erated depreciation				70.95
	۰۰۰۰۰۰ ۲۰۰۰ ۲۰۰۰ ۲۰۰۰ ۲۰۰۰ ۲۰۰۰ ۲۰۰۰ ۲				

Heal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CO	CN: 15-0048	Period:	Worksheet E	
				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/25/2017 3:1	
		Title	XVIII	Hospi tal	PPS	-
			FFY	(уууу)	Amount	
				0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column O		0	0	70.96
	the corresponding federal year for the period prior to 10/1)					
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70.97
	the corresponding federal year for the period ending on or aft	ter 10/1)				
	Low Volume Payment-3				0	70.98
	HAC adjustment amount (see instructions)				0	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			63, 929, 573	71.00
71.01	Sequestration adjustment (see instructions)				1, 278, 591	71.01
	Interim payments				62, 484, 135	72.00
	Tentative settlement (for contractor use only)				0	73.00
	Balance due provider (Program) (line 71 minus lines 71.01, 72,				166, 847	74.00
75.00	Protested amounts (nonallowable cost report items) in accordar	nce with			0	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	tructions)			0	
	Capital outlier from Wkst. L, Pt. I, line 2				0	
	Operating outlier reconciliation adjustment amount (see instru				0	
	Capital outlier reconciliation adjustment amount (see instruct				0	
	The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
	Time value of money for operating expenses (see instructions)				0	1 201 00
96.00	Time value of money for capital related expenses (see instruct	tions)			0	96.00
				Prior to 10/1		
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.000000000		
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102.00

HRR Adjustment for HSP Bonus Payment (see instructions) HRR adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions)

0.0000 103.00 0 104.00

0. 0000 0 Health Financial Systems

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

		15-0048	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
	Title XV	VIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)			28, 152	1.00
00	Medical and other services reimbursed under OPPS (see instructions)			35, 654, 835	
00	PPS payments			41, 321, 371	3.00
00	Outlier payment (see instructions)			50, 288	
00 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0,00	
00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, li	ine 200		196, 568	9.00
	Organ acqui si ti ons			0	10.00
. 00	Total cost (sum of lines 1 and 10) (see instructions)			28, 152	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
00	Reasonable charges			00.115	12.00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			90, 115 0	12.00
	Total reasonable charges (sum of lines 12 and 13)			90, 115	
. 00	Customary charges			90, 113	14.00
5. 00	Aggregate amount actually collected from patients liable for payment for ser	rvices on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for s			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		-	1	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	
	Total customary charges (see instructions)			90, 115	1
0. 00	Excess of customary charges over reasonable cost (complete only if line 18 e instructions)	exceeds li	ne 11) (see	61, 963	19.00
0. 00	Excess of reasonable cost over customary charges (complete only if line 11 e	ovcoode Li	no 19) (coo	0	20.00
. 00	instructions)	exceeds 11	lie io) (see	0	20.00
. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions))		28, 152	21.00
	Interns and residents (see instructions)			0	
8.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			41, 568, 227	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			100	05.00
	Deductibles and coinsurance (for CAH, see instructions)	tructions)		108	
	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see inst		and 231 (see	7, 812, 209 33, 784, 062	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of instructions)	1 111103 22		55, 704, 002	27.00
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	1 111103 22		93, 374	
7.00 8.00	instructions)	1 111103 22			28.00
7.00 8.00 9.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	1 111103 22		93, 374	28.00 29.00
2.00 3.00 0.00 0.00 .00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments	111103 22		93, 374 0 33, 877, 436 4, 850	28.00 29.00 30.00 31.00
2.00 3.00 0.00 0.00 .00 2.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31)			93, 374 0 33, 877, 436	28.00 29.00 30.00 31.00
2.00 3.00 0.00 0.00 1.00 2.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			93, 374 0 33, 877, 436 4, 850 33, 872, 586	28.00 29.00 30.00 31.00 32.00
2.00 3.00 0.00 0.00 2.00 2.00 3.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			93, 374 0 33, 877, 436 4, 850 33, 872, 586	28. 00 29. 00 30. 00 31. 00 32. 00
2.00 3.00 0.00 0.00 1.00 2.00 3.00 4.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00
7.00 8.00 9.00 0.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
7.00 8.00 9.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613	28.00 29.00 30.00 31.00 32.00 34.00 35.00 36.00
7.00 8.00 9.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
7.00 8.00 9.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
2.00 3.00 2.00 2.00 2.00 3.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 50
2.00 3.00 2.00 2.00 2.00 3.00 <t< td=""><td><pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer AC0 demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see </pre></td><td></td><td></td><td>93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0</td><td>28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 39.50 39.90</td></t<>	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer AC0 demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see </pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0	28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 39.50 39.90
3.00 3.00 <t< td=""><td><pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION</pre></td><td></td><td></td><td>93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 0</td><td>28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 50 39. 96 39. 96</td></t<>	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 50 39. 96 39. 96
3.00 3.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 34, 855, 880	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 50 39. 96 39. 96 39. 96
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer AC0 demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 34, 855, 880 697, 118	28. 00 29. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 90 39. 90 39. 98 39. 98 40. 00 40. 00
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 34, 855, 880	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 50 39. 96 39. 96 39. 96 40. 00 41. 00
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer AC0 demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)</pre>			93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 34, 855, 880 697, 118 33, 857, 799	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 90 39. 90 39. 99 40. 00 41. 00 42. 00
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Interim payments Tentative settlement (for contractors use only)</pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 0 0 0 0 34, 855, 880 697, 118 33, 857, 799 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 90 39. 90 40. 00 40. 00 41. 00 42. 00 43. 00
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Aljusted reimbursable bad debts (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer AC0 demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Requestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) in accordance with CMS Pu S115.2</pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 90 39. 90 40. 00 40. 00 41. 00 42. 00
1.00 3.00 0.00 <t< td=""><td><pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pu 5115.2 TO BE COMPLETED BY CONTRACTOR</pre></td><td>ee instruc</td><td>ti ons)</td><td>93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963 0</td><td>28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 39. 90 39. 90 39. 90 39. 90 39. 90 40. 00 40. 01 41. 00 42. 00 44. 00</td></t<>	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pu 5115.2 TO BE COMPLETED BY CONTRACTOR</pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963 0	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 39. 90 39. 90 39. 90 39. 90 39. 90 40. 00 40. 01 41. 00 42. 00 44. 00
1.00 3.00 2.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Interim payments Tentative settlement (nonallowable cost report items) in accordance with CMS Pu §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) </pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 -96 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 90 39. 90 40. 00 41. 00 42. 00 44. 00 90. 00
1.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pt \$115.2 TO BE COMPLETED BY CONTRACTOR Driginal outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)</pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 60 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 99 40. 00 40. 07 41. 00 42. 00 43. 00 44. 00 90. 00 91. 00
1.00 3.00 3.00 0.00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Interim payments Tentative settlement (nonallowable cost report items) in accordance with CMS Pu §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) </pre>	ee instruc	ti ons)	93, 374 0 33, 877, 436 4, 850 33, 872, 586 0 1, 512, 613 983, 198 800, 350 34, 855, 784 60 0 0 34, 855, 880 697, 118 33, 857, 799 0 300, 963 0	28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 35. 00 36. 00 37. 00 39. 90 39. 90 40. 00 40. 00 41. 00 42. 00 43. 00 41. 00 42. 00 41. 00 90. 00 91. 00 92. 00

	Financial Systems REID HOSPITAL & HEALTH ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Period: From 01/01/2016	u of Form CMS-: Worksheet E Part B	
		Component CCN: 15-SO48	To 12/31/2016		
		Title XVIII	Subprovider - IPF	PPS	
		1		1.00	
-	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions)	+:)		1, 715	
	Medical and other services reimbursed under OPPS (see instruct PPS payments	tions)		999 1, 756	
	Outlier payment (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instruct	ctions)		0. 000	5
	Line 2 times line 5			0	
	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0.00 0	
	Ancillary service other pass through costs from Wkst. D, Pt. 1	IV. col. 13. line 200		0	
	Organ acqui si ti ons			0	
	Total cost (sum of lines 1 and 10) (see instructions)			1, 715	11
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonable charges Ancillary service charges			5, 427	12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ine 69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13)			5, 427	14
	Customary charges				1 45
	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e			0	
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
1	Total customary charges (see instructions)			5, 427	
	Excess of customary charges over reasonable cost (complete onl instructions)	ly if line 18 exceeds li	ne 11) (see	3, 712	19
	Excess of reasonable cost over customary charges (complete onl	lvifline 11 exceeds li	ne 18) (see	0	20
	instructions)	· · · · · · · · · · · · · · · · · · ·	(_	
1	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		1, 715	
1	Interns and residents (see instructions)	nueti enc)		0	
1	Cost of physicians' services in a teaching hospital (see insti Total prospective payment (sum of lines 3, 4, 8 and 9)	ructions)		0 1, 756	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1,700	1
1	Deductibles and coinsurance (for CAH, see instructions)			0	
	Deductibles and Coinsurance relating to amount on line 24 (for			27	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pinstructions)	plus the sum of lines 22	and 23] (see	3, 444	27
	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			3, 444	
	Primary payer payments Subtotal (line 30 minus line 31)			0 3, 444	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		3, 444	1 52
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
1	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	Subtotal (see instructions)			3, 444	
3. 00	MSP-LCC reconciliation amount from PS&R			0	38
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	、 、		0	
	Pioneer ACO demonstration payment adjustment (see instructions Partial or full credits received from manufacturers for replace		tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION	Leu uevices (see Instruc	u 0115 <i>)</i>	0	
	Subtotal (see instructions)			3, 444	
	Sequestration adjustment (see instructions)			69	
	Interim payments			3, 298	
	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 77	
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2.	chapter 1,	0	
	§115. 2		10 C C C C C C C C C C C C C C C C C C C		· ·
	TO BE COMPLETED BY CONTRACTOR			-	1 ~~
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
00	Total (sum of lines 91 and 93)			0	94

	Financial Systems REID HOSPITAL & HEALT ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016		
		Component CCN: 15-T048	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Title XVIII	Subprovider - IRF	PPS	
			1	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
	Medical and other services (see instructions)			38	
	Medical and other services reimbursed under OPPS (see instruc PPS payments	tions)		33	
	Outlier payment (see instructions)			55	
	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
	Line 2 times line 5			0	
	Sum of line 3 plus line 4 divided by line 6			0.00	
	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	
	Organ acquisitions	TV, COL. 13, TTHE 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			38	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			107	1 1 2
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		187 0	
	Total reasonable charges (sum of lines 12 and 13)			187	
	Customary charges				
1	Aggregate amount actually collected from patients liable for		U U	0	
	Amounts that would have been realized from patients liable fo had such payment been made in accordance with 42 CFR §413.13(n a chargebasis	0	16
	Ratio of line 15 to line 16 (not to exceed 1.000000)	()		0.000000	17
	Total customary charges (see instructions)			187	18
	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	149	19
	instructions) Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	n_{0} (coo	0	20
	instructions)	ity if the firexceeds fi	116 10) (See	0	20
	Lesser of cost or charges (line 11 minus line 20) (for CAH se	e instructions)		38	21
1	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0 55	
	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			55	24
	Deductibles and coinsurance (for CAH, see instructions)			0	25
1	Deductibles and Coinsurance relating to amount on line 24 (fo	· · · · · · · · · · · · · · · · · · ·		0	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	93	27
	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			93	
	Primary payer payments			0	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		93	32
	Composite rate ESRD (from Wkst. 1-5, line 11)	623)		0	33
1	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		93	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			93	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	Pioneer ACO demonstration payment adjustment (see instruction			0	
	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	
1	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 93	
	Sequestration adjustment (see instructions)			2	
1	Interim payments			111	
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions)	neo with CMS Dub 15 0	chaptor 1	-20	
	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with UMS PUD. 15-2,	chapter I,	0	44
	TO BE COMPLETED BY CONTRACTOR				1
0. 00	Original outlier amount (see instructions)			0	
1	Outlier reconciliation adjustment amount (see instructions)			0	
1	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	
1	Total (sum of lines 91 and 93)			0	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0048	Period: From 01/01/2016 To 12/31/2016		pared
		Title	XVIII	Hospi tal	PPS	
			t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		62, 484, 1	35	33, 510, 399	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0 08/02/2016	347, 400	3.
02				0	0	3.
03				0	0	3
04				0	0	3
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM	1		0	0	3
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	Ő	3
54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	347, 400	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		62, 484, 1	35	33, 857, 799	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					-
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5 5
03	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			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER		166, 8	17	300, 963	6
02	SETTLEMENT TO PROVIDER		100, 0	+ / O	300, 983	6
02	Total Medicare program liability (see instructions)		62, 650, 9	U	34, 158, 762	
55			02,000,7	Contractor	NPR Date	Ĺ
				Number	(Mo/Day/Yr)	
)	1,00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-0048 CCN: 15-S048	Period: From 01/01/2016 To 12/31/2016		pareo
		Title	XVIII	Subprovider -	PPS	<u>, pii</u>
		Inpatien	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		6, 621, 9	47 0	3, 298 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	ABOUT AND AN AND AN AND AND AND AND AND AND A			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 53				0	0	3 3
53 54				0	0	3 3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6, 621, 9	47	3, 298	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51	ILIVIATI VE TU PRUGRAW			0	0	5 5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		138, 4	02	77	6
02	SETTLEMENT TO PROGRAM		(7/0 0	0	0	6
00	Total Medicare program liability (see instructions)		6, 760, 3	49 Contractor	3,375 NPR Date	7
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	_

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0048 CCN: 15-T048	Period: From 01/01/2016 To 12/31/2016		pareo
		Title	XVIII	Subprovider - IRF	PPS	5 pm
		Inpatien	t Part A		тв	
		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		3, 711, 6	67 0	111 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			0	0	3
00	3.50-3.98)		2 711 4	47	111	4
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 711, 6	07	111	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
)1	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)1)2	TENTATIVE TO PROVIDER			0	0	э 5
)2)3				0	0	5
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	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			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		78, 7	43	0	6
2	SETTLEMENT TO PROGRAM			0	20	6
00	Total Medicare program liability (see instructions)		3, 790, 4		91	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(1.00	2.00	_

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu o					
CALCUL				Worksheet E-1		
			From 01/01/2016		a no ma di	
	To 12/31/2016					
	Ti tl e XVI I Hospi tal					
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00	
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3, 042	3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		34, 528	4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			733, 037, 489	5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		10, 129, 399	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)			653, 020	8.00	
9.00	Sequestration adjustment amount (see instructions)			13, 060	9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		639, 960	10.00	
	I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	639, 960	32.00	

	Financial Systems REID HOSPITAL & H ATION OF REIMBURSEMENT SETTLEMENT	IEALTH CARE SERVICES Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-SO48	From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
		Title XVIII	Subprovider -	5/25/2017 3:1 PPS	5 pm
			I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	d medical education payments)		7, 526, 320	1.
. 00	Net IPF PPS Outlier Payments			0	2.
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most rece	ent cost report filed on or b	efore November	0.00	4
	15, 2004. (see instructions)				
01	Cap increases for the unweighted intern and resident FTE			0.00	4
	program or hospital closure, that would not be counted wi	thout a temporary cap adjust	ment under 42		
. 00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	6
00	teaching program" (see instuctions)			0.00	
. 00	Current year's unweighted I&R FTE count for residents wit	thin the new program growth p	eriod of a "new	0.00	7
00	teaching program" (see instuctions)			0.00	'
00	Intern and resident count for IPF PPS medical education a	adiustment (see instructions)		0.00	8
00	Average Daily Census (see instructions)	······································		28.852459	
0. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.00000	10
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		7, 526, 320	12
3. 00	Nursing and Allied Health Managed Care payment (see instr	ruction)		0	13
4.00	Organ acquisition (DO NOT USE THIS LINE)				14
5.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	15
6.00	Subtotal (see instructions)			7, 526, 320	16
7.00	Primary payer payments			2, 548	17
3.00	Subtotal (line 16 less line 17).			7, 523, 772	18
. 00	Deducti bl es			360, 472	19
	Subtotal (line 18 minus line 19)			7, 163, 300	
	Coinsurance			406, 182	
	Subtotal (line 20 minus line 21)			6, 757, 118	
	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		213, 781	
	Adjusted reimbursable bad debts (see instructions)			138, 958	
	Allowable bad debts for dual eligible beneficiaries (see	instructions)		164, 913	
	Subtotal (sum of lines 22 and 24)			6, 896, 076	
	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	27
	Other pass through costs (see instructions)			2, 239	28
	Outlier payments reconciliation			0	29
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruct	stions)		0	30
	Recovery of Accel erated Depreciation			0	30
	Total amount payable to the provider (see instructions)			6, 898, 315	
. 00	Sequestration adjustment (see instructions)			137, 966	
2.00	Interim payments			6, 621, 947	
	Tentative settlement (for contractor use only)				33
1. 00	Balance due provider/program (line 31 minus lines 31.01,	32 and 33)		138, 402	34
	Protested amounts (nonallowable cost report items) in acc		chapter 1,	0	35
	§115.2 TO BE COMPLETED BY CONTRACTOR				
0. 00	Original outlier amount from Worksheet E-3, Part II, line	e 2		0	50
	Outlier reconciliation adjustment amount (see instruction			0	51
	The rate used to calculate the Time Value of Money			0.00	
2 00	Time Value of Money (see instructions)			0	53

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	Worksheet E-3	
		Component CCN: 15-TO48	From 01/01/2016 To 12/31/2016	Part III Date/Time Pre	pare
		Title XVIII	Subprovider -	5/25/2017 3: 1 PPS	5 pm
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
00	Net Federal PPS Payment (see instructions)			3, 751, 305	1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0447	2
00	Inpatient Rehabilitation LIP Payments (see instructions	;)		137, 673	3
00	Outlier Payments			12, 664	4
00	Unweighted intern and resident FTE count in the most re	cent cost 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 FT			0.00	5
	program or hospital closure, that would not be counted		ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions	5)			
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FT	Es in the new program growth p	eriod of a "new	0.00	7
~ ~	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents w	within the new program growth p	eriod of a "new	0.00	8
~~	teaching program" (see instructions)			0.00	
00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)		0.00	
). 00	Average Daily Census (see instructions)			9.609290	
. 00	Teaching Adjustment Factor (see instructions)			0.00000	
. 00	Teaching Adjustment (see instructions)			0	12
. 00	Total PPS Payment (see instructions)			3, 901, 642	
1.00	Nursing and Allied Health Managed Care payments (see in	istruction)		0	14
	Organ acquisition (DO NOT USE THIS LINE)				15
	Cost of physicians' services in a teaching hospital (se	e instructions)			16
. 00	Subtotal (see instructions)			3, 901, 642	
3.00	Primary payer payments			0	
. 00	Subtotal (line 17 less line 18).			3, 901, 642	19
	Deductibles			19, 320	
. 00	Subtotal (line 19 minus line 20)			3, 882, 322	
	Coinsurance			21, 252	
	Subtotal (line 21 minus line 22)			3, 861, 070	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		9, 727	
	Adjusted reimbursable bad debts (see instructions)			6, 323	
	Allowable bad debts for dual eligible beneficiaries (se	e instructions)		4, 913	
. 00	Subtotal (sum of lines 23 and 25)			3, 867, 393	
. 00	Direct graduate medical education payments (from Wkst.	E-4, line 49)		0	28
	Other pass through costs (see instructions)			372	
	Outlier payments reconciliation			0	30
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	31
. 99	Recovery of Accel erated Depreciation			0	31
. 00	Total amount payable to the provider (see instructions)			3, 867, 765	
. 01	Sequestration adjustment (see instructions)			77, 355	
	Interim payments			3, 711, 667	
. 00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program (line 32 minus lines 32.01	· · · · ·		78, 743	
b. 00	Protested amounts (nonallowable cost report items) in a §115.2	ccordance with CMS Pub. 15-2,	chapter 1,	0	36
	TO BE COMPLETED BY CONTRACTOR				_
	Original outlier amount from Wkst. E-3, Pt. III, line 4			12, 664	
. 00	Outlier reconciliation adjustment amount (see instructi	ons)		0	51
2.00	The rate used to calculate the Time Value of Money			0.00	

	Financial Systems REID HOSPITAL & HEALTH (ATION OF REIMBURSEMENT SETTLEMENT F	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E-3 Part VII Date/Time Pre 5/25/2017 3:1	pared
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	CES FOR TITLES V OR >	(IX SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES				
	Inpatient hospital/SNF/NF services		2, 340, 488		1.0
	Medical and other services			3, 327, 443	
	Organ acquisition (certified transplant centers only)		0		3.0
	Subtotal (sum of lines 1, 2 and 3)		2, 340, 488	3, 327, 443	
	Inpatient primary payer payments		0		5.0
	Outpatient primary payer payments			0	
	Subtotal (line 4 less sum of lines 5 and 6)		2, 340, 488	3, 327, 443	7.(
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonabl e Charges		-		
	Routine service charges		0	40 474 400	8.
	Ancillary service charges		5, 581, 465	13, 174, 420	
	Organ acquisition charges, net of revenue		0		10.
	Incentive from target amount computation		0	40 474 400	11.
	Total reasonable charges (sum of lines 8 through 11)		5, 581, 465	13, 174, 420	12.
	CUSTOMARY CHARGES	· · · · · ·			1 4 0
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.
~~	basis			0	14
00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		on 0	0	14.
00	5 1 5	CFR 9413.13(e)	0,000000	0,00000	15
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 14 exceede	5, 581, 465	13, 174, 420	
00	5 5 1 5	IT TINE 16 exceeds	3, 240, 977	9, 846, 977	17.
00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	ne O	0	10
00	16) (see instructions)	IT THE 4 exceeds IT	1e 0	0	18.
00	Interns and Residents (see instructions)		0	0	19.
	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16		2, 340, 488	3, 327, 443	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			5, 527, 445	21.
	Other than outlier payments	bilpreted for FFS provi	0	0	22.
	Outlier payments		0	0	
	Program capital payments		0	0	23.
	Capital exception payments (see instructions)		0		24.
	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	
	Titles V or XIX (sum of lines 21 and 27)		2, 340, 488	3, 327, 443	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		2, 340, 400	5, 527, 445	27.
	Excess of reasonable cost (from line 18)		0	0	30.
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 340, 488	3, 327, 443	
	Deducti bl es		2, 340, 488	3, 327, 443	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35.
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	2, 340, 488	3, 327, 443	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	2, 340, 400	3, 327, 443	
	Subtotal (line 36 ± 1 ine 37)		2, 340, 488	3, 327, 443	
	Direct graduate medical education payments (from Wkst. E-4)		2, 340, 400	5, 527, 445	39.
	Total amount payable to the provider (sum of lines 38 and 39)		2, 340, 488	2 277 112	
				3, 327, 443	
	Interim payments Relance due provider/program (Lipe 40 minus Lipe 41)		2, 340, 488	3, 327, 443	
	Balance due provider/program (line 40 minus line 41)	a with CMC Dut 15 C	0	0	
00	Protested amounts (nonallowable cost report items) in accordance	e with UMS PUB 15-2,	0	0	43.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet E-3 Part VII	
		Component CCN: 15-SO48	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		97		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0	_	3
00	Subtotal (sum of lines 1, 2 and 3)		97	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		07	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		97	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges				
00 00	Routine service charges Ancillary service charges		0 473	0	
. 00	Organ acquisition charges, net of revenue		473	0	10
	Incentive from target amount computation		0		11
	Total reasonable charges (sum of lines 8 through 11)		473	0	
. 00	CUSTOMARY CHARGES		473	0	1 14
. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	113
. 00	basi s	Services on a charge	Ŭ	0	
. 00	Amounts that would have been realized from patients liable for	r payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	1!
. 00	Total customary charges (see instructions)		473	0	10
. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	376	0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds lin	e 0	0	18
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line '		97	0	2
~~	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi			
	Other than outlier payments		0	0	
. 00	Outlier payments		0	0	
. 00 . 00	Program capital payments Capital exception payments (see instructions)		0		24
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		97	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 2
. 00	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	97	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	97	0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	3
. 00	Subtotal (line 36 ± line 37)		97	0	3
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)		97	0	4
	Interim payments		97	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
	0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0				43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2016	Worksheet E-3 Part VII	
		Component CCN: 15-T048	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
		Title XIX	Subprovider - IRF	Cost	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR Y		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		TX SERVICES		1
00	Inpatient hospital/SNF/NF services		0		1 -
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				-
	Reasonabl e Charges				Ι.
00	Routi ne servi ce charges		0	0	8
00 00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	10
00	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		0	0	
00	CUSTOMARY CHARGES		0	0	1''
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	11:
	basi s				
00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	1!
00	Total customary charges (see instructions)		0	0	1
00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	0	0	1
~~	line 4) (see instructions)			0	
00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds lin	e 0	0	18
00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				1
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	23
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0		2!
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		0	0	20
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	1 2/
00 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
00			0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0	Ū	3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	3
00	Subtotal (line 36 ± line 37)		0	0	3
00	Direct graduate medical education payments (from Wkst. E-4)		0		3
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments		0	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43

	Financial Systems REID HOSPITAL & HEALT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C		Peri od:	u of Form CMS-2 Worksheet E-4	
/EDI CA	AL EDUCATION COSTS			From 01/01/2016 To 12/31/2016	Date/Time Pre	aarad
					5/25/2017 3:1	
		Title	e XVIII	Hospi tal	PPS	
					1.00	
00	COMPUTATION OF TOTAL DIRECT GME AMOUNT			n n n a nt a sta	0.00	1.0
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng perioas	0.00	1. (
. 00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	uctions)	0.00	2. (
. 00	Amount of reduction to Direct GME cap under section 422 of MM) 6412 70 (m)	(222	0.00	3.0
. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	e with 42 CFR	(11).	(See	0.00	3.
. 00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0.00	4.
. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	na periods	0.00	4.
. 01	straddling 7/1/2011)		cost reporti	ng per l'ous	0.00	4.
. 02	ACA Section 5506 number of additional direct GME FTE cap slot	ts (see inst	ructions for	cost reporting	0.00	4.
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 nlus l	ines 4 01 and	0.00	5.
. 00	4.02 plus applicable subscripts		inte i pius i		0.00	0.
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	0.00	6.
. 00	records (see instructions) Enter the lesser of line 5 or line 6				0.00	7.
			Primary Care		Total	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athi a	1.00	2.00 0 0.00	3.00	8.
. 00	program for the current year.	Jathic	0.0	0.00	0.00	8.
. 00	If line 6 is less than 5 enter the amount from line 8, otherw		0.0	0 0.00	0.00	9.
	multiply line 8 times the result of line 5 divided by the amo	ount on line				
D. 00	Weighted dental and podiatric resident FTE count for the curr	rent year		0.00		10.
D. 01	Unweighted dental and podiatric resident FTE count for the cu	urrent year		0.00		10.
1.00 2.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir	a waar (caa	0.0			11. 12.
2.00	instructions)	ig year (see	0.0	0.00		12.
3.00	Total weighted resident FTE count for the penultimate cost re	eporting	0.0	0.00		13.
4.00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	d hy 3)	0.0	0 0.00		14.
5.00	Adjustment for residents in initial years of new programs	a by 0).	2.4			15.
5. 01	Unweighted adjustment for residents in initial years of new p	orograms	2.4	4 1.95		15.
6.00	Adjustment for residents displaced by program or hospital clo	osure	0.0	0.00		16.
6. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0.0	0 0.00		16.
7.00	closure Adjusted rolling average FTE count		2.4	4 1.95		17.
8.00	Per resident amount		85, 000. 0			18.
9.00	Approved amount for resident costs		207, 40	0 165, 750	373, 150	19.
					1.00	
D. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots rec	eived under 42	0.00	20.
1.00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	(ctions)			0.00	21.
2.00	Allowable additional direct GME FTE Resident Count (see instru	,			0.00	
3.00	Enter the locally adjustment national average per resident an		structions)		0.00	
			,		0	24.
5 00	Total direct GME amount (sum of lines 19 and 24)				373, 150	25.
. 00			Inpatient Par	t Managed care		
0.00			A 1.00	2.00	3.00	
0.00						
	COMPUTATION OF PROGRAM PATIENT LOAD		1			24
6. 00	Inpatient Days (see instructions)		30, 26			
6. 00 7. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		48, 75	4 48, 754		27.
6. 00 7. 00 8. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		48, 75 0. 62085	4 48, 754 2 0. 080424		27. 28.
26. 00 27. 00 28. 00 29. 00	Inpatient Days (see instructions) Total Inpatient Days (see instructions)		48, 75	4 48, 754 2 0. 080424		26. 27. 28. 29. 30.

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0048	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2016 To 12/31/2016	Date/Time Pre	aarad
			10 12/31/2010	5/25/2017 3:1	
		Title XVIII	Hospi tal	PPS	<u> </u>
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum of col. 20 an	d 23, lines 74	0	32.00
	and 94)				
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	774, 296	
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.00000	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00 36.00
36.00					
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost			(0.0(0.000	
37.00	Reasonable cost (see instructions)			63, 063, 832	
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39.00
40.00	Primary payer payments (see instructions)	- 15 10)		23, 789	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu Part B Reasonable Cost	s TThe 40)		63, 040, 043	41.00
42.00	Reasonable cost (see instructions)			35, 882, 340	12 00
42.00	Primary payer payments (see instructions)			35, 882, 340 4, 850	
43.00	Total Part B reasonable cost (line 42 minus line 43)			35, 877, 490	
45.00	Total reasonable cost (sum of lines 41 and 44)			98, 917, 533	
46.00	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line 45)		0. 637299	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0.362701	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			27002701	
48.00				257, 441	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		164, 067	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			93, 374	
		. ,	1		

ALANCE	nancial Systems REID HOSPITAL & HEA SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column	Provi der C	CN: 15-0048	Period: From 01/01/2016	u of Form CMS-: Worksheet G	
ly)				To 12/31/2016	5/25/2017 3:1	
		General Fund	Specific Purpose Fund			
CU	JRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	29, 193, 417		0 0	0	1 1
00 Te	emporary investments	281, 100, 981		0 0	0	
00 No	otes receivable	0)	0 0	0	
00 Ad	ccounts receivable	120, 033, 260		0 0	0	4
00 01	ther recei vabl e	-663, 095		0 0	0	5
DO AI	lowances for uncollectible notes and accounts receivable	-70, 330, 984		0 0	0	6
00 Ir	nventory	7, 180, 402		0 0	0	
00 Pr	repaid expenses	6, 163, 999		0 0	0	8
	ther current assets	0		0 0	0	9
. 00 Du	ue from other funds	0		0 0	0	10
. 00 <u>T</u> o	otal current assets (sum of lines 1-10)	372, 677, 980		0 0	0	11
FI	XED ASSETS					
1	and	13, 579, 037		0 0	0	12
	and improvements	35, 550, 113		0 0	0	13
	ccumulated depreciation	-20, 045, 000	1	0 0	0	14
	uildings	280, 957, 511		0 0	0	15
	ccumulated depreciation	-112, 164, 309		0 0	0	16
	easehold improvements	12, 344, 443		0 0	0	17
	ccumulated depreciation	-5, 411, 838		0 0	0	18
	xed equipment	2, 090, 615	1	0 0	0	19
	ccumulated depreciation	-1, 256, 469		0 0	0	20
	utomobiles and trucks	C		0 0	0	21
	ccumulated depreciation	0		0 0	0	22
	ajor movable equipment	171, 369, 690		0 0	0	23
	ccumulated depreciation	-136, 274, 496		0 0	0	24
	nor equipment depreciable	0		0 0	0	25
	ccumulated depreciation	0		0 0	0	26
	IT designated Assets	0		0 0	0	27
	ccumulated depreciation	0		0 0	0	28
	nor equipment-nondepreciable			0 0	0	29
	otal fixed assets (sum of lines 12-29)	240, 739, 297		0 0	0	30
	HER ASSETS			0 0	0	3
	eposits on Leases			0 0	0	32
	ue from owners/officers			0 0	0	33
	ther assets	42, 830, 201		0 0	0	34
	otal other assets (sum of lines 31-34)	42, 830, 201	1	0 0	0	35
	otal assets (sum of lines 11, 30, and 35)	656, 247, 478	1	0 0	0	
	IRRENT LI ABI LI TI ES	030, 247, 470		0 0	0	1 30
	ccounts payable	15, 801, 995	1	0 0	0	37
	al ari es, wages, and fees payable	20, 799, 762	1	0 0	0	38
	ayroll taxes payable	20,777,702		0 0	0	39
	ptes and loans payable (short term)	6, 528, 503			0	
	eferred income	0, 520, 505			0	
	ccelerated payments	4, 278, 540			0	42
	ue to other funds	-, 270, 340 Ω	1	0 0	0	
1	ther current liabilities			0 0	0	
	otal current liabilities (sum of lines 37 thru 44)	47, 408, 800		0 0	0	
	ONG TERM LIABILITIES	1, 1, 400, 000	1	- U	0	1
	prtgage payable			0 0	0	46
	otes payable	217, 600, 195		0 0	0	47
	nsecured Loans				0	
	ther long term liabilities			o o	0	
	otal long term liabilities (sum of lines 46 thru 49)	217, 600, 195		0 0	0	
	otal liabilities (sum of lines 45 and 50)	265,008,995		0 0	0	51
	API TAL ACCOUNTS				0	1
	eneral fund balance	391, 238, 483				52
	pecific purpose fund		1	0		53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	ant fund balance - invested in plant			0	0	
1	ant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion				0	
	otal fund balances (sum of lines 52 thru 58)	391, 238, 483		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	656, 247, 478	1	0 0	0	60
		, , 170	1	- I	0	

Health Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0048	Period: From 01/01/2016 To 12/31/2016		pared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	5 511
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions ROUNDING5.006.006.007.008.009.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.00Fund balance at end of period per balance sheet (line 11 minus line 18)	80 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	391, 442, 316 -203, 913 391, 238, 403 80 391, 238, 483 0 391, 238, 483			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 19.\ 00\\ 19.\ 00\\ \end{array}$
	Endowment Fund	PI ant	Fund			
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions ROUNDING 5.00 6.00 7.00 8.00 9.00	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 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 18.00 Total deductions (sum of lines 12-17)	000	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 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

ATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	15-0048	Period: From 01/01/2016 To 12/31/2016		pared
	Cost Center Description		Inpati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
00	Hospi tal		45, 088, 14	49	45, 088, 149	1.0
00	SUBPROVIDER - IPF		11,010,3	58	11, 010, 358	2.0
00	SUBPROVIDER - IRF		3, 647, 8	72	3, 647, 872	3.0
00	SUBPROVI DER		-, - , -			4.0
00	Swing bed - SNF			0	0	
00	Swing bed - NF			0	0 0	
00	SKILLED NURSING FACILITY			U U	, o	7.0
00	NURSING FACILITY					8.0
00	OTHER LONG TERM CARE					9.0
			EO 744 2	70	E0 744 270	
. 00	Total general inpatient care services (sum of lines 1-9)		59, 746, 3	/9	59, 746, 379	10. (
~~	Intensive Care Type Inpatient Hospital Services		0 405 0	76	0 405 075	1
. 00	INTENSIVE CARE UNIT		9, 135, 8	/5	9, 135, 875	
	CORONARY CARE UNIT					12. (
	BURN INTENSIVE CARE UNIT					13.0
. 00	SURGICAL INTENSIVE CARE UNIT					14.0
. 00	OTHER SPECIAL CARE (SPECIFY)					15.0
. 00	Total intensive care type inpatient hospital services (sum of I 11-15)	i nes	9, 135, 8	75	9, 135, 875	16. (
. 00	Total inpatient routine care services (sum of lines 10 and 16)		68, 882, 2	54	68, 882, 254	17.0
. 00	Ancillary services		188, 362, 1			
	Outpatient services		26, 70			
. 00	RURAL HEALTH CLINIC		20, 10	0 00,000,070		
. 00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	-	
	HOME HEALTH AGENCY			0	0	22.0
. 00						22.0
	AMBULANCE SERVICES					
. 00						24.0
. 00	AMBULATORY SURGICAL CENTER (D. P.)		005 0	0.001.000	0 017 704	25.0
. 00	HOSPICE		835, 98			
. 00	OTHER		40, 309, 04			
. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	:o Wkst.	298, 416, 10	05 611, 606, 966	910, 023, 071	28. (
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
	Operating expenses (per Wkst. A, column 3, line 200)			414, 214, 856		29. (
. 00	ADD (SPECIFY)			0		30.0
. 00				0		31. (
. 00				0		32. (
. 00				0		33. (
. 00				0		34.0
. 00				0		35.0
. 00	Total additions (sum of lines 30-35)			0		36. (
. 00	DEDUCT (SPECIFY)			0		37.0
. 00				0		38. (
. 00				0		39.
. 00				0		40.
. 00				0		40.
	Total deductions (sum of lines 27 41)			~		
. 00	Total deductions (sum of lines 37-41)			0		42.0
. 00	Total operating expenses (sum of lines 29 and 36 minus line 42) to Wkst. G-3, line 4)	(transfer		414, 214, 856		43.0

Heal th	Fin	anci	al S	Syste	ms	
CTATEM						EVDENCE

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0048	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Pre	
				5/25/2017 3:1	5 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			910, 023, 071	1.00
2.00	Less contractual allowances and discounts on patients' account	ts		519, 642, 406 390, 380, 665	
3.00					
4.00					4.00
5.00	Net income from service to patients (line 3 minus line 4)			-23, 834, 191	5.00
	OTHER I NCOME			0.054.007	
6.00	Contributions, donations, bequests, etc			8,054,987	
7.00	Income from investments	19, 141, 923 0			
	8.00 Revenues from telephone and other miscellaneous communication services				8.00 9.00
	2.00 Revenue from television and radio service				
	Purchase di scounts			105, 950	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			278, 765 3, 540, 910	
	Revenue from meals sold to employees and guests				14.00
	Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to other th	an nationto		0	
	Revenue from sale of drugs to other than patients	lan patrents		17, 940	
	Revenue from sale of medical records and abstracts			44, 029	
	Tuition (fees, sale of textbooks, uniforms, etc.)			39, 252	
	Revenue from gifts, flowers, coffee shops, and canteen			37,232	20.00
	Rental of vending machines			16, 928	
	Rental of hospital space			5, 886, 174	
	Governmental appropriations			0,000,174	
	OTHER I NCOME			-13, 496, 580	
	Total other income (sum of lines 6-24)			23, 630, 278	
	Total (line 5 plus line 25)			-203, 913	
	OTHER EXPENSES (SPECIFY)			200, 710	
	Total other expenses (sum of line 27 and subscripts)			0	
	Net income (or loss) for the period (line 26 minus line 28)			-203, 913	

MCRI F32 - 10. 5. 160. 2

	Financial Systems REII SIS OF HOSPITAL-BASED HOSPICE COSTS	D HOSPITAL & HEAL		CN: 15-0048	Period:	u of Form CMS- Worksheet O	
			Hospi ce CC		From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
				10-1524		5/25/2017 3:1	5 pm
		SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
		1.00	2.00	1 plus col. 2 3.00	2) CATLONS 4.00	5.00	
	GENERAL SERVICE COST CENTERS			1			
. 00	CAP REL COSTS-BLDG & FIXT*		C)	0 0	0	1.
. 00	CAP REL COSTS-MVBLE EQUIP*		9, 434			9, 434	
. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	81, 823			81, 823	
. 00	ADMINISTRATIVE & GENERAL*	183, 910	42, 225			226, 135	
. 00	PLANT OPERATION & MAINTENANCE*	0	25		25 0	25	
. 00	LAUNDRY & LINEN SERVICE*	0	0		0 0	0	
. 00	HOUSEKEEPI NG*	0	2 505		0 0 95 0	0	
. 00 . 00	DI ETARY* NURSI NG ADMI NI STRATI ON*	0	3, 595	3, 59	0 0	3, 595 0	
0.00	ROUTINE MEDICAL SUPPLIES*	0			0 0	0	
1.00	MEDICAL RECORDS*	0			0 0	0	
2.00	STAFF TRANSPORTATI ON*	0	(0 0	0	
3.00	VOLUNTEER SERVICE COORDINATION*	0	(0 0	0	
4.00	PHARMACY*	0	111, 524	111, 52		111, 524	
5.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	114, 847			114, 847	
6.00	OTHER GENERAL SERVICE*	0	C		0 0	0	16.
7.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.
	DIRECT PATIENT CARE SERVICE COST CENTERS						
5.00	INPATIENT CARE-CONTRACTED**	0	C		0 0	0	
6.00	PHYSICIAN SERVICES**	0	C		0 0	0	
7.00	NURSE PRACTITIONER**	0	C		0 0	0	
B. 00	REGI STERED NURSE**	771, 997	0			771, 997	
9.00		6, 996	0			6, 996	
0.00 1.00	PHYSI CAL THERAPY** OCCUPATI ONAL THERAPY**	0	0		0 0 0 0	0	
2.00	SPEECH/LANGUAGE PATHOLOGY**	0			0 0	0	
3.00	MEDICAL SOCIAL SERVICES**	0			0 0	0	
4.00	SPIRITUAL COUNSELING**	0	(0 0	0	
5.00	DI ETARY COUNSELING**	0	(0 0	0	
6.00	COUNSELING - OTHER**	0	C		0 0	0	
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	89, 869	C	89, 80	69 0	89, 869	37.
8. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	C		0 0	0	38.
9.00	PATI ENT TRANSPORTATI ON**	0	88, 093	8 88, 04	93 0	88, 093	39.
0. 00	I MAGI NG SERVI CES**	0	C		0 0	0	40.
1.00	LABS & DIAGNOSTICS**	0	65		65 0	65	
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	264, 799			264, 799	
3.00	OUTPATIENT SERVICES**	0	361, 168			361, 168	
4.00	PALLIATIVE RADIATION THERAPY**	0	C		0 0	0	
5.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	
6. 00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	U		/	0 0	0	46.
0 00	BEREAVEMENT PROGRAM *	0			0 0	0	60.
1.00	VOLUNTEER PROGRAM *	0	((0	
2.00	FUNDRAI SI NG*	0	ſ		0 0	0	
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	(0 0	0	
4.00	PALLIATIVE CARE PROGRAM*	0	C	b	0 0	0	
5.00	OTHER PHYSICIAN SERVICES*	0	C	þ	0 0	0	
5.00	RESIDENTIAL CARE*	0	C	þ	0 0	0	66.
7.00	ADVERTI SI NG*	0	317	3	17 0	317	67.
3. 00	TELEHEALTH/TELEMONI TORI NG*	0	C		0 0	0	68.
9.00	THRI FT STORE*	0	C)	0 0	0	
D. 00	NURSING FACILITY ROOM & BOARD*	0	C		0 0	0	
1.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	C		0 0	0	
<u>00 00</u>	TOTAL	1, 052, 772	1, 077, 915	2, 130, 68	37 0	2, 130, 687	100.

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

NALYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	: 15-0048	Peri od:	Worksheet	0
			Hospice CCN:	15-1524	From 01/01/2016 To 12/31/2016	Date/Time 5/25/2017	
					Hospi ce I		
		ADJUSTMENTS -	TOTAL (col. 5				
		6.00	<u>± col. 6)</u> 7.00				
	GENERAL SERVICE COST CENTERS	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
. 00	CAP REL COSTS-BLDG & FIXT*	0	0				1
. 00	CAP REL COSTS-MVBLE EQUIP*	0	9, 434				2
. 00	EMPLOYEE BENEFITS DEPARTMENT*	-124	81, 699				3
l. 00	ADMI NI STRATI VE & GENERAL*	0	226, 135				4
. 00	PLANT OPERATION & MAINTENANCE*	0	25				5
. 00	LAUNDRY & LINEN SERVICE*	0	0				6
. 00	HOUSEKEEPI NG*	0	0				7
. 00	DI ETARY*	0	3, 595				8
. 00	NURSI NG ADMI NI STRATI ON*	0	0				9
0.00	ROUTINE MEDICAL SUPPLIES*	0	0				10
1.00	MEDI CAL RECORDS*	0	0				11
2.00	STAFF TRANSPORTATION*	0	0				12
3.00	VOLUNTEER SERVICE COORDINATION*	0	0				13
4.00	PHARMACY*	0	111, 524				14
5.00	PHYSI CLAN ADMINI STRATI VE SERVI CES*	0	114, 847				15
6.00	OTHER GENERAL SERVICE*	0	0				16
7.00	PATIENT/RESIDENTIAL CARE SERVICES						17
E 00	DI RECT PATIENT CARE SERVICE COST CENTERS	0	0				25
5.00	INPATIENT CARE-CONTRACTED**	0	0				25
6.00 7.00	PHYSI CI AN SERVI CES** NURSE PRACTI TI ONER**	0	0				20
8.00	REGISTERED NURSE**	0	771, 997				28
9.00	LPN/LVN**	0	6, 996				20
0.00	PHYSICAL THERAPY**	0	0, 990				30
1.00	OCCUPATIONAL THERAPY**	0	o				31
2.00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
3.00	MEDICAL SOCIAL SERVICES**	0	0				33
4.00	SPIRITUAL COUNSELING**	0	0				34
35.00	DI ETARY COUNSELING**	0	o				35
36.00	COUNSELING - OTHER**	0	o				36
7.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	89, 869				37
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0				38
9.00	PATI ENT TRANSPORTATI ON**	0	88, 093				39
0.00	I MAGI NG SERVI CES**	0	0				40
1.00	LABS & DI AGNOSTI CS**	0	65				41
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	264, 799				42
3.00	OUTPATI ENT SERVI CES**	0	361, 168				43
4.00	PALLIATIVE RADIATION THERAPY**	0	0				44
5.00	PALLIATIVE CHEMOTHERAPY**	0	0				45
6.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46
	NONREIMBURSABLE COST CENTERS						
	BEREAVEMENT PROGRAM *	0	0				60
1.00	VOLUNTEER PROGRAM *	0	0				61
2.00	FUNDRAI SI NG*	0	0				62
3.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
	PALLIATIVE CARE PROGRAM*	0	0				64
	OTHER PHYSICIAN SERVICES*	0	0				65
6.00	RESIDENTIAL CARE*	0	0				66
7.00	ADVERTI SI NG*	-317	0				67
8.00	TELEHEALTH/TELEMONI TORI NG*	0	0				68
	THRIFT STORE*	0	0				69
	NURSING FACILITY ROOM & BOARD*	0	0				70
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71
$n \cap \cap \cap$	TOTAL	-441	2, 130, 246				100

 100.00
 TOTAL
 -441
 2,130,240

 * Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

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

Heal th	Financial Systems REID	HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E CONTI NUOUS	Provider CC		Peri od:	Worksheet 0-1	
HOME C	ARE		Hospice CCN		From 01/01/2016 To 12/31/2016	Date/Time Pre	nared
			nospi ce ooi	. 10 1021	10 12/01/2010	5/25/2017 3:1	5 pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
				1 + col. 2)	CATIONS		
		1.00	2.00	3.00	4.00	5.00	
	DI RECT PATI ENT CARE SERVI CE COST CENTERS						
	INPATIENT CARE-CONTRACTED						25.00
	PHYSI CI AN SERVI CES	0	0		0 0	0	
	NURSE PRACTITIONER		0	2.50	0 0		27.00
	REGI STERED NURSE	2, 596	0	2, 59		2, 596	
	PHYSICAL THERAPY	24	0	2	0	24	
	OCCUPATIONAL THERAPY	0	0		0 0	0	30.00 31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0		31.00
	MEDICAL SOCIAL SERVICES	0	0		0 0		32.00
	SPIRITUAL COUNSELING	0	0		0 0	0	34.00
	DI ETARY COUNSELING	0	0		0 0		34.00
	COUNSELING - OTHER	0	0			0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	302	0	30		302	37.00
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	50	0 0	0	
	PATIENT TRANSPORTATION	0	296	29	6 0	296	
	I MAGI NG SERVI CES	0	0	-	0 0	0	
	LABS & DI AGNOSTI CS	0	0		0 0	0	
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	890	89	0 0	890	
43.00	OUTPATI ENT SERVICES	0	1, 214	1, 21	4 0	1, 214	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00	TOTAL *	2, 922	2, 400	5, 32	2 0	5, 322	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS		1		
25.00	INPATIENT CARE-CONTRACTED			25.	5.00
26.00	PHYSI CI AN SERVI CES	0	0	26.	6.00
27.00	NURSE PRACTITIONER	0	0	27.	1.00
28.00	REGI STERED NURSE	0	2, 596	28.	3. 00
29.00	LPN/LVN	0	24	29.	9.00
30.00	PHYSI CAL THERAPY	0	0	30.). 00
31.00	OCCUPATIONAL THERAPY	0	0	31.	. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.	2.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.	3.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.	1.00
35.00	DI ETARY COUNSELI NG	0	0	35.	5.00
36.00	COUNSELING - OTHER	0	0	36.	o. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	302	37.	. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.	3. 00
39.00	PATIENT TRANSPORTATION	0	296	39.	9.00
40.00	I MAGI NG SERVI CES	0	0	40.). 00
41.00	LABS & DI AGNOSTI CS	0	0	41.	. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	890	42.	2.00
43.00	OUTPATI ENT SERVICES	0	1, 214	43.	3.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.	1.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.	5.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		o. 00
100.00	TOTAL *	0	5, 322	100.). 00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 50.			

ALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provider CC		Peri od:	Worksheet 0-2	
RE		Hospi ce CCN		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
			1 + col. 2)	CATIONS		<u> </u>
	1.00	2.00	3.00	4.00	5.00	<u> </u>
DIRECT PATIENT CARE SERVICE COST CENTERS	- <u>I</u>					
. 00 INPATIENT CARE-CONTRACTED						25.
. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.
. 00 NURSE PRACTITIONER	0	0		0 0	0	27.
. 00 REGI STERED NURSE	729, 378	0	729, 37		729, 378	
. OO LPN/LVN	6, 609	0	6,60	9 0	6, 609	
. 00 PHYSI CAL THERAPY	0	0		0 0	0	30
. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31
. 00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32
. 00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33
. 00 SPIRITUAL COUNSELING	0	0		0 0	0	34
. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35
. 00 COUNSELING - OTHER	0	0		0 0	0	36
. 00 HOSPICE AIDE & HOMEMAKER SERVICES	84, 908	0	84, 90	8 0	84, 908	
. OO DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0		0 0	0	38
. 00 PATIENT TRANSPORTATION	0	83, 230	83, 23	0 0	83, 230	
. OO I MAGI NG SERVI CES	0	0	,	0 0	0	40
. 00 LABS & DI AGNOSTI CS	0	62	6		62	41
. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	250, 181	250, 18		250, 181	
. 00 OUTPATIENT SERVICES . 00 PALLIATIVE RADIATION THERAPY	0	341, 230	341, 23		341, 230	43
. OO PALLIATIVE RADIATION THERAPY	0	0			0	44
.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0			0	45
0.00 TOTAL *	820, 895	674, 703	1, 495, 59		1, 495, 598	

		ADJUSTMENTS	TOTAL (col. 5		
		AD5051WENT5	± col. 6)		
		6,00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS			I	
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	729, 378		28.00
29.00	LPN/LVN	0	6, 609		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	84, 908		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	83, 230		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	62		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	250, 181		42.00
43.00	OUTPATI ENT SERVI CES	0	341, 230		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	1, 495, 598		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51.			

	SIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI		TH CARE SERVI Provider C	CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet 0-3	
RESPI I	FE CARE				From 01/01/2016		
			Hospi ce CC	N: 15-1524	To 12/31/2016	Date/Time Pre 5/25/2017 3:1	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (co 1 + col. 2)		SUBTOTAL	
	DI DEGT. DATIENT GADE CEDVILOE OOCT GENTEDO	1.00	2.00	3.00	4.00	5.00	
	DI RECT PATI ENT CARE SERVI CE COST CENTERS	0	C	N.	0 0	0	25.0
25.00	PHYSICIAN SERVICES	0	C		0 0 0 0	0	25.0
26.00	NURSE PRACTITIONER		C		0 0		
27.00		0	C		-	0	27.0
8.00	REGI STERED NURSE	3, 634	Ĺ	3,6		3, 634	28.
9.00	LPN/LVN	33	C)	33 0	33	
0.00	PHYSI CAL THERAPY	0	C)	0 0	0	30.
1.00	OCCUPATI ONAL THERAPY	0	C)	0 0	0	31.
2.00	SPEECH/LANGUAGE PATHOLOGY	0	C		0 0	0	32.
3.00	MEDICAL SOCIAL SERVICES	0	C		0 0	0	33.
4.00	SPI RI TUAL COUNSELI NG	0	C		0 0	0	34.
5.00	DI ETARY COUNSELING	0	C		0 0	0	35.
6.00	COUNSELING - OTHER	0	C		0 0	0	36.
7.00	HOSPICE AIDE & HOMEMAKER SERVICES	423	C	4	23 0	423	37.
8.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	120				120	38.
9.00	PATIENT TRANSPORTATION	0	415	1	15 0	415	
0.00	I MAGI NG SERVI CES	0	413		0 0		40.
		0	C C			-	
1.00	LABS & DI AGNOSTI CS	0	1 01(1 1 0	0 0	0	41.
2.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 246			1, 246	
3.00	OUTPATI ENT SERVI CES	0	1, 700	1,7		1, 700	
4.00	PALLIATIVE RADIATION THERAPY	0	C)	0 0	0	
15.00	PALLIATIVE CHEMOTHERAPY	0	C		0 0	0	45.0
16.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	C)	0 0	0	46. (
	TOTAL *	4, 090	3, 361	7,4	51 0	7, 451	100. (
Tran	nsfer the amount in column 7 to Wkst. 0-5, co	lumn 1, line 52.					_
		ADJUSTMENTS	TOTAL (col. 5				
		6.00	<u>± col. 6)</u> 7.00	1			
	DI RECT PATI ENT CARE SERVI CE COST CENTERS	6.00	± col. 6) 7.00	1			
5. 00	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00		1			25.
			7.00	1			
6.00	INPATIENT CARE-CONTRACTED		7.00 C				26.
6. 00 7. 00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES		7.00 C				26. 27.
6.00 7.00 8.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER		7.00 C C C 3,634				26. 27. 28.
6.00 7.00 8.00 9.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN		7.00 C C 3,634 33				26. 27. 28. 29.
6.00 7.00 8.00 9.00 0.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY		7.00 C C C 3,634				26. 27. 28. 29. 30.
6.00 7.00 8.00 9.00 0.00 1.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY		7.00 C C 3,634 33				26. 27. 28. 29. 30. 31.
6.00 7.00 8.00 9.00 0.00 1.00 2.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY		7.00 C C 3,634 33				26. 27. 28. 29. 30. 31. 32.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES		7.00 C C 3,634 33				26. 27. 28. 29. 30. 31. 32. 33.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG		7.00 C C 3,634 33				26. 27. 28. 29. 30. 31. 32. 33. 34.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN		7.00 C C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN		7.00 C C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON I MAGI NG SERVI CES		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41.
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON I MAGI NG SERVI CES LABS & DI AGNOSTI CS MEDI CAL SUPPLI ES-NON-ROUTI NE		7.00 C C 3,634 33 C C C C C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42.
26.00 27.00 28.00 29.00 30.00 31.00 32.00 34.00 35.00 36.00 37.00 38.00 39.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 33.00 33.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON I MAGI NG SERVI CES LABS & DI AGNOSTI CS MEDI CAL SUPPLI ES-NON-ROUTI NE OUTPATI ENT SERVI CES		7.00 0 0 0 3,634 33 0 0 0 0 0 0 0 0 0 0 0 0 0				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43.
26.00 27.00 28.00 29.00 30.00 31.00 32.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 39.00 40.00 41.00 42.00 43.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON I MAGI NG SERVI CES LABS & DI AGNOSTI CS MEDI CAL SUPPLI ES-NON-ROUTI NE OUTPATI ENT SERVI CES PALLI ATI VE RADI ATI ON THERAPY		7.00 C C 3,634 33 C C C C C C C C C C C C C				26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43.
39.00 40.00 41.00 42.00 43.00 44.00 45.00	I NPATI ENT CARE-CONTRACTED PHYSI CI AN SERVI CES NURSE PRACTI TI ONER REGI STERED NURSE LPN/LVN PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH/LANGUAGE PATHOLOGY MEDI CAL SOCI AL SERVI CES SPI RI TUAL COUNSELI NG DI ETARY COUNSELI NG COUNSELI NG - OTHER HOSPI CE AI DE & HOMEMAKER SERVI CES DURABLE MEDI CAL EQUI PMENT/OXYGEN PATI ENT TRANSPORTATI ON I MAGI NG SERVI CES LABS & DI AGNOSTI CS MEDI CAL SUPPLI ES-NON-ROUTI NE OUTPATI ENT SERVI CES PALLI ATI VE RADI ATI ON THERAPY		7.00 0 0 0 3,634 33 0 0 0 0 0 0 0 0 0 0 0 0 0				25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45.

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

NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSP						2552-10
	ICE GENERAL	Provider C		Period:	Worksheet 0-4	1
NPATI ENT CARE		Hospi ce CCI	N: 15-1524	From 01/01/2010 To 12/31/2010	5 Date/Time Pre	
				Hospi ce I	5/25/2017 3: 1	is pm
	SALARI ES	OTHER	SUBTOTAL (COI		SUBTOTAL	
	SALARIES	OTHER	1 + col . 2		SOBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATI ENT CARE SERVICE COST CENTERS			. <u> </u>			
5. 00 INPATIENT CARE-CONTRACTED	0	0		0	0 0	25.00
6. 00 PHYSI CLAN SERVI CES	0	0		0	0 0	26.00
7. 00 NURSE PRACTITIONER	0	0		0	ol o	27.00
8.00 REGISTERED NURSE	36, 389	0	36, 38	39	36, 389	28.00
29.00 LPN/LVN	330	0	33	30	330	29.00
0. 00 PHYSI CAL THERAPY	0	0		0	ol o	30.00
1. 00 OCCUPATIONAL THERAPY	0	0		0	ol o	31.00
2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0		
3. 00 MEDI CAL SOCIAL SERVICES	0	0		0		
4.00 SPIRITUAL COUNSELING	0	0		0		34.00
5.00 DI ETARY COUNSELING	0	0		0		
6.00 COUNSELING - OTHER	0	0		0		
7. 00 HOSPICE AIDE & HOMEMAKER SERVICES	4, 236	0	4, 23	36	4,236	
8. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	., 200	0	., _		1,200	38.00
9.00 PATIENT TRANSPORTATION	0	4, 152	4, 15	52	0 4, 152	
0.00 I MAGI NG SERVI CES	0	0	.,	0		
1. 00 LABS & DI AGNOSTI CS	0	3		3	0 3	
2.00 MEDICAL SUPPLIES-NON-ROUTINE	0	12, 482	12, 48	32	12, 482	
3. 00 OUTPATIENT SERVICES	0	17, 024			0 17,024	
4.00 PALLIATIVE RADIATION THERAPY	0	021	17,02	0		
5.00 PALLI ATI VE CHEMOTHERAPY	0	0		0		
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0		
00. 00 TOTAL *	40, 955	33, 661	74, 61	16		100.00
Transfer the amount in column 7 to Wkst. 0-5, c		33,001	74,0		<u>, , , , , , , , , , , , , , , , , , , </u>	100.00
	ADJUSTMENTS	TOTAL (col. 5				
		± col. 6)				
	6.00	7.00				
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED	0	0				25.00
26. 00 PHYSI CI AN SERVI CES	0	0				26.00
7. 00 NURSE PRACTITIONER	0	0				27.00
8.00 REGI STERED NURSE	0	36, 389				28.00
29.00 LPN/LVN	0	330				29.00

26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	36, 389		28.00
29.00	LPN/LVN	0	330		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4, 236		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	4, 152		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DI AGNOSTI CS	0	3		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	12, 482		42.00
43.00	OUTPATI ENT SERVICES	0	17, 024		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	· · · · · · · · · · · · · · · · · · ·	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	· · · · · · · · · · · · · · · · · · ·	46.00
100.00	TOTAL *	0	74, 616	10	00.00

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

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0048	Period:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION			From 01/01/2016		
		Hospi ce CC	N: 15-1524	To 12/31/2016		
				Hospi ce I	5/25/2017 3:1	5 pili
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			i nstructi ons			
				WKST B PART I	/	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 539	539	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		9,4	34 0	9, 434	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		81, 6	99 135, 063	216, 762	3.00
4.00	ADMI NI STRATI VE & GENERAL		226, 1	35 328, 941	555, 076	4.00
5.00	PLANT OPERATION & MAINTENANCE			25 0	25	5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPING			0 19, 589	19, 589	7.00
8.00	DI ETARY		3, 5	95 0	3, 595	8.00
9.00	NURSING ADMINISTRATION			0 0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			0 252	252	10.00
11.00	MEDI CAL RECORDS			0 36, 074	36, 074	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY		111, 5	24 129, 174	240, 698	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES		114, 8	47	114, 847	15.00
16.00	OTHER GENERAL SERVICE			0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			28, 340	28, 340	17.00
	LEVEL OF CARE		-		1	
50.00	HOSPI CE CONTI NUOUS HOME CARE		5, 3		5, 322	
51.00	HOSPICE ROUTINE HOME CARE		1, 495, 5		1, 495, 598	1
52.00	HOSPICE INPATIENT RESPITE CARE		7,4		7, 451	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		74,6	16	74, 616	53.00
	NONREI MBURSABLE COST CENTERS		1		1	
60.00	BEREAVEMENT PROGRAM			0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	61.00
62.00	FUNDRAI SI NG			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES			0	0	65.00
66.00	RESIDENTIAL CARE			0	0	66.00
67.00	ADVERTI SI NG			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
69.00	THRIFT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	71.00
99.00	NEGATI VE COST CENTER TOTAL		2 120 2	0	0 2, 808, 218	99.00
100.00	וויסותב		2, 130, 2	46 677, 972	2,000,218	1100.00

	Financial Systems REID LLLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	HOSPI TAL & HEALT RVI CE COSTS	H CARE SERVI Provider CO Hospice CCI	CN: 15-0048	In Lie Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet O-6 Part I Date/Time Pre 5/25/2017 3:1	pared:
					Hospi ce I	572572017 5.1	
	Descriptions	TOTAL EXPENSESCA	P REL BLDG & FIX	CAP REL MVBL EQUI P		SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	539	539				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 434		9, 43	34		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	216, 762	0		0 216, 762		3.00
4.00	ADMI NI STRATI VE & GENERAL	555, 076	539		0 37, 866	593, 481	4.00
5.00	PLANT OPERATION & MAINTENANCE	25	0		0 0	25	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	19, 589	0		0 0	19, 589	7.00
8.00	DI ETARY	3, 595	0		0 0	3, 595	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	252	0		0 0	252	10.00
11.00	MEDI CAL RECORDS	36, 074	0		0 0	36, 074	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	240, 698	0		0 0	240, 698	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	114, 847	0		0 0	114, 847	•
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	28, 340	17.00
	LEVEL OF CARE	I I					
50.00	HOSPICE CONTINUOUS HOME CARE	5, 322			602	5, 924	50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 495, 598			169, 020	1, 664, 618	
52.00	HOSPICE INPATIENT RESPITE CARE	7, 451	0	84	48 842	9, 141	
53.00	HOSPICE GENERAL INPATIENT CARE	74, 616	0	8, 5			
	NONREIMBURSABLE COST CENTERS						
60, 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	
66.00	RESI DENTI AL CARE	0	0		0 0	0	
67.00	ADVERTI SI NG	0	0		0 0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
69.00	THRI FT STORE	0	0		0 0	0	
70.00	NURSING FACILITY ROOM & BOARD	0	0		-	0	
70.00	OTHER NONREI MBURSABLE (SPECIFY)	0	Ο		0 0	0	
99.00	NEGATI VE COST CENTER	0	0		0 0	0	99.00
	TOTAL	2, 808, 218	539	9, 4	216, 762	2, 808, 218	
100.00		2,000,210	557	J 7, 4.	210,702	2,000,210	1.00.00

COST A	Financial Systems R NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC	CN: 15-0048 N: 15-1524				pared:
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVI		Hospi ce I HOUSEKEEPI NG	DI ETARY	
		4.00	5.00	6.00		7.00	8.00	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMI NI STRATI VE & GENERAL	593, 481						4.00
5.00	PLANT OPERATION & MAINTENANCE	7	32					5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0			6.00
7.00	HOUSEKEEPING	5, 249	C			24, 838		7.00
8.00	DI ETARY	963	C	D		0	4, 558	
9.00	NURSI NG ADMI NI STRATI ON	0	C	D		0		9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	68	C	D		0		10.00
11.00	MEDI CAL RECORDS	9, 667	C	2		0		11.00
12.00	STAFF TRANSPORTATION	0	C	2		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C	2		0		13.00
14.00	PHARMACY	64, 500	C	2		0		14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	30, 775	C	2		0		15.00
16.00	OTHER GENERAL SERVICE	0	C			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	7, 594	(<u>ן</u>		0		17.00
F0 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	1 507		T				50.00
50.00 51.00	HOSPICE CONTINUOUS HOME CARE	1, 587 446, 066						50.00
51.00	HOSPICE ROUTINE HOME CARE			,	0	2 2 2 2	414	
52.00	HOSPICE TNPATTENT RESPICE CARE	2, 450 24, 555			0	2, 233 22, 605	414	1
55.00	NONREI MBURSABLE COST CENTERS	24, 555	29	1	U	22,000	4, 144	55.00
60, 00	BEREAVEMENT PROGRAM	0	C	1	-	0		60,00
61.00	VOLUNTEER PROGRAM	0				0		61.00
62.00	FUNDRAI SI NG	0				0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	c c			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0				0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	c c			0		65.00
66.00	RESI DENTI AL CARE	0	c c		0	0	0	
67.00	ADVERTI SI NG	0	r c		5	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C C			0		68.00
69.00	THRI FT STORE	0				0		69.00
70.00	NURSING FACILITY ROOM & BOARD					Ű		70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	C		0	o	0	
99.00	NEGATI VE COST CENTER	0			0	o	0	
	TOTAL	593, 481	32		0	24, 838	1 660	100.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part I Date/Time Pre 5/25/2017 3:1	pared:
					Hospi ce I	572572017 5.1	5 pili
	Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	320				10.00
11.00	MEDI CAL RECORDS	0		45, 74	1		11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE		-		-		
50.00	HOSPICE CONTINUOUS HOME CARE	0	1	15		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	302			0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	2	21		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	15	2, 15	6 0	0	53.00
(0.00	NONREI MBURSABLE COST CENTERS						1 (0.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00		0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTI SI NG				0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00 70.00	THRIFT STORE NURSING FACILITY ROOM & BOARD	0			0	0	69.00 70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	70.00
99.00	NEGATIVE COST CENTER	0	0		0	0	99.00
	TOTAL	0	320	45, 74	1 0		100.00
100.00		, U	320		U U	0	1.00.00

OST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC		Period:	Worksheet 0-6	
			Hospi ce CCN		From 01/01/2016 To 12/31/2016		
		r			Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL		TOTAL	
		A	ADMI NI STRATI VE	SERVI CE	RESIDENTI AL		
		14.00	SERVI CES	16.00	CARE SERVICES	10.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	18.00	
I. 00	CAP REL COSTS-BLDG & FIXT	T		T		· · · · · · · · · · · · · · · · · · ·	1.00
2.00	CAP REL COSTS-BEDG & FIXT		,	1		1	2.00
2.00 3.00			,	1		1	3.00
1.00	EMPLOYEE BENEFITS DEPARTMENT		,	1	- · · · · · · · · · · · · · · · · · ·	1	
	ADMI NI STRATI VE & GENERAL		,	1		1	4.00
. 00	PLANT OPERATION & MAINTENANCE		,	1	- · · · · · · ·	1	5.00
b. 00	LAUNDRY & LINEN SERVICE		,	1	- · · · · · · ·	1	6.00
. 00	HOUSEKEEPING		,	1	-	1	7.00
. 00			,	1	-	1	8.00
. 00	NURSI NG ADMI NI STRATI ON		,	1	-	1	9.00
0.00	ROUTINE MEDICAL SUPPLIES		,	1		1	10.00
1.00	MEDICAL RECORDS		,	1	- · · · · · · ·	1	11.00
2.00	STAFF TRANSPORTATION		,	1	- · · · · · · ·	1	12.00
3.00	VOLUNTEER SERVICE COORDINATION	205 100	,	1		1	13.00
4.00		305, 198	145 (22	1	- · · · · · · ·	1	14.00
5.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	145, 622			1	15.00
6.00	OTHER GENERAL SERVICE	0	,	1	0	1	16.00
7.00	PATIENT/RESIDENTIAL CARE SERVICES			L	35, 934	L	17.00
~ ~~	LEVEL OF CARE	1.02/	400			0.102	1
0.00	HOSPICE CONTINUOUS HOME CARE	1,026	490		0	9, 182	
1.00	HOSPICE ROUTINE HOME CARE	288, 349	137, 582		0	2, 580, 133	
2.00	HOSPICE INPATIENT RESPITE CARE	1, 437	686		0 3, 263		
3.00	HOSPICE GENERAL INPATIENT CARE	14, 386	6, 864	L	0 32, 671	199, 059	53.00
	NONREI MBURSABLE COST CENTERS				-1		1,000
0.00	BEREAVEMENT PROGRAM	0	,		0	0	
1.00	VOLUNTEER PROGRAM	0	,		0	0	
2.00		0	,		0	0	62.00
53.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	U	,		0	0	
64.00	PALLIATIVE CARE PROGRAM	U U	,		0	0	64.00
5.00	OTHER PHYSI CI AN SERVI CES	U			0	0	
6.00	RESIDENTIAL CARE	U	0	1	0 0	0	66.00
57.00	ADVERTI SI NG	0	,	1	0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0	,		0	0	68.00
59.00	THRI FT STORE	0	,	1	0	0	
70.00	NURSING FACILITY ROOM & BOARD		,	1		0	
1.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0'		0 0	0	
99.00	NEGATIVE COST CENTER	0	O		0 0	0	99.00
	DITOTAL	305, 198	145, 622		0 35,934	2, 808, 218	1100 00

CUST A			Durate di al a se Cr	NI 1E 0040	Devel end	Washington at O (
STATI S	LLOCATION - HOSPITAL-BASED HOSPICE GENEI TICAL BASIS	AL SERVICE CUSIS	Provider CO		Period: From 01/01/2016	Worksheet 0-6 Part II	
5177110			Hospi ce CC		To 12/31/2016	Date/Time Pre	
					Hospi ce I	5/25/2017 3:1	5 pm
	Cost Center Descriptions	CAP REL BLDG &	CAP REL MVRLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	cost center bescriptions	FLX	EQUI P	BENEFITS	RECONCIENTION	& GENERAL	
		(SQUARE FEET)		DEPARTMENT		(ACCUMULATED	
			`````	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	445					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		445	4 050 7	70		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1, 052, 77		0 044 707	3.00
4.00	ADMI NI STRATI VE & GENERAL	445	0	183, 91		2, 214, 737	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	25	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	19, 589	7.00
8.00 9.00	DI ETARY NURSI NG ADMI NI STRATI ON	0	0		0 0	3, 595 0	9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES	0	0		0 0	252	10.00
11.00	MEDICAL RECORDS	0	0		0 0	36,074	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	30, 074	12.00
12.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	240, 698	
14.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	114, 847	14.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	28, 340	
	LEVEL OF CARE					20,010	
50.00	HOSPICE CONTINUOUS HOME CARE			2, 92	22 0	5, 924	50.00
51.00	HOSPICE ROUTINE HOME CARE			820, 89	95 0	1, 664, 618	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	40	4, 09	90 0	9, 141	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	405	40, 95	55 0	91, 634	53.00
	NONREIMBURSABLE COST CENTERS						
60. 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.0
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.0
69.00 70.00	THRIFT STORE NURSING FACILITY ROOM & BOARD	0	0		0	0	69.0 70.0
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	70.0
	NEGATIVE COST CENTER	0	0			0	99.0
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	rt I) 539	9, 434	216, 76	52	593, 481	
100.00	UNIT COST MULTIPLIER	1. 211236	21. 200000				100.00

Heal th	Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S TICAL BASIS	SERVICE COSTS	Provider C Hospice CC		Period: From 01/01/2016 To 12/31/2016		pared:
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPI NO (SQUARE FEET	G DI ETARY	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	0100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATI VE & GENERAL PLANT OPERATI ON & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DI ETARY NURSI NG ADMINI STRATI ON ROUTI NE MEDI CAL SUPPLIES MEDI CAL RECORDS STAFF TRANSPORTATI ON VOLUNTEER SERVICE COORDINATI ON PHARMACY PHYSICI AN ADMINI STRATI VE SERVICES OTHER GENERAL SERVICE PATI ENT/RESI DENTI AL CARE SERVICES	445 00 00 00 00 00 00 00 00 00 00 00 00 00	C	44	45 0 848 0 0 0 0 0 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           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
50. 00 51. 00 52. 00 53. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	40 405	C		40 77 05 771	0 0 0 0	50.00 51.00 52.00 53.00
	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAISING HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES RESIDENTIAL CARE ADVERTISING TELEHEALTH/TELEMONITORING THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I UNIT COST MULTIPLIER	) 32 0.071910	C C C O. 000000	24, 83			60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 99. 00 100. 00 101. 00

Heal th	Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	RVICE COSTS	Provider C Hospice CC		Period: From 01/01/2016 To 12/31/2016	Worksheet 0-6 Part II Date/Time Pre 5/25/2017 3:1	pared:
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES ( (PATI ENT DAYS)	MEDI CAL RECORDS PATI ENT DAYS)	STAFF TRANSPORTATIC (MILEAGE)	COORDI NATI ON (HOURS OF	PHARMACY (CHARGES)	
		10.00	11.00	10.00	SERVICE)	11.00	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS			1			1
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	16, 357					10.00
11.00	MEDI CAL RECORDS	10/00/	16, 357				11.00
12.00	STAFF TRANSPORTATI ON		10,007		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	16, 357	
					0 0		
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES				0 0	0	
16.00	OTHER GENERAL SERVICE				0 0	0	
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	55	55	1	0 0		•
51.00	HOSPICE ROUTINE HOME CARE	15, 454	15, 454		0 0	15, 454	
52.00	HOSPICE INPATIENT RESPITE CARE	77	77		0 0	77	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	771	771		0 0	771	53.00
	NONREI MBURSABLE COST CENTERS	1		1		-	
60.00	BEREAVEMENT PROGRAM				0 0		
61.00	VOLUNTEER PROGRAM				0 0	-	
62.00	FUNDRAI SI NG				0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0 0	0	65.00
66.00	RESI DENTI AL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	
69.00	THRI FT STORE				0 0	0	
70.00	NURSING FACILITY ROOM & BOARD				-	Ű	70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)				0 0	0	
99.00	NEGATI VE COST CENTER					0	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	320	45, 741		0 0	305, 198	
	UNIT COST MULTIPLIER	0. 019563	2. 796417		-		•
101.00		0.01/000	2. 7 70417	1 0.00000	0.00000	10.000000	1.51.00

	Financial Systems REID ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	HOSPITAL & HEA	Provider C		Peri od:	u of Form CMS Worksheet O-	
	TICAL BASIS			N: 15-1524	From 01/01/2016 To 12/31/2016	Part II	epared:
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL				
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVICES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASI S)	(IN-FACILIT DAYS)	Ŷ		
		15.00	16.00	17.00			
	GENERAL SERVICE COST CENTERS	15.00	10.00	17.00			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	16, 357					15.00
16.00	OTHER GENERAL SERVICE		C				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			8	48		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	55	C	I			50.00
51.00	HOSPICE ROUTINE HOME CARE	15, 454	0				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	77	C		77		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	771	C	7	71		53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0				60.00
61.00	VOLUNTEER PROGRAM		C				61.00
62.00	FUNDRAI SI NG		C				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		C				63.00
64.00	PALLIATIVE CARE PROGRAM		C				64.00
65.00	OTHER PHYSI CI AN SERVI CES		C				65.00
66.00	RESI DENTI AL CARE	0	C		0		66.00
67.00	ADVERTI SI NG		C				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0		71.00
99.00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			0011			100.00
101.00	UNIT COST MULTIPLIER	8. 902733	0. 000000	42.3750	00		101.0

Heal th	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ICE COSTS BY	Provider CC	CN: 15-0048	Peri od:	Worksheet 0-7	
LEVEL (	OF CARE		Hospi ce CCN	l: 15-1524	From 01/01/2016 To 12/31/2016		pared:
					Hospi ce I	572572017 5.15	<u>o piii</u>
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C	ost to Charge	HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line					
		0	1.00	2.00	3.00	4.00	
	ANCI LLARY SERVI CE COST CENTERS	(( 00)	0.705407			0	1 00
1.00	PHYSI CAL THERAPY	66.00	0. 705437		0 0	0	
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00	0.0150/0		0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 315960		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.510463		0 0	0	
6.00		60.00	0. 185965		0 0	0	
7.00	MEDI CAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 157365		0 0	0	7.00
8.00	PATIENT CARE CENTER - OCC	93.00	0. 482966		0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0.000000				9.00
	ANCI LLARY - OTHER	76.00	0.00000		0 0	0	
	CARDI AC REHABI LI TATI ON	76. 97	0. 309649		0 0	0	
11.00	Totals (sum of lines 1–11)						11.00
		Charges by LOC (from Provider		Shared Servi	ce Costs by LOC		
		Records)					
	Cost Center Descriptions				xHIRC (col. 1 x		
	cost center bescriptions		col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9,00	
	ANCI LLARY SERVI CE COST CENTERS	0.00	0.00		0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
1.00	PHYSICAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY		-				2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	5.00
6.00	LABORATORY	0	0		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	7.00
8.00	PATIENT CARE CENTER - OCC	0	0		0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C						9.00
10.00	ANCILLARY - OTHER	0	0		0 0	0	10.00
10.97	CARDI AC REHABI LI TATI ON	0	0		0 0	0	10.97
10.97			<b>v</b>				

CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CC	CN: 15-0048	Peri	i od:	u of Form CMS-2 Worksheet 0-8	
		Hospi ce CCN	l: 15-1524	To	m 01/01/2016 12/31/2016	Date/Time Pre 5/25/2017 3:1	
					Hospi ce I		
			TITLE XVIII MEDICARE		TITLE XIX MEDICAID	TOTAL	
			1.00		2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,				9, 182	1.00
	line 11)						
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)					55	2.00
. 00	Total average cost per diem (line 1 divided by line 2)					166.95	3.00
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		1	0		4.00
. 00	Program cost (line 3 times line 4)		1	67	0		5.00
	HOSPICE ROUTINE HOME CARE						
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,				2, 580, 133	6.00
	line 11)						
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 11)					15, 454	7.0
. 00	Total average cost per diem (line 6 divided by line 7)					166.96	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	13, 8	03	672		9.00
0.00	Program cost (line 8 times line 9)		2, 304, 5	49	112, 197		10.00
	HOSPICE INPATIENT RESPITE CARE						
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,				19, 844	11.0
	line 11)						
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)						12.0
3.00	Total average cost per diem (line 11 divided by line 12)					257.71	
4.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		74	0		14.00
5.00	Program cost (line 13 times line 14)		19, 0	71	0		15.0
	HOSPICE GENERAL INPATIENT CARE						
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,				199, 059	16.00
	line 11)						
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					771	
8.00	Total average cost per diem (line 16 divided by line 17)					258.18	•
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		40	11		19.0
0. 00	Program cost (line 18 times line 19)		165, 2	35	2, 840		20.0
	TOTAL HOSPICE CARE						
1. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)					2, 808, 218	
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)					16, 357	
23.00	Average cost per diem (line 21 divided by line 22)					171.68	23.0

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0048 Peri od: Worksheet L From 01/01/2016 Parts I-II Date/Time Prepared: 5/25/2017 3:15 pm То 12/31/2016 Title XVIII Hospi tal PPS 1.00 PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 3, 858, 837 1.00 Model 4 BPCI Capital DRG other than outlier 1.01 1 01 0 Capital DRG outlier payments 2.00 120, 584 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) 96.42 3.00 4.00 Number of interns & residents (see instructions) 4.39 4.00 5.00 Indirect medical education percentage (see instructions) 1.29 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 6.00 49, 779 6.00 1.01) (see instructions) 7 00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 0.00 7 00 30) (see instructions) 0.00 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 9.00 Sum of lines 7 and 8 0.00 9.00 Allowable disproportionate share percentage (see instructions) 0.00 10.00 10.00 Disproportionate share adjustment (see instructions) 11.00 0 11.00 12.00 Total prospective capital payments (see instructions) 4,029,200 12.00 1.00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 0 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 Total inpatient program capital cost (line 1 plus line 2) 3 00 0 3 00 4.00 Capital cost payment factor (see instructions) 0 4.00 Total inpatient program capital cost (line 3 x line 4) 5.00 0 5.00 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 0 1.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 2 00 2 00 0 3.00 Net program inpatient capital costs (line 1 minus line 2) 0 3.00 Applicable exception percentage (see instructions) 0.00 4.00 4.00 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 5.00 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 0.00 6.00 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 7.00 Capital minimum payment level (line 5 plus line 7) 8.00 0 8.00 9.00 Current year capital payments (from Part I, line 12, as applicable) 0 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 10.00 10.00 0 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00 11.00 Worksheet L, Part III, line 14) 12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 0 12.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 13.00 13.00 0 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 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 Current year operating and capital costs (see instructions) 16.00 0 16.00

17.00 Current year exception offset amount (see instructions)

0 17.00