Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0048 Worksheet S Peri od. From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: То 5/7/2018 3:57 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: Ti me: use only Manually submitted cost report 2 [ ]If this is an amended report enter the number of times the provider resubmitted this cost report ]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

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

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

 Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. ]I have read and agree with the above certification statement. I certify that I intend my electronic Г signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) Title Date

					· · · · · · · · · · · · · · · · · · ·				
				Title XVIII					
	Cost Center Description		Title V		Part A	Part B	HI T	Title XIX	
			1.00		2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY								
1.00	Hospi tal			0	4, 431		0	0	1.00
2.00	Subprovider - IPF			0	2, 093	52		0	2.00
3.00	Subprovider - IRF			0	17, 678	23		0	3.00
5.00	Swing bed - SNF			0	0	0		0	5.00
6.00	Swing bed - NF		1	0				0	6.00
200.00	) Total			0	24, 202	36, 941	0	0	200.00

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

11	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Pr	rovider CC	N: 15-0048	Period: From 01/0	1/2017	Worksh Part I	eet S-2	2
							1/2017	Date/T	ime Pre 18 3:57	
	1.00	2.00		3.00			4.00	577720	10 3. 57	
	Hospital and Hospital Health Care Co									_
) )	Street: 1401 CHESTER BOULEVARD City: RICHMOND	PO Box: State: IN	Zin	Code: 473	274 Cou	inty: WAYNE				1
<u> </u>		Component Name		CN CB			Payme	ent Syst	tem (P,	2
			Num	ber Numl	ber Type	Certified	т <u></u> 1	<u>, 0, or</u>	N)	
		1.00	2	00 20	00 4.00	E 00	V	XVIII 7.00	-	-
	Hospital and Hospital-Based Componen	I	2.	00 3.0	00 4.00	5.00	6.00	1.00	8.00	
)	Hospi tal	REID HOSPITAL & HEA	LTH 150	048 999	15 1	07/01/196	6 N	Р	0	3
)		CARE SERVI CES SUBPROVI DER	155	048 999	15 4	01/01/200	1 N	P	0	4
)		REHAB UNIT	153 15T			01/01/200		P	0	5
	Subprovider - (Other)									6
)	Swing Beds - SNF									7
) )	Swing Beds - NF Hospital-Based SNF									8
	Hospi tal -Based NF									10
00	Hospital-Based OLTC									11
	Hospital-Based HHA Separately Certified ASC									12
	Hospi tal -Based Hospi ce	HOSPI CE	151	524 999	15	11/03/199	3			14
00	Hospital-Based Health Clinic - RHC									15
)0 )0	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16
	Renal Dialysis									18
00	Other									19
						From 1. 0		 2.		-
0	Cost Reporting Period (mm/dd/yyyy)					01/01/		12/31		20
00	Type of Control (see instructions)					2				21
00	Inpatient PPS Information Does this facility qualify and is it	currently, receiving	n payments	s for disr	proportionat	te Y		1	J	22
	share hospital adjustment, in accord	ance with 42 CFR §41	2.106? I	In column	1, enter "	("			-	
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				5 <mark>(c) (2)</mark> (Pi cl	<le< td=""><td></td><td></td><td></td><td></td></le<>				
)1	Did this hospital receive interim un				st rep <mark>or</mark> ting	a Y		١	(	22
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to for no for the portion of the cost re									
	(see instructions)	cporting period deet	arring on		october 1.					
)2	Is this a newly merged hospital that							1	1	22
	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.		Care as a surely a							
13	Did this hospital receive a geograph of the OMB standards for delineating							1	N	22
	in column 1, "Y" for yes or "N" for	no for the portion o	of the cos	st reporti	ng period					
	prior to October 1. Enter in column cost reporting period occurring on o					the				
	hospital contain at least 100 but no					th				
	42 CFR 412.105)? Enter in column 3,									
00	Which method is used to determine Mer 1, enter 1 if date of admission, 2 i					nn	3	ſ	1	23
	method of identifying the days in th	is cost reporting pe	eriod dift	ferent fro	om the metho					
	used in the prior cost reporting per			for yes c In-State	o <u>r "N" for r</u> Out-of	no. Out-of	Medi ca	id	ther	
				Medi cai d	State	State	HMO da		di cai d	
		pa	id days	eligible	Medi cai d	Medi cai d			days	
				unpai d days	paid days	el i gi bl e unpai d				
			1.00	2.00	3.00	4.00	5.00		5.00	
0	If this provider is an IPPS hospital	, enter the	942	567				144		1 24
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col									
	out-of-state Medicaid paid days in c									
	out-of-state Medicaid eligible unpai	d days in column								
	<ol> <li>Medicaid HMO paid and eligible bu column 5, and other Medicaid days in</li> </ol>									
	If this provider is an IRF, enter the		о	35	0	34		240		25
		in state								1
00	Medicaid paid days in column 1, the		I							
00	Medicaid eligible unpaid days in col	umn 2,								
00		umn 2, 3, out-of-state umn 4, Medicaid								

		LTH CARE SERVIC			eu of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΤA	Provider CC	F	Period: From 01/01/201			
				To 12/31/2017	5/7/20	<u>18 3:57</u>	'pm
				Urban/Rural S 1.00	S Date of 2.0	U	-
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			jinning of the		2		26.00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) sta ~ "2" fo	atus at the end or rural. If ap			2		27.00
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		1		35.00
				Begi nni ng: 1. 00	Endi 2.		-
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter	es.			01/01/2017	12/31.		36.00 37.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for th	ne MDH 1	transitional pa	yment in				37.00
accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) 38.00   f  ine 37 is 1, enter the beginning and ending dates	5						38.00
greater than 1, subscript this line for the number of enter subsequent dates.	f period	ds in excess of	one and	YZN	Y/	ΎΝ	
20.00 Deep this facility multiply for the line is the			on Low - 1	1.00	2.	00	20.02
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	) or (ii eage re	)? Enter in co equirements in	lumn 1 "Y" accordance		N	I	39.00
40.00 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.	per 1. E	Enter "Y" for y		N	Ν	l	40.00
				V 1. (		XI X 3.00	_
45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for a	di sproporti onat	e share in ac	cordance N	N	N	45.00
46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 48.00 Is the facility electing full federal capital payment						N N	47.00 48.00
56.00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes Y			56.00
57.00 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	r y <mark>es</mark> or th of th (", comp	r "N" for no ir nis cost report plete Worksheet	n column 1. If ing period?	column 1 Enter "Y"			57.00
<ul> <li>58.00 If line 56 is yes, did this facility elect cost reimbio defined in CMS Pub. 15-1, chapter 21, §2148? If yes,</li> <li>59.00 Are costs claimed on line 100 of Worksheet A? If yes</li> </ul>	complet	te Wkst. D-5.		as N			58.00
	<u>s, comp</u>		NAHE 413.85 Y/N	Worksheet A Line #		cation	
			1.00	2.00	3.0	00	-
<ul> <li>60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?</li> <li>60.01 If line 60 is yes, complete columns 2 and 3 for each</li> </ul>	(see ins	structions)	Y	23.00			60. 00 60. 01
instructions)	Y/N	I ME	Direct GME	I ME	Direc		00.01
	1.00	2.00	3.00	4.00	5.0	00	-
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.0			61.00
61.01 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							61.01
<ul> <li>instructions)</li> <li>61.02 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</li> </ul>							61.02
<ul> <li>ACA). (see instructions)</li> <li>61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> </ul>							61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017		
	Y/N	IME	Direct GME	IME	5/7/2018 3:57 Direct GME	pm
	1711		DITECT GWL	T WIL	DITECT GWL	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)</li> </ul>						61.04
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
care or general surgery. (see first detroits)	Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		i in this cost	reporting pe	riod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	n Teachi 11 Teachi	ee instructio		o your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider se	ettings	during this c			N	63.00
"Y" for yes or "N" for no in column 1. If yes, comple			Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No	onpr <mark>ovi</mark> c	ler Settings				
period that begins on or after July 1, 2009 and before June 30, 2010.         64.00       Enter in column 1, if line 63 is yes, or your facility trained residents       0.00       0.00       0.00         64.01       Enter in column 1, if line 63 is yes, or your facility trained residents       0.00       0.00       0.00         64.02       Enter in column 1, if line 63 is yes, or your facility trained residents       0.00       0.00       0.00         64.03       Enter in column 2, the number of unweighted non-primary care       resident FTEs that trained in your hospital. Enter in column 3 the ratio       0.00       0.00         66.03       FTEs that trained in your hospital. Enter in column 3 the ratio       0.00       0.00       0.00						64.00
			Unweighted	Unweighted	Ratio (col. 3/	
Program Name	Pro	ogram Code	FTEs Nonprovi der Si te	FTEsin	(col. 3 + col. 4))	

	EX IDENTIFICATION DA	.TA Provider (		riod: om 01/01/2017	Worksheet S- Part I	
			To			repared
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs	FTEs in	(col. 3 + co	
			Nonprovi der	Hospi tal	4))	
	1 00	2.00	Si te	4.00	F 00	_
.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.0000	00 65 0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column						
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col.	
			FTËs Nonprovider Site	FTEs in Hospital	(col. 1 + co 2))	Ι.
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	gsEffective fo	r cost reporti	ng periods	
FTEs attributable to rotations oc Enter in column 2 the number of un FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primai L. Enter in column 3	ry care resident	Unweighted FTEs	Unweighted FTEs in	Ratio (col. (col. 3 + co	
			Nonprovi der Si te	Hospi tal	4))	
.00 Enter in column 1, the program	1.00	2,00	3.00	4.00	5.00 0.0000	00 67 1
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)	5					
Inputiont Doublists's Facility DD	2			1.00	0 2.00 3.00	0
00 Is this facility an Inpatient Psychiatric		PF), or does it cont	tain an IPF subp	rovi der? Y		70. (
Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Colu program in accordance with 42 CFR Column 3: If column 2 is Y, indica (see instructions)	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	yes or "N" for n s in a new teach yes or "N" for n	o. (see ing o.	0	71. (
	222					75. (
Inpatient Rehabilitation Facility .00 Is this facility an Inpatient Reh subprovider? Enter "Y" for yes a	abilitation Facility	(IRF), or does it o	contain an IRF	Y		/0.0

# Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 1

From	01/01/2017	Worksheet S-2 Part I Date/Time Pre 5/7/2018 3:57	pared:
		5/1/2010 3. 57	piii

			12/31/2017	5/7/2018 3:57	7 pm
				1.00	-
Long Term Care Hospital PPS					4
<pre>00 Is this a long term care hospital (LTCH)? Enter "Y" for y 00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.</pre>			period? Enter	N N	80. 81.
TEFRA Providers00Is this a new hospital under 42 CFR Section §413.40(f)(1)(00Did this facility establish a new Other subprovider (exclu		2		N	85. 86.
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	tal classified	under section		N	87.
			V	XI X	
			1.00	2.00	
Title V and XIX Services					
00 Does this facility have title V and/or XIX inpatient hospi yes or "N" for no in the applicable column.	tal services? E	nter "Y" for	N	Y	90.
00 Is this hospital reimbursed for title V and/or XIX through			Ν	Y	91.
full or in part? Enter "Y" for yes or "N" for no in the ap				N	92.
00 Are title XIX NF patients occupying title XVIII SNF beds ( instructions) Enter "Y" for yes or "N" for no in the appli		I OII)? (See		N	92.
00 Does this facility operate an ICF/IID facility for purpose	s of title V an	d XIX? Enter	Ν	N	93.
"Y" for yes or "N" for no in the applicable column. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes	, and "N" for n	o in the	Ν	N	94.
applicable column. 00 If line 94 is "Y", enter the reduction percentage in the a			0.00	0.00	95.
00  If line 94 is "Y", enter the reduction percentage in the a 00 Does title V or XIX reduce operating cost? Enter "Y" for y			0.00 N	0. 00 N	95.
applicable column.				07	
00   f line 96 is "Y", enter the reduction percentage in the a 00 Does title V or XIX follow Medicare (title XVIII) for the			0. 00 Y	0.00 Y	97.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			·		/0.
column 1 for title V, and in column 2 for title XIX. 01 Does title V or XIX follow Medicare (title XVIII) for the	concreting of ch	argae on Wkst	Y	Y	98.
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for			I	T	90.
title XIX.	and out attach of	abaanvati an	Y	Y	
02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Ŷ	Y Y	98.
for title V, and in column 2 for title XIX.	N	N			
03 Does title V or XIX follow Medicare (title XVIII) for a cr reimbursed 101% of inpatient services cost? Enter "Y" for	N	98.			
for title V, and in column 2 for title XIX.		104 6			
04 Does title V or XIX follow Medicare (title XVIII) for a CA outpatient services cost? Enter "Y" for yes or "N" for no			Ν	N	98.
in column 2 for title XIX.					
05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in			Y	Y	98.
column 2 for title XIX.		rtre v, and rn			
06 Does title V or XIX follow Medicare (title XVIII) when cos			Y	Y	98.
Pts. I through IV? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.	mn 1 for title	V, and in			
Rural Providers					
5.00 Does this hospital qualify as a CAH?			N		105.
5.00 If this facility qualifies as a CAH, has it elected the al	l-inclusive met	hod of payment	Ν		106.
for outpatient services? (see instructions)	st reimbursemen	t for I&R	Ν		107.
training programs? Enter "Y" for yes or "N" for no in colu		· ·			
yes, the GME elimination is not made on Wkst. B, Pt. I, co reimbursed. If yes complete Wkst. D-2, Pt. II.	I. 25 and the p	rogram is cost			
B. 00 Is this a rural hospital qualifying for an exception to th	e CRNA fee sche	dul e? See 42	Ν		108.
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupational	Speech	Respi ratory	4
2.00 If this hospital qualifies as a CAH or a cost provider, ar	1.00 e N	2.00 N	3.00 N	4.00 N	109.
		IN	IN	IN IN	109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
				4.00	-
	tal Domonstrati	op project (841)	24	1.00 N	110.

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES	In	Li e	u of For		
F	Period: From 01/01/2 Fo 12/31/2		Workshe Part I Date/Ti 5/7/201	me Pre	epared:
	1.00				-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	1.00 N		2. (		111.00
		1.00	2.00	3.00	
<ul> <li>Miscellaneous Cost Reporting Information</li> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter 3 either "93" percent for short term hospital or "98" percent for long term care (inclu psychiatric, rehabilitation and long term hospitals providers) based on the definition Pub. 15-1, chapter 22, §2208.1.</li> <li>116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.</li> </ul>	in column des	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or inc.	"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy claim-made. Enter 2 if the policy is occurrence.	is	1			118.00
Premi ums	Losses		Insur	ance	
1.00	2.00		3. (		
118.01 List amounts of malpractice premiums and paid losses:	0	0		(	0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center other than the	1.00 N		2. (	00	118.02
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless 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.	Y		N		119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5. (	)6	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If	N				125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00 f this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
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
<ul> <li>133.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</li> <li>134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1</li> </ul>					133.00 134.00
and termination date, if applicable, in column 2. All Providers					-
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

alth Financial Systems )SPITAL AND HOSPITAL HEALTH CARE C			Provider CC		Peri o		u of Form CMS- Worksheet S-2			
					From	01/01/2017 12/31/2017	Part I			
1.00							5/7/2018 3:5	7 pm		
1.00 If this facility is part of a	a chai n organi zati on o	2.00	nos 141 throu	ugh 142 th	<u> </u>	3.00	of the	_		
home office and enter the home					e name a	nu auuress	of the			
1.00Name:	Contractor's				actor's M	lumber:		141.		
2.00Street:	PO Box:							142.		
3. 00 Ci ty:	State:			Zip Co	ode:			143.		
							1.00	-		
4.00 Are provider based physicians	s' costs included in Wor	rksheet A?	)				Y	144.		
noophio provider based prijererane										
						1.00	2.00			
5.00 If costs for renal services a						Y		145.		
inpatient services only? Ente					5					
no, does the dialysis facilit period? Enter "Y" for yes or			or this cost	reporting						
6.00 Has the cost allocation metho			ly filed cost	report?		Ν		146.		
Enter "Y" for yes or "N" for					lf					
yes, enter the approval date	(mm/dd/yyyy) in column	2.								
							1.00	-		
7.00 Was there a change in the sta	atistical basis? Enter '	"Y" for ve	s or "N" for	no			1.00 N	147.		
8.00 Was there a change in the ord							N	148.		
9.00 Was there a change to the sim					for no.		N	149.		
			Part A	Part I	3	Title V	Title XIX			
			1.00	2.00		3.00	4.00	_		
Does this facility contain a										
or charges? Enter "Y" for yes 5.00Hospital	S OF IN TOF NO TOF Each	n componen	N	And Part N	B. (See	4 <u>2 CFR 9413</u> N	N	155.		
6. 00 Subprovi der – IPF			N	N		N	N	156.		
7.00Subprovider - IRF			Ν	N		Ν	N	157.		
8. 00 SUBPROVI DER								158.		
9.00 SNF			N	N		N	N	159.		
0.00 HOME HEALTH AGENCY 01.00 CMHC			N	N N		N	N	160.		
						N	N	161.		
							1.00	1		
Multicampus							1			
5.001s this hospital part of a Mu		t has one	or more campu	ises in dit	fferent (	CBSAs?	N	165.		
Enter "Y" for yes or "N" for	no. Name		County	State	Zip Code	e CBSA	FTE/Campus			
	0		County 1.00	2.00	3.00	4.00	5.00	-		
6.00 If line 165 is yes, for each			1.00	2.00	0.00	1.00		0166.		
campus enter the name in colu	umn									
0, county in column 1, state										
column 2, zip code in column										
CBSA in column 4, FTE/Campus column 5 (see instructions)										
						1				
							1.00			
Health Information Technology	y (HIT) incentive in the						1			
						an the	Y	167. 0168.		
7.00 Is this provider a meaningful				10/15	r), ente	er the		0108.		
7.00 s this provider a meaningful 8.00 f this provider is a CAH (li		STRUCTIONS		qualifv	for a hai	rdshi p		168.		
7.00 Is this provider a meaningful 8.00 If this provider is a CAH (li reasonable cost incurred for	the HIT assets (see ins		168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (Ii reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes	ser, does s or "N" f	or no. (see i					9169.		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is '	ser, does s or "N" f	or no. (see i			enter the	9.9			
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (Ii reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is '	ser, does s or "N" f	or no. (see i		s "N"),					
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is '	ser, does s or "N" f	or no. (see i		s "N"),	Begi nni ng	Endi ng	_		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning transition factor. (see instruction)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions)	ser, does s or "N" f "Y") and i	for no. (see i s not a CAH (	line 105 i	s "N"),	egi nni ng 1. 00	Endi ng 2. 00	170		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning transition factor. (see instruction)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions) EHR beginning date and	ser, does s or "N" f "Y") and i	for no. (see i s not a CAH (	line 105 i	s "N"),	Begi nni ng	Endi ng	170.		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for</li> <li>8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning transition factor. (see instruction factor)</li> <li>0.00 Enter in columns 1 and 2 the</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions) EHR beginning date and	ser, does s or "N" f "Y") and i	for no. (see i s not a CAH (	line 105 i	s "N"),	egi nni ng 1. 00	Endi ng 2. 00	170.		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for 8.01 If this provider is a CAH and exception under §413.70(a)(6)</li> <li>9.00 If this provider is a meaning transition factor. (see instr</li> <li>0.00 Enter in columns 1 and 2 the period respectively (mm/dd/y)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions) EHR beginning date and yyy)	ser, does s or "N" f "Y") and i ending da	for no. (see i s not a CAH ( ite for the re	line 105 i	s "N"),	Begi nni ng 1. 00 1/01/2017 1. 00	Endi ng 2. 00 03/31/2017 2. 00	170.		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for a exception under §413.70(a) (6)</li> <li>9.00 If this provider is a meaning transition factor. (see instruction factor)</li> <li>0.00 Enter in columns 1 and 2 the period respectively (mm/dd/y)</li> <li>1.00 If line 167 is "Y", does this</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions) EHR beginning date and yyy) s provider have any days	ser, does s or "N" f "Y") and i ending da s for indi	for no. (see i s not a CAH ( ite for the re viduals enrol	line 105 i eporting	s "N"), <u>E</u> 0	egi nni ng 1. 00 1/01/2017	Endi ng 2. 00 03/31/2017 2. 00	170. 0 171.		
<ul> <li>7.00 Is this provider a meaningful</li> <li>8.00 If this provider is a CAH (li reasonable cost incurred for 1 f this provider is a CAH and exception under §413.70(a) (6)</li> <li>9.00 If this provider is a meaning transition factor. (see instr</li> <li>0.00 Enter in columns 1 and 2 the period respectively (mm/dd/y)</li> </ul>	the HIT assets (see ins d is not a meaningful us )(ii)? Enter "Y" for yes gful user (line 167 is ' ructions) EHR beginning date and yyy) s provider have any days lans reported on Wkst. S	ser, does s or "N" f "Y") and i ending da s for indi S-3, Pt. I	for no. (see i s not a CAH ( ite for the re viduals enrol , line 2, col	line 105 i eporting led in . 6? Enter	s "N"), E 0	Begi nni ng 1. 00 1/01/2017 1. 00	Endi ng 2. 00 03/31/2017 2. 00			

	Financial Systems REID HOSPITAL & HEA			In Lie	eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	1	Period: From 01/01/2017 To 12/31/2017		pared:
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Enter	r all dates in	the	
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	o boginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a		instructions)	IN		1.00
	preparent and the ges, enter the date of the enange find	001 dilli1 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare F	Program? If	N	2100	0100	2.00
	yes, enter in column 2 the date of termination and in colur	nn 3, "V" for				
3.00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of	offices, drug	Y			3. 00
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe	of the board				
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
4 00	Financial Data and Reports		Y	•	04/00/0010	1 4 00
4.00	Column 1: Were the financial statements prepared by a Cerr Accountant? Column 2: If yes, enter "A" for Audited, "C" or or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/23/2018	4.00
5.00	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
	those on the filed financial statements? If yes, submit rea					
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities				1	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	N		6.00
7.00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	nstructions		Y		7.00
8.00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed		Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved		cal education	Y		9.00
10.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	Y		10.00
	cost reporting period? If yes, see instructions.					
11.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
					Y/N 1.00	
	Bad Debts				1.00	
12 00	Is the provider seeking reimbursement for bad debts? If yes	s see instruct	tions		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection			st reporting	Ň	13.00
	period? If yes, submit copy.	, , , , , , , , , , , , , , , , , , ,	0			
14.00		ents waived? If	<sup>°</sup> yes, see ins <sup>.</sup>	tructions.	N	14.00
45 00	Bed Complement		· · ·			1 45 00
15.00	Did total beds available change from the prior cost reportion		4		N nt B	15.00
		Y/N	-t A Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data			1	1	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/06/2018	Y	04/06/2018	17.00
18.00	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	N		Ν		18. 00
19. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.00

Health Financial System

REID HOSPITAL & HEALTH CA	RE SERVICES
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	FINANCIAI SYSTEMS REID HUSPITAL & HEA								
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S- Part II Date/Time Pr 5/7/2018 3:5	repared:			
		Descri	ption	Y/N	Y/N				
		(	)	1.00	3.00				
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00			
		Y/N	Date	Y/N	Date				
		1.00	2.00	3.00	4.00				
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00			
					1.00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS H	OSPLTALS)		1.00				
	Capital Related Cost		001111120)			-			
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00			
	Have changes occurred in the Medicare depreciation expense		als made durir	a the cost	N	23.00			
20.00	reporting period? If yes, see instructions.			ig the cost		20.00			
24.00	Were new leases and/or amendments to existing leases enter	orting period?	Ν	24.00					
	lf yes, see instructions	-							
25.00	Have there been new capitalized leases entered into during instructions.	f yes, see	N	25.00					
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	yes, see	Ν	26.00					
27.00	Has the provider's capitalization policy changed during the	ves submit	Ν	27.00					
271.00	copy.		g por our 11 j			27100			
	Interest Expense								
28.00	Were new loans, mortgage agreements or letters of credit e	eporting	Ν	28.00					
29.00	period? If yes, see instructions.	arua Fund)	Y	29.00					
29.00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y treated as a funded depreciation account? If yes, see instructions								
30.00	Has existing debt been replaced prior to its scheduled mat	see	Y	30.00					
31.00	instructions. Has debt been recalled before scheduled maturity without is	600	Ν	31.00					
31.00	instructions.	ssuance of new	debt? IT yes,	566	IN	31.00			
	Purchased Servi ces								
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni she	d through cont	ractual	Y	32.00			
	arrangements with suppliers of services? If yes, see instru	uctions.	Ŭ						
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pert <mark>ai</mark> nin	<mark>g to co</mark> mpetiti	ve bidding? If	Y	33.00			
	no, see instructions.					_			
	Provi der-Based Physi ci ans				<u>.</u> .				
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-base	ed physicians?	N	34.00			
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agroomon	te with the pr	ovider based	Ν	35.00			
35.00	physicians during the cost reporting period? If yes, see in		ts with the pi	ovi del -based	IN	35.00			
				Y/N	Date				
				1.00	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	repared by the	nome 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			
	the provider? If yes, enter in column 2 the fiscal year en								
39.00	If line 36 is yes, did the provider render services to oth					39.00			
	see instructions.								
40.00	If line 36 is yes, did the provider render services to the	home office?	lfyes, see			40.00			
	instructions.								
		1.	00	2.	00	-			
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position	BKD, LLP		BKD, LLP		41.00			
	held by the cost report preparer in columns 1, 2, and 3,								
	respectively.								
42.00	Enter the employer/company name of the cost report	BKD, LLP				42.00			
40.00	preparer.	5005046405		LVAAATEERARTE		10.00			
43.00	Enter the telephone number and email address of the cost	5025810435		LVCOSTREPORTS@	SKD. COM	43.00			
	report preparer in columns 1 and 2, respectively.	T		1		11			

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVICES	In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet S-2 Part II	2
				Date/Time Pre 5/7/2018 3:57	pared: pm
		2.00			
		3.00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the titl	e/position	BKD, LLP			41.00
held by the cost report preparer in columns	1. 2. and 3.				
respectively.	., _,				
42.00 Enter the employer/company name of the cost	report				42.00
1 5 1 5	report				42.00
preparer.					40.00
43.00 Enter the telephone number and email address					43.00
report preparer in columns 1 and 2, respecti	vel y.				

Health Financial Systems

### REID HOSPITAL & HEALTH CARE SERVICES

Non-CMS HFS Worksheet

eal th	Financial Systems REID HOSPITAL & HEALTH	CARE SERVICES		Non-CMS HES Wo	rkshee
IFS Su	pplemental Information	Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part IX Date/Time Pre 5/7/2018 3:57	epared
			Title V	Title XIX	
			1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns	s and Residence post	Y	Y	1. (
	stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in	column 1 for Title V			
	and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)				
. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report			Y	2.0
	Part I (e.g. net of Physician's component)? Enter Y/N in column	n 1 for Title V and Y/N			
	in column 2 for Title XIX. (see S-2, Part I, line 98.01)				
6.00	Do Title V or XIX follow Medicare (Title XVIII) for the calcula			Y	3.
	Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Ti	itle V and Y/N in colum	1		
	2 for Title XIX. (see S-2, Part I, line 98.02)				
. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.
			Inpati ent	Outpati ent	
			1.00	2.00	_
~~	CRITICAL ACCESS HOSPITALS		N	N	•
. 00	Does Title V follow Medicare (Title XVIII) for Critical Access		N	Ν	4.
	reimbursed 101% of cost? Enter Y or N in column 1 for inpatient for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	t and y or N in column .	2		
. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Acces	cc Hocpitalc (CAH) being	a N	N	5.
. 00	reimbursed 101% of cost? Enter Y or N in column 1 for inpatien			IN	5.
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		2		
	[10] Outpatrent. (See 5-2, Tart 1, Thes 70.05 and 70.04)		Title V	Title XIX	
			1, 00	2.00	-
	RCE DI SALLOWANCE		1.00	2.00	
. 00	Do Title V or XIX follow Medicare and add back the RCE Disallo	wance on W/S C Part L	Y	Y	6.0
	column 4? Enter Y/N in column 1 for Title V and Y/N in column 2				
	S-2, Part I, line 98.05)				
	PASS THROUGH COST				
. 00	Do Title V or XIX follow Medicare when cost reimbursed (paymen	t system is "O") for	Y	Y	7.
	worksheets D, parts I through IV? Enter Y/N in column 1 for Ti				
	2 for Title XIX. (see S-2, Part I, line 98.06)				
	RHC				
. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter	r Y/N in column 1 for	N	Ν	8.
	Title V and Y/N in column 2 for Title XIX.				
	FQHC				
. 00	For fiscal year beginning on/after 10/01/2014, use M-series for		N	Ν	9.
	XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for	Title XIX.			
			1	I	1

) \* / (\_ ^

ISPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/7/2018 3:57	pare
						I/P Days / O/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
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) HMO and other (see instructions)	30. 00	133	48, 54	45 0. 00	0	2.
00	HMO I PF Subprovi der						3.
00	HMO I RF Subprovider					0	4.
00	Hospital Adults & Peds. Swing Bed SNF					0	
00 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		133	48, 54	45 0.00	0	6
00	INTENSIVE CARE UNIT	31.00	30	10, 95	50 0.00	0	8
00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGICAL INTENSIVE CARE UNIT						11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY	43.00				0	13
00	Total (see instructions)		163	59, 49	95 0.00	0	
00	CAH visits					0	15
00	SUBPROVIDER - IPF	40. 00	38			0	16
00	SUBPROVIDER - IRF	41.00	20	7,30	00	0	17
00	SUBPROVIDER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY		•				20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY						22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE	116.00	0		0		24
10	HOSPICE (non-distinct part)	30.00					24
00	CMHC - CMHC						25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
00	Total (sum of lines 14-26)		221				27
00	Observation Bed Days	-				0	
00	Ambul ance Trips						29
. 00	Employee discount days (see instruction)						30
. 00	Employee discount days - 1RF						31
. 00 . 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)		0		0		32 32
00	LTCH non-covered days						33
	LTCH site neutral days and discharges						33
01	Eron si te neutrar uays anu urscharges			I	1		1 33

SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		Provider CO		Period: From 01/01/2017 To 12/31/2017	5/7/2018 3:57	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	18, 507	770	30, 13	5		1.
00	HMO and other (see instructions)	3, 196	7, 339				2.
00	HMO IPF Subprovider	822	0				3.
0C	HMO IRF Subprovider	261	309				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, 507	770	30, 13			7
00	I NTENSI VE CARE UNI T	1, 756	122	4, 75	9		8
00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGI CAL I NTENSI VE CARE UNI T						11
00	OTHER SPECIAL CARE (SPECIFY)		50	1 05	,		12
00	NURSERY	00.0/0	50	1, 95		0 400 50	13
00	Total (see instructions)	20, 263	942	36, 85		2, 182. 58	
00	CAH visits	0	0		0	(/ )5	15
00 00	SUBPROVIDER - IPF	6,095	0	10, 08			
00	SUBPROVI DER – I RF SUBPROVI DER	1, 747	0	3, 15	2 0.00	19.05	18
00	SUBPROVIDER SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY						22
00	AMBULATORY SURGICAL CENTER (D. P. )						23
00	HOSPICE	0	0		0 0.00	19.89	
10	HOSPICE (non-distinct part)	853	66	1, 06		17.07	24
00	CMHC - CMHC			1,00	0		25
00	RURAL HEALTH CLINIC						26
25	FEDERALLY QUALIFIED HEALTH CENTER	o	0		0 0.00	0.00	
00	Total (sum of lines 14-26)				8.85		
00	Observation Bed Days		105	3, 11	7		28
00	Ambul ance Trips	0					29
00	Employee discount days (see instruction)			1, 23	1		30
00	Employee discount days - IRF			15	7		31
00	Labor & delivery days (see instructions)	0	114	16	1		32
. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0		32
00	LTCH non-covered days	0					33
01	LTCH site neutral days and discharges	0					33

)SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/7/2018 3:57	pare
		Full Time		Di s	charges		
	Component	Equivalents Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
00 00 00 00 00 00 00 00 00 00 00 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) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0.00 0.00 0.00 0.00 0.00		5, 5( 7 5, 5( 4)	05 344 73 2,682 0 0	15. 00 11, 011 11, 011 747 224	2 3 4 5 6 7 7 8 9 10 11 12 13 14 15 16
00 00 00	Employee discount days (see instruction) Employee discount days - 1RF Labor & delivery days (see instructions)						30 31 32
01 00 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges		•		0		32 33 33

Health Financial Systems

REI D	HOSPI	TAL	&	HEALTH	CARE	SERVI CES	

eal th	Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-1
OSPI T	AL WAGE INDEX INFORMATION			Provider CC		eriod: rom 01/01/2017 o 12/31/2017		pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							-
. 00	SALARIES Total salaries (see	200. 00	162, 742, 940	0	162, 742, 940	5,074,144.00	32.07	1.0
. 00	instructions)	200.00	102, 742, 740	0	102, 742, 740	5, 074, 144. 00	52.07	1.0
. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.0
. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.0
. 00	B		0	0	0	0.00	0.00	3.0
. 00	Physician-Part A -		0	0	0	0.00	0. 00	4.0
. 01	Administrative		0		0	0.00	0.00	4.0
. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0.00		
. 00	Physician-Part B		0	Ŭ	0	0.00	0.00	
. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.0
. 00	Interns & residents (in an	21.00	0	1, 521, 667	1, 521, 667	22, 224. 00	68.47	7.0
	approved program)		-					
. 01	Contracted interns and		0	0	0	0.00	0. 00	7.0
	residents (in an approved programs)							
. 00	Home office and/or related		0	0	0	0.00	0. 00	8.0
	organization personnel							
. 00 0. 00	SNF Excluded area salaries (see	44.00	0 78, 213, 433	0 82, 095	0 78, 295, 528	0. 00 1, 678, 049. 91		
0.00	instructions)		70, 213, 433	02,075	10, 275, 520	1,070,047.71	40.00	10.0
	OTHER WAGES & RELATED COSTS						1	
1.00	Contract Labor: Direct Patient Care		5, 903, 299	0	5, 903, 299	122, 657. 62	48.13	11.0
2.00	Contract Labor: Top Level		o	0	0	0.00	0.00	12.0
	management and other							
	management and administrative							
3.00	services Contract Labor: Physician-Part		0		0	0.00	0.00	13.0
	A - Administrative							
4.00	Home office and/or related		0	0	0	0.00	0.00	14. C
	orgainzation salaries and wage-related costs							
4. 01	Home office salaries		0	0	0	0.00	0. 00	14.0
	Related organization salaries		0	0	0	0.00		14.0
5.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.0
6. 00	Home office and Contract		0	0	0	0.00	0.00	16.0
	Physicians Part A - Teaching							
7.00	WAGE-RELATED COSTS Wage-related costs (core) (see		26, 938, 649	0	26, 938, 649		1	17.0
7.00	instructions)		20, 730, 047	0	20, 930, 049			17.0
8.00	Wage-related costs (other)		0	0	0			18. (
9.00	(see instructions) Excluded areas		15, 222, 997		15, 222, 997			19. (
9.00 0.00	Non-physician anesthetist Part		10, 222, 997	0	10, 222, 997			20. (
	A		0		0			
1. 00	Non-physician anesthetist Part		0	0	0			21. (
2.00	B Physician Part A -		Ω	0	Ο			22. (
00	Admi ni strati ve		0		0			
2.01	Physician Part A - Teaching		0	0	0			22. (
3.00 4.00	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23.0
4.00 5.00	Interns & residents (in an		175, 996	0	175, 996			24.0
	approved program)		,		,			
5.50	Home office wage-related		0	0	0			25. !
5. 51	(core) Related organization		Ω		0			25.5
2.01	wage-related (core)		0		0			20.0
F F 2	Home office: Physician Part A - Administrative -		0	0	0			25. 5
5. 52	words related ()				0			25.5
	wage-related (core) Home office & Contract		∩					1 20.0
	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	0			
5. 53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			
5. 53	Home office & Contract Physicians Part A - Teaching -	ES 4.00	1, 969, 926		1, 969, 926	60, 318. 00	32.66	

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	CN: 15-0048 F	Period:	Worksheet S-3	
					F	rom 01/01/2017		
					T	o 12/31/2017		
							5/7/2018 3: 57	
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	$(col.2 \pm col.$	Salaries in	col. 5)	
				A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under		3, 865, 440	0	3, 865, 440	59, 309. 19	65. 17	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0	C	0.00		29.00
30.00	Operation of Plant	7.00	2, 437, 646		2, 437, 646			
31.00	Laundry & Linen Service	8.00	399, 353	-82, 095	317, 258	23, 543. 09	13.48	31.00
32.00	Housekeepi ng	9.00	1, 614, 916	0	1, 614, 916	116, 349. 00	13.88	32.00
33.00	Housekeeping under contract		0	0	C	0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	2, 507, 352	-2, 017, 343	490, 009	34, 815. 49	14.07	34.00
35.00	Dietary under contract (see		0	0	C	0.00	0.00	35.00
	instructions)							
36.00	Cafeteri a	11.00	52, 237	2, 017, 343	2, 069, 580	131, 694. 51	15. 72	36.00
37.00	Maintenance of Personnel	12.00	0	0	c c	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	221, 709	221, 709	4, 612. 00	48.07	38.00
39.00	Central Services and Supply	14.00	582, 019	0	582, 019	39, 735. 00	14.65	39.00
40,00	Pharmacy	15.00	3, 688, 157		3, 688, 157			
41.00	Medical Records & Medical	16.00	3, 086, 678		3, 086, 678			41.00
	Records Library		-,,			,		
42.00	Soci al Servi ce	17.00	2, 770, 142	0	2, 770, 142	25, 440. 00	108.89	42.00
43.00	Other General Service	18.00		Ó		0.00		43.00
	· · · · · · · · · ·			-	-			

Health Financial Systems	REI D	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provider CO		eriod: rom 01/01/2017	Worksheet S-3 Part III	
				1	o 12/31/2017	Date/Time Prep 5/7/2018 3:57	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX	SUMMARY			_		_	
1.00 Net salaries (see		166, 608, 380	-1, 521, 667	165, 086, 713	5, 111, 229. 19	32.30	1.00
instructions)							
2.00 Excluded area salaries (see		78, 213, 433	82, 095	78, 295, 528	1, 678, 049. 91	46.66	2.00
instructions)							
3.00 Subtotal salaries (line 1		88, 394, 947	-1, 603, 762	86, 791, 185	3, 433, 179. 28	25. 28	3.00
minus line 2)							
4.00 Subtotal other wages & relate	b	5, 903, 299	0	5, 903, 299	122, 657. 62	48. 13	4.00
costs (see inst.)							
5.00 Subtotal wage-related costs		26, 938, 649	0	26, 938, 649	0.00	31.04	5.00
(see inst.)							
6.00 Total (sum of lines 3 thru 5)		121, 236, 895	-1, 603, 762	119, 633, 133	3, 555, 836. 90	33.64	6.00
7.00 Total overhead cost (see		39, 966, 370	88, 384	40, 054, 754	1, 603, 424. 28	24.98	7.00
instructions)							

ITAL WAGE RELATED COSTS	Provider CCN: 15-0048	Peri od:	Worksheet S-3
		From 01/01/2017 To 12/31/2017	Part IV Date/Time Prep 5/7/2018 3:57
			Amount
			Reported 1.00
PART IV - WAGE RELATED COSTS			1.00
Part A - Core List			
RETI REMENT COST			
401K Employer Contributions			0
Tax Sheltered Annuity (TSA) Employer Contribution			4, 722, 119
Nonqualified Defined Benefit Plan Cost (see instructions	5)		0
Qualified Defined Benefit Plan Cost (see instructions)			0
PLAN ADMINISTRATIVE COSTS (Paid to External Organization	)		-
401K/TSA Plan Administration fees			0
Legal /Accounting/Management Fees-Pension Plan			0
Employee Managed Care Program Administration Fees			0
HEALTH AND INSURANCE COST Health Insurance (Purchased or Self Funded)			0
Health Insurance (Self Funded without a Third Party Admi	nistrator)		0
Health Insurance (Self Funded without a Third Party Adminis			23, 824, 233
Heal th Insurance (Purchased)			23, 024, 233
Prescription Drug Plan			779, 680
0 Dental, Hearing and Vision Plan			671, 995
0 Life Insurance (If employee is owner or beneficiary)	•		173, 805
0 Accident Insurance (If employee is owner or beneficiary)			0
0 Disability Insurance (If employee is owner or beneficiar	-y)		565, 518
0 Long-Term Care Insurance (If employee is owner or benefi	ciary)		0
0 'Workers' Compensation Insurance			934, 006
0 Retirement Health Care Cost (Only current year, not the	extraordinary accrual require	ed by FASB 106.	0
Non cumulative portion)			
TAXES			10.051.070
0 FICA-Employers Portion Only			10, 251, 073
0 Medicare Taxes - Employers Portion Only			0
0 Unemployment Insurance			103, 341 0
0 State or Federal Unemployment Taxes OTHER			0
0 Executive Deferred Compensation (Other Than Retirement C	ost Reported on Lines 1 throu	igh 4 above (see	0
instructions))	lost keported on trites i through	agii 4 above. (See	Ŭ
0 Day Care Cost and Allowances			0
0 Tuition Reimbursement			311, 872
0 Total Wage Related cost (Sum of lines 1 -23)			42, 337, 642
Part B - Other than Core Related Cost			
0 OTHER WAGE RELATED COSTS (SPECIFY)			0

Heal th	Financial Systems REID HOSPITAL	& HEALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0048	Peri od:	Worksheet S-3	
			From 01/01/2017	Part V	l
			To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Cost Center Description		Contract Labor	Benefit Cost	pin
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		5, 903, 299	42, 337, 642	1.00
2.00	Hospi tal		5, 903, 299	26, 938, 649	2.00
3.00	Subprovider - IPF		0	1, 034, 948	3.00
4.00	Subprovider - IRF		0	308, 350	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
	Hospital-Based HHA				11.00
12.00	Separately Certified ASC				12.00
	Hospi tal -Based Hospi ce		0	0	13.00
	Hospital-Based Health Clinic RHC				14.00
	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
	Renal Dialysis		0	0	17.00
18.00	Other		0	14, 055, 695	18.00

Hear th	FINANCIAI Systems	REID	HUSPITAL & HEA	LIH CARE SERVI	CES	In Lie	U OI FOIM CMS-2	2552-10
HOSPI 1	FAL-BASED HOSPICE IDENTIFICATION	DATA			CN: 15-0048 N: 15-1524	Period: From 01/01/2017 To 12/31/2017		GH IV pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursing Facility	Facility		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1 1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							1 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)							
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days report	ed in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
								1

				Utilei	Total (Sum Of	
	🔺				col s. 1	
					through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGI	NING ON OR AFT	ER OCTOBER 1, 2	2015		
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	14, 110	777	2, 140	17, 027	11.00
12.00	Hospice Inpatient Respite Care	125	5	13	143	12.00
13.00	Hospice General Inpatient Care	728	61	128	917	13.00
14.00	Total Hospice Days	14, 963	843	2, 281	18, 087	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PL	ERIODS BEGI <mark>N</mark> NIN	G ON OR AFTER (	OCTOBER 1, 2015	5	
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

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

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

111 21 01		
od:	Worksheet S-10	
01/01/2017		

Incompensated and indigent care cost computation         1.00           1.00         Cost to charge ratio (Worksheet G, Part   line 202 colum 3 divided by line 202 colum 8)         0.288281           1.00         Need caid (See Instructions for each line)         23, 569, 246           2.00         Not revenue from Modicaid         23, 569, 246           3.00         If line 3 is no, then enter DSH and/or supplemental payments from Medicaid?         2, 00           0.00         If line 4 is no, then enter DSH and/or supplemental payments from Medicaid         39, 437, 201 7, 00           0.00         Medicaid cost (line 1 times 1 ine 6)         39, 437, 201 7, 00           0.00         Not revenue from stand-alone CHP         39, 437, 201 7, 00           0.00         Not revenue from stand-alone CHP         (line 7 minus sum of lines 2 and 5; if 1           0.01         Stand-alone CHP         (See instructions for each line)           0.01         Stand-alone CHP         (See instructions for each line)           0.02         Stand-alone CHP         (See instructions for each line)           0.03         Stand-alone CHP         (See instructions for each line)           0.10         Stand-alone CHP         (See instructions for each line)           10.00         Stand-alone CHP         (See instructions for each line)           11.00 <t< th=""><th></th><th></th><th></th><th>To 12/31/201</th><th></th><th></th></t<>				To 12/31/201		
Uncompensated and indigent care cost computation         0           100         Cost to charge ratio (00rsheed C, Part Line 202 colum 3 divided by line 202 colum 8)         0.288281           100         Cost to charge ratio (00rsheed C, Part Line 202 colum 3 divided by line 202 colum 8)         0.288281           100         Cost to charge ratio (00rsheed C, Part Line 202 colum 3 divided by line 202 colum 8)         0.288281           100         Cost to charge ratio (00rsheed C, Part Line 202 colum 8)         0.288281           100         File a is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 7         0.300           100         Intel a is no, then enter DSH and/or supplemental payments from Medicaid 7         1.00           100         If File a is yes, does line 2 include all DSH and/or supplemental payments from Medicaid 7         1.00           100         Difference between net revenue and costs for Wedicaid program (line 7 minus sum of lines 2 and 5; if 1         16.801.3667.955           100         Stand-alone CHP cost (line 1 times line 10)         0         0         0           1100         Stand-alone CHP cost (line 1 times line 10)         0         11.00           1100         Stand-alone CHP cost (line 1 times line 10)         0         12.00           1100         Stand-alone CHP cost (line 1 times line 10)         0         13.00						
1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 8)       0.288281       1.00         2.00       Net revenue from Medicaid       23,669,746       2.00         3.00       Did you receive USH or supplemental payments from Medicaid?       N       3.00         3.00       Did you receive USH or supplemental payments from Medicaid?       N       3.00         4.00       IF line 3 is so, the enter DSH and/or supplemental payments from Medicaid?       N       3.00         5.00       IF line 4 is so, the enter DSH and/or supplemental payments from Medicaid?       N       3.00         6.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       15, 867, 855       8.00         7.01       Medicaid cost (line 1 times line 0)       Stand-alone CHIP cost (line 1 times line 10)       9.00       9.00       Net revenue from stand-alone CHIP       0       9.00         10.00       Stand-alone CHIP cost (line 1 times line 10)       10.00					1.00	
Medicaid (see instructions for each line)       23, 569, 24         0.00       Net revenue from Medicaid       23, 569, 24         0.00       If line 3 is yes, does line 2 include all DSI and/or supplemental payments from Medicaid?       3, 00         0.00       If line 4 is no, then enter DSI and/or supplemental payments from Medicaid?       1, 00         0.00       Medicaid charges       1, 00         0.01       Medicaid charges       0, 00         0.01       Stand-alone CHIP Charges       0, 10, 00         1.00       Stand-alone CHIP Charges       0, 10, 00         1.00       Medicaid charges       0, 10, 00         1.00       Medicaid charges       0, 00, 00         1.00       Medicaid charges       0, 00, 00         1.00       Medicaid charges       0, 00, 00 </td <td>1 00</td> <td></td> <td></td> <td>1</td> <td>0.000001</td> <td>1 1 00</td>	1 00			1	0.000001	1 1 00
2:00       Not revenue from Medicaid       23, 569, 240       2.00       Not revenue from Medicaid       3.00         0:00       Did you receive DSI or supplemental payments from Medicaid?       23, 569, 240       2.00       3.00         0:00       If line 4 is no. thon enter DSI and/or supplemental payments from Medicaid       3.00       4.00       Not       5.00       15.00       5.00       15.00       5.00       15.00       5.00       10.00       5.00       10.00	1.00		ded by line 202 co	Tumn 8)	0. 288281	1.00
3.00       Did you receive DSH or supplemental payments from Medicaid?       N       3.00       If line 3 is yes, does line 2 include all DSH ad/or supplemental payments from Medicaid?       N       3.00       4.00         0.00       Medicaid charges       3.04       0.00       11 line 4 is yes, does line 2 include all DSH ad/or supplemental payments from Medicaid?       N       4.00         0.00       Medicaid charges       3.64,07,204       0.50       0.56,001,24,06       0.50         0.00       Difference between and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       3.64,07,204       6.00         0.00       Stand-alone CHP charges       0       9.00       0.00       10.00         0.01       Stand-alone CHP charges       0       9.00       0.00       10.00       10.00         0.01       Stand-alone CHP charges       0       9.00       0.00       10.00	2 00				22 560 246	2 00
4.00       If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?       4.00         5.00       IF line 4 is no, then enter DSH and/or supplemental payments from Medicaid?       5.00         0.00       Medicaid charges       33, 437, 201 7.00         0.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if s.867, 955       8.00         0.01       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)						
5.00       If line 4 is no, then enter DSH and/or supplemental payments from Medicald       0       5.00         6.00       Medicaid cost (line 1 times line 6)       136,801,249       6.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       136,801,249       6.00         9.00       Net revenue from stand-alone CHP       0       9.00       0			al navments from Me	di cai d2	IN	
6.00       Medicaid cost (line 1 times line 6)       136, 801, 249       6.00         7.00       Medicaid cost (line 1 times line 6)       39, 437, 201       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       15, 867, 955       8.00         Children's Health Insurance Program (CHIP) (see instructions for each line)       0       9, 00       8.00         0.00       Stand-alone CHIP cost (line 1 times line 10)       0				ui cui u:	0	
7.00       Medicald.cost <sup>2</sup> (ilne 1 times line 6)       39, 437, 201       7.00         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if       15, 867, 965         9.00       Net revenue from stand-alone CHP (Line 1 times line 10)       0       9.00         10.00       Stand-alone CHP cost (line 1 times line 10)       0       10.00         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9: if < zero then enter zero)						
8.00       Difference between net revenue and costs for Medical program (line 7 minus sum of lines 2 and 5; if       15, 867,955       8.00         0.00       Net revenue from stand-alone CHIP       0       9,00       0		5				•
Children's Health Insurance Program (CHIP) (see instructions for each line)       9.00         9.00       Net revenue from stand-alone CHIP cost (line 1 times line 10)       0         10.00       Stand-alone CHIP cost (line 1 times line 10)       0         12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	8.00		ine 7 minus sum of	lines 2 and 5; if		
9.00       Net revenue from stand-alone CHIP       0       9.00       9.00       0.00       Stand-alone CHIP charges       0       10.00         10.00       Stand-alone CHIP cost (i.i.e. 1 times line 10)       0       10.00       11.00		< zero then enter zero)				
10.00       Stand-alone CHIP cost (line 1 times line 10)       0       0       10.00       Stand-alone CHIP cost (line 1 times line 10)       0       0       10.00       13.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       16.00       15.867.955       19.00       18.00       18.00       15.867.955       19.00       18.00       15.867.955       19.00       18.00       10.00       2.00       3.00       10.00 <td></td> <td></td> <td>r each line)</td> <td></td> <td></td> <td></td>			r each line)			
11.00       Stand-al one CHIP cost <sup>+</sup> (line 1 times line 10)       0       0       0       0         12.00       Difference between net revenue and costs for stand-al one CHIP (line 11 minus line 9; if < zero then enter zero).						
12.00       Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9: if < zero then other zero)		5			-	
enter zero)       0         0 Other state or local government indigent care program (see instructions for each line)       13.00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0)       0       13.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       0       0         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)       15.00       0       16.00         17.00       Private grants, donations, or endownent income restricted to funding charity care       0       17.00         17.00       Foriate grants, donations, or endownent income restricted to funding charity care       0       18.00         19.00       Cotal unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 15, 867, 955       19.00         19.00       Charity care charges and uninsured discounts for each line)       10.00       2.00       3.00         19.00       Charity care charges and uninsured discounts for the entire facility       16.820,644       3,743,898       8,592,970       21.00         10.01       Cost of patients approved for charity care and uninsured discounts (see instructions					-	
Other state or local government indigent care program (see instructions for each line)       13.00         13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         15.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)       0         16.00       Difference between net revenue and costs for state or local indigent care programs (see instructions for each line)       0         17.00       Private grants, donations, or endowment income restricted to funding charity care 0       0       17.00         18.00       Overnment grants, appropriations or transfers for support of hospital operations 0       18.00       0         19.00       Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 15, 867, 955       19.00         19.00       Charity care charges and uninsured discounts for the entire facility 16, 820, 644       3, 743, 898       20, 564, 542       20.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16, 820, 644       3, 743, 898       8, 592, 970       21.00         21.00	12.00		ine 11 minus line	9; if < zero then	0	12.00
13.00       Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.00         14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)       0         17.00       Private grants, donations, or endowment income restricted to funding charity care instructions for each line)       0       17.00         17.00       Private grants, donations, or endowment income restricted to funding charity care instructions for each line)       0       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       10.01       18.00         19.00       Charity care charges and uninsured discounts for each line)       0       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       0       0       0       0       22.00       0       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00			suctions for each L	ino)		-
14.00       Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)       0       14.00         15.00       State or local indigent care program cost (line 1 times line 14)       0       0         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0)       0       15.00         17.00       Private grants, donations, or endowment income restricted to funding charity care 0       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations 0       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 15, 867, 955       19.00         19.00       Cost of patients approved for charity care charges and uninsured discounts for each line)       1.00       2.00       3.00         10.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4, 849, 072       3, 743, 898       8, 592, 970       21.00         20.00       Cost of patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid complex (see instructions)       20.02, 02, 777       26.00         24.00       D	13 00				0	1 13 00
10)       10.0       15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line       0       15.00         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 hospital operations       0       15.80         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       15.867,955       19.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       15.867,955       19.00         19.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16.80,00       20.00       3.00         20.00       Cost of patients approved for charity care and uninsured discounts (see linstructions)       4.849,072       3.743,898       8.592,970       21.00         20.00       Cost of patients covered by Medicaid or other indigent care program's length of stay limit linposed on patients covered by Medicaid or other indigent care program's length of stay limit       N       24.00         21.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit       N						
15.00       State or local indigent care program cost (line 1 times line 14)       0       15.00         16.00       Difference between net revenue and costs for state or local indigent care program (line 15 minus line       0         13: if < zero then enter zero)		5 1 5			Ū.	
13: if < zero then enter zero)	15.00	State or local indigent care program cost (line 1 times line 14)	)		0	15.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)       0         17.00       Private grants, donations, or endowment income restricted to funding charity care 0       0         18.00       Government grants, appropriations or transfers for support of hospital operations 0       15, 867, 955         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)       15, 867, 955         10.00       Uninsured Insured Insured Insured Insured (col. 1 + patients + col. 2)       1.00       2.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16, 820, 644       3, 743, 898       20, 564, 542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       0       0       0       22.00         22.00       Statistic for amounts previously written off as 0       0       0       22.00         23.00       Cost of patients covered by Medicaid or other indigent care program?       1.00       22.00         23.00       Cost of charity care (line 21 minus line 22)       4, 849, 072       3, 743, 898       8, 592, 970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Me	16.00	Difference between net revenue and costs for state or local indi	gent care program	(line 15 minus line	e 0	16.00
instructions for each line)       17.00       Private grants, donations, or endownent income restricted to funding charity care       0       17.00         18.00       Government grants, appropriations or transfers for support of hospital operations       0       15.867,955         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       15.867,955       19.00         10.00       2.00       3.00       15.867,955       19.00         0       Insured patients       Insured patients       Total (col. 1 + col. 2)         1       0.00       2.00       3.00       15.867,955         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16.820,644       3.743,898       20.564,542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4.849,072       3.743,898       8.592,970       21.00         22.00       Payments received from patients for amounts previously written off as 0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4.849,072       3.743,898       8.592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit i imposed on patients covered by Medicaid or othe						
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 hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines       15,867,955       19.00         0       Decompensated Care (see instructions for each line)       Uninsured patients       Total (col. 1       + col. 2)         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16,820,644       3,743,898       20,564,542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4,849,072       3,743,898       8,592,970       21.00         22.00       Payments received from patients for amounts previously written off as o o o charity care       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       20,325,779       26.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay			o and state/local i	ndigent care progra	ams (see	
18.00       Government grants, appropriations or transfers for support of hospital operations       0       18.00         19.00       Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines       15,867,955       19.00         10.00       2.00       Insured patients       Total (col. 1 + col. 2)       + col. 2)       + col. 2)         10.00       2.00       3.00       0       0       0       0       0         20.00       Charity care charges and uninsured discounts for each line)       0       0       3.743,898       20,564,542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       0       0       0       22.00         22.00       Payments received from patients for amounts previously written off as ocarity care       0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imit imposed on patients covered by Medicaid or other indigent care program?       1.00       25.00         25.00       Total bad debt expense for the entire hospital complex (see instructions)       20,325,779       26.00         26.	17 00					1 1 7 00
19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 15, 867, 955       19.00         19.00       Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines patients (see 1.00       15, 867, 955       19.00         0       Uncompensated Care (see instructions for each line)       1.00       2.00       3.00         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16, 820, 644       3, 743, 898       20, 564, 542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4, 849, 072       3, 743, 898       8, 592, 970       21.00         22.00       Payments received from patients for amounts previously written off as 0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4, 849, 072       3, 743, 898       8, 592, 970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       20, 325, 779       26.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       1.02, 500       20, 325, 77						
8, 12 and 16)       Uninsured patients       Insured patients       Total (col. 1)         Uncompensated Care (see instructions for each line)       1.00       2.00       3.00         20.00       Chari ty care charges and uninsured discounts for the entire facility       16,820,644       3,743,898       20,564,542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4,849,072       3,743,898       8,592,970       21.00         22.00       Payments received from patients for amounts previously written off as ocare charity care       0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       0       25.00         25.00       Total bad debt expense for the entire hospital complex (see instructions)       20,325,779       26.00       26.00       1,202,500       27.00         26.00       Total bad debt sfor the entire hospital complex (see instructions)       1,202,500       27.00       1,202,500       27.00         27.00       Medicare rainbursable bad debts for the entire hospital complex (see instructions)				rams (sum of lines		
Uncompensated Care (see instructions for each line)Uninsured patientsInsured patientsTotal (col. 1 + col. 2)20.00Charity care charges and uninsured discounts for the entire facility16,820,6443,743,89820,564,54220.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)4,849,0723,743,8988,592,97021.0022.00Payments received from patients for amounts previously written off as charity care0022.0023.00Cost of charity care (line 21 minus line 22)4,849,0723,743,8988,592,97023.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.001.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program is length of stay limit20,325,77926.0027.00Medicare allowable bad debts for the entire hospital complex (see instructions) 1,850,0001,850,00027.0128.00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 18,475,77918,475,77928.0029.00Cost of nucompensated care (line 23 column 3 plus line 29)1.850,0001.18,475,77929.00Cost of nucompensated care (line 23 column 3 plus line 29)14,566,6860.00	17.00		Thangent care prog		13,007,733	17.00
1.002.003.0020.00Chari ty care charges and uninsured discounts for the entire facility (see instructions)16,820,6443,743,89820,564,54220.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)4,849,0723,743,8988,592,97021.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)4,849,0723,743,8988,592,97023.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?1.0025.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?20,325,77926.0027.01Medicare reinbursable bad debts for the entire hospital complex (see instructions)1,202,50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,850,00027.0128.00Non-Medicare bad debt spense (see instructions)1,8475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of uncompensated care (line 23 column			Uni nsu	red Insured	Total (col. 1	
Uncompensated Care (see instructions for each line)         20.00       Charity care charges and uninsured discounts for the entire facility (see instructions)       16,820,644       3,743,898       20,564,542       20.00         21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       4,849,072       3,743,898       8,592,970       21.00         22.00       Payments received from patients for amounts previously written off as charity care       0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       20,325,779       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       20,325,779       26.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       1,850,000       27.01         28.00       Non-Medicare bad debt expense (see instructions)       1,850,000       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare						
20.00Charity care charges and uninsured discounts for the entire facility16,820,6443,743,89820,564,54220.0021.00Cost of patients approved for charity care and uninsured discounts (see instructions)4,849,0723,743,8988,592,97021.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)4,849,0723,743,8988,592,97023.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?20,325,77926.0026.00Total bad debt expense for the entire hospital complex (see instructions)1,202,50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,850,00027.0129.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,8475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)<			1.00	2.00	3.00	
(see instructions)       21.00       Cost of patients approved for charity care and uninsured discounts (see instructions)       3,743,898       8,592,970       21.00         22.00       Payments received from patients for amounts previously written off as charity care       0       0       0       22.00         23.00       Cost of charity care       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit       0       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       20,325,779       26.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       1,202,500       27.00         29.00       Cost of non-Medicare bad debt expense (see instructions)       1,875,779       28.00         29.00       Cost of non-Medicare (line 23 column 3 plus line 29)       14,566,686       30.00	~~ ~~			0 ( ( ( ) ) 0 7 ( 0 ) 0 0		
21.00Cost of patients approved for charity care and uninsured discounts (see instructions)4,849,0723,743,8988,592,97021.0022.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)4,849,0723,743,8988,592,97023.001.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)20,325,77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,202,50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,850,00077.0128.00Non-Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00	20.00		1 i ty 16, 82	0, 644 3, 743, 89	8 20, 564, 542	20.00
instructions)22.00Payments received from patients for amounts previously written off as charity care00022.0023.00Cost of charity care (line 21 minus line 22)4,849,0723,743,8988,592,97023.0024.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)20,325,77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,202,50027.0027.01Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,850,00027.0128.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00	21 00			0 0 7 2 7 4 2 00		21 00
22.00       Payments received from patients for amounts previously written off as one charity care       0       0       0       22.00         23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       20,325,779       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       20,325,779       26.00         27.00       Medicare allowable bad debts for the entire hospital complex (see instructions)       1,202,500       27.00         27.01       Medicare bad debt expense (see instructions)       1,8475,779       28.00         28.00       Non-Medicare bad debt expense (see instructions)       18,475,779       28.00         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       5,973,716       29.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       14,566,686       30.00	21.00		4, 04	.9,012 3,143,09	0, 392, 970	21.00
charity care       23.00       Cost of charity care (line 21 minus line 22)       4,849,072       3,743,898       8,592,970       23.00         24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       20,325,779       26.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       20,325,779       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       1,202,500       27.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       1,800,000       27.01         28.00       Non-Medicare bad debt expense (see instructions)       1,850,000       27.01         29.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       5,973,716       29.00         29.00       Cost of uncompensated care (line 23 column 3 plus line 29)       14,566,686       30.00	22.00		off as	0	0 0	22.00
24.00       Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       1.00         25.00       If line 24 is yes, enter the charges for patient days beyond the indigent care program?       0       25.00         26.00       Total bad debt expense for the entire hospital complex (see instructions)       20, 325, 779       26.00         27.00       Medicare reimbursable bad debts for the entire hospital complex (see instructions)       20, 325, 779       26.00         27.01       Medicare allowable bad debts for the entire hospital complex (see instructions)       1, 202, 500       27.00         28.00       Non-Medicare bad debt expense (see instructions)       1, 850, 000       27.00         28.00       Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)       18, 475, 779       28.00         30.00       Cost of uncompensated care (line 23 column 3 plus line 29)       14, 566, 686       30.00						
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)20,325,77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)20,325,77926.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,202,50027.0028.00Non-Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)18,475,77928.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00	23.00	Cost of charity care (line 21 minus line 22)	4, 84	9, 072 3, 743, 89	8 8, 592, 970	23.00
24.00Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limitN24.0025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?025.0026.00Total bad debt expense for the entire hospital complex (see instructions)20,325,77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)20,325,77926.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,202,50027.0028.00Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00						
imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit26.00Total bad debt expense for the entire hospital complex (see instructions)20, 325, 77927.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)20, 325, 77927.01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 202, 50028.00Non-Medicare bad debt expense (see instructions)1, 8475, 77929.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5, 973, 71630.00Cost of uncompensated care (line 23 column 3 plus line 29)14, 566, 686						
25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)20,325,77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1,202,50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,202,50027.0128.00Non-Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00	24.00			gth of stay limit	N	24.00
stay limit26.00Total bad debt expense for the entire hospital complex (see instructions)20, 325, 77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1, 202, 50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 202, 50027.0028.00Non-Medicare bad debt expense (see instructions)18, 475, 77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5, 973, 71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14, 566, 68630.00	25 00			arom's longth of	0	25 00
26.00Total bad debt expense for the entire hospital complex (see instructions)20, 325, 77926.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1, 202, 50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 850, 00027.0128.00Non-Medicare bad debt expense (see instructions)18, 475, 77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5, 973, 71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14, 566, 68630.00	25.00		e murgent care pro	grain's renyth of	0	25.00
27.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)1, 202, 50027.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)1, 850, 00027.0128.00Non-Medicare bad debt expense (see instructions)18, 475, 77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5, 973, 71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14, 566, 68630.00	26 00		tructions)		20 325 779	26 00
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,850,00027.0128.00Non-Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00						
28.00Non-Medicare bad debt expense (see instructions)18,475,77928.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5,973,71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14,566,68630.00						
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)5, 973, 71629.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)14, 566, 68630.00						•
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 14,566,686 30.00	29.00		ense (see instructi	ons)		•
31.00  Total unreimbursed and uncompensated care cost (line 19 plus line 30) 30,434,641 31.00	30.00					
	31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)		30, 434, 641	31.00

	Financial Systems REID SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HOSPITAL & HEAL F EXPENSES	Provider CC	CN: 15-0048 P	eriod:	u of Form CMS-2 Worksheet A	
				T	rom 01/01/2017 o 12/31/2017	Date/Time Prep 5/7/2018 3:57	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE		0 0	0		20, 128, 404 5, 977, 497	1.00 1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUI P		0	0		0, 777, 177	2.00
4.00 5.01		1, 969, 926	27, 199, 364	29, 169, 290		41, 749, 608	4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	249, 140 2, 904, 199	20, 140 19, 244, 173	269, 280 22, 148, 372		269, 280 22, 136, 215	5. 01 5. 02
5.03	00560 PURCHASING RECEIVING AND STORES	873, 664	808, 500	1, 682, 164	0	1, 682, 164	5. 03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 135, 456 3, 036, 771	1, 044, 012 5, 262, 701	3, 179, 468 8, 299, 472		3, 164, 292 8, 143, 775	5.04 5.05
5.06	00590 OTHER A&G	7, 793, 274	20, 758, 250			28, 037, 254	5.06
7.00	00700 OPERATION OF PLANT	2, 437, 646	966, 238			3, 379, 234	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	399, 353 1, 614, 916	445, 408 535, 100	844, 761 2, 150, 016	- 183, 593 0	661, 168 2, 150, 016	
10.00	01000 DI ETARY	2, 507, 352	2, 932, 034	5, 439, 386		1, 062, 668	
11.00		52, 237	373, 611	425, 848		4, 802, 306	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0 582, 019	0	0 3, 888, 285		221, 709 3, 888, 285	13.00 14.00
15.00	01500 PHARMACY	3, 688, 157	27, 566, 158	31, 254, 315	-9, 038	31, 245, 277	15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 086, 678 2, 053, 355	1, 617, 125 522, 062	4, 703, 803 2, 575, 417		4, 694, 918 2, 575, 417	16.00 17.00
17.01	01701 I NSERVI CE EDUCATI ON	716, 787	1, 330, 049			2, 046, 836	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0		1, 566, 807	21.00
22.00 23.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	1, 586, 275 211, 787	482, 175 49, 211	2, 068, 450 260, 998		501, 643 260, 998	22.00 23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	211,707	47,211	200, 770		200, 770	25.00
30.00	03000 ADULTS & PEDIATRICS	16, 652, 002	6, 409, 136			23, 044, 359	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	3, 550, 403 3, 533, 380	2, 347, 527 470, 789	5, 897, 930 4, 004, 169		5, 897, 930 4, 004, 169	
41.00	04100 SUBPROVI DER - I RF	1, 150, 291	31 <mark>6,</mark> 500	1, 466, 791	0	1, 466, 791	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	441, 141	94, 067	535, 208	-2, 385	532, 823	43.00
50.00	05000 OPERATI NG ROOM	1, 291, 114	40, 503, 676	41, 794, 790	-8, 505, 561	33, 289, 229	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	625, 783	259, 174	884, 957		882, 599	
54.00 59.00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	5, 567, 203 1, 556, 196	6, 200, 806 9, 993, 096	11, 768, 009 11, 549, 292		11, 632, 234 6, 049, 167	54.00 59.00
50.00	06000 LABORATORY	3, 321, 498	7, 339, 608	10, 661, 106		10, 624, 185	•
5.00	06500 RESPI RATORY THERAPY	1, 283, 318	484, 936	1 1		1, 767, 838	
56.00 59.00	06900 ELECTROCARDI OLOGY	4, 669, 388 785, 308	1, 387, 756 562, 029			5, 849, 396 1, 347, 133	
70.00	07000 ELECTROENCEPHALOGRAPHY	195, 492	82, 283	277, 775	0	277, 775	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	0	0	0		0 14, 027, 293	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	14, 027, 293	14, 027, 275	
74.00	07400 RENAL DI ALYSI S	0	748, 297	748, 297	0	748, 297	
76.00 76.97	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON	183, 169	0 85, 995	0 269, 164	0 - 37, 939	0 231, 225	
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	4, 847, 619	1, 938, 475	6, 786, 094	-402, 564	6, 383, 530	
91.00 92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	1, 836, 007	431, 092	2, 267, 099	-151, 644	2, 115, 455	92.00 93.00
92.00 93.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED			2, 267, 099	-151, 644		92.00 93.00
92.00 93.00 96.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	1, 836, 007	431, 092	2, 267, 099	- 151, 644 -9, 511	2, 115, 455 419, 714	92.00 93.00 96.00
92.00 93.00 96.00 13.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE	1, 836, 007 36, 661 1, 191, 305	431, 092 392, 564 7, 558, 166 1, 377, 749	2, 267, 099 429, 225 7, 558, 166 2, 569, 054	-151, 644 -9, 511 -7, 558, 166 0	2, 115, 455 419, 714 0 2, 569, 054	96. 00 113. 00 116. 00
92.00 93.00 96.00 113.00 116.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	1, 836, 007	431, 092 392, 564 7, 558, 166	2, 267, 099 429, 225 7, 558, 166 2, 569, 054	-151, 644 -9, 511 -7, 558, 166 0	2, 115, 455 419, 714 0	92.00 93.00 96.00 113.00 116.00
92.00 93.00 96.00 13.00 16.00 18.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE	1, 836, 007 36, 661 1, 191, 305	431, 092 392, 564 7, 558, 166 1, 377, 749	2, 267, 099 429, 225 7, 558, 166 2, 569, 054	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967	92.00 93.00 96.00 113.00 116.00
<ul> <li>22.00</li> <li>23.00</li> <li>26.00</li> <li>13.00</li> <li>16.00</li> <li>18.00</li> <li>90.00</li> <li>92.00</li> </ul>	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 836, 007 36, 661 1, 191, 305	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770	92.00 93.00 96.00 113.00 116.00 118.00 190.00 192.00
<ul> <li>22.00</li> <li>23.00</li> <li>26.00</li> <li>13.00</li> <li>14.00</li> <li>18.00</li> <li>90.00</li> <li>92.00</li> <li>94.00</li> </ul>	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE	1, 836, 007 36, 661 1, 191, 305 90, 616, 270 0 0 0	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931 15, 958, 710	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931 15, 958, 710	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770 4, 048, 386	92. 00 93. 00 96. 00 113. 00 116. 00 118. 00 190. 00 192. 00 194. 00
<ul> <li>22.00</li> <li>23.00</li> <li>26.00</li> <li>13.00</li> <li>14.00</li> <li>18.00</li> <li>90.00</li> <li>92.00</li> <li>94.00</li> <li>94.01</li> <li>94.02</li> </ul>	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 207952 RETAIL SERVICES	1, 836, 007 36, 661 1, 191, 305 90, 616, 270	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324 -760	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770 4, 048, 386 412, 377 132, 688	92.00 93.00 96.00 113.00 116.00 118.00 190.00 192.00 194.00 194.01 194.02
<ul> <li>22.00</li> <li>23.00</li> <li>26.00</li> <li>13.00</li> <li>16.00</li> <li>18.00</li> <li>90.00</li> <li>92.00</li> <li>94.00</li> <li>94.01</li> <li>94.02</li> <li>94.03</li> </ul>	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 207952 RETAIL SERVICES	1, 836, 007 36, 661 1, 191, 305 90, 616, 270 0 0 0 178, 546 110, 223 0	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931 15, 958, 710 234, 591 22, 465 0	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931 15, 958, 710 413, 137 132, 688 0	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324 -760 0 183, 593	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770 4, 048, 386 412, 377 132, 688 183, 593	92. 00 93. 00 96. 00 113. 00 116. 00 118. 00 190. 00 192. 00 194. 01 194. 02 194. 03
2.00 3.00 6.00 13.00 14.00 18.00 90.00 92.00 94.00 94.01 94.02 94.03 94.04	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	1, 836, 007 36, 661 1, 191, 305 90, 616, 270 0 0 0 178, 546	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931 15, 958, 710 234, 591	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931 15, 958, 710 413, 137 132, 688	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324 -760 0 183, 593	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 3, 191, 770 4, 048, 386 412, 377 132, 688 183, 593 97, 203, 142	92.00 93.00 96.00 113.00 116.00 118.00 190.00 192.00 194.00 194.01 194.03 194.03
22.00 23.00 26.00 13.00 16.00 18.00 90.00 92.00 94.00 94.00 94.00 94.03 94.04 94.05 94.06	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07956 VACANT SPACE	1, 836, 007 36, 661 1, 191, 305 90, 616, 270 0 0 0 178, 546 110, 223 0 70, 842, 734 0 0 0	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931 15, 958, 710 234, 591 22, 465 0 38, 771, 757 0 0	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931 15, 958, 710 413, 137 132, 688 0 109, 614, 491 0 0	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324 -760 0 183, 593 -12, 411, 349 0 0	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770 4, 048, 386 412, 377 132, 688 183, 593 97, 203, 142 0 0	92. 00 93. 00 96. 00 113. 00 114. 00 190. 00 194. 00 194. 01 194. 03 194. 04 194. 05 194. 05
<ul> <li>22.00</li> <li>23.00</li> <li>23.00</li> <li>24.00</li> <li>113.00</li> <li>113.00</li> <li>114.00</li> <li>194.00</li> <li>194.01</li> <li>194.02</li> <li>194.03</li> <li>194.04</li> <li>194.05</li> <li>194.06</li> </ul>	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC 07955 VACANT SPACE 07958 CAMBRIDGE RHC	1, 836, 007 36, 661 1, 191, 305 90, 616, 270 0 0 0 178, 546 110, 223 0	431, 092 392, 564 7, 558, 166 1, 377, 749 203, 446, 298 0 8, 491, 931 15, 958, 710 234, 591 22, 465 0	2, 267, 099 429, 225 7, 558, 166 2, 569, 054 294, 062, 568 0 8, 491, 931 15, 958, 710 413, 137 132, 688 0 109, 614, 491 0 0 1, 299, 633	-151, 644 -9, 511 -7, 558, 166 0 29, 443, 399 0 -5, 300, 161 -11, 910, 324 -760 0 183, 593 -12, 411, 349 0 0 -4, 398	2, 115, 455 419, 714 0 2, 569, 054 323, 505, 967 0 3, 191, 770 4, 048, 386 412, 377 132, 688 183, 593 97, 203, 142 0	92. 00 93. 00 96. 00 113. 00 116. 00 118. 00 190. 00 194. 00 194. 00 194. 00 194. 02 194. 04 194. 05 194. 05 194. 05

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF	TRIAL BALANCE OF EXPENSES	Provider CCN: 15-0048	Peri od: Erom 01/01/2017	Worksheet A

LULAS	SIFICATION AND ADJUSTMENTS OF IRTAL BALANCE O	I LAFENJEJ	Provider CC	ля. тэ=0048	From 01/01/2017 To 12/31/2017	
	Cost Center Description	Adjustments	Net Expenses			5/7/2018 3:57 pm
			For Allocation			
	GENERAL SERVICE COST CENTERS	6.00	7.00			
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-7, 290, 598	12, 837, 806			1.
. 01	00101 NEW CAP BLDG & FIXT - OFFSITE	0				1.
. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0			2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-11, 885, 582	29, 864, 026			4.
. 01	00540 NONPATI ENT TELEPHONES	0	269, 280			5.
. 02	00550 DATA PROCESSI NG	-460, 676	21, 675, 539			5.
. 03	00560 PURCHASING RECEIVING AND STORES	-418, 699				5.
. 04	00570 ADMI TTI NG	-95				5.
. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-2, 243				5.
. 06	00590 OTHER A&G	-13, 027, 592				5.
. 00		-3, 269				7.
. 00 . 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	661, 168 2, 150, 016			8.
0.00	01000 DI ETARY	-615, 240				9.
1.00	01100 CAFETERI A	-3, 023, 274				11.
3.00	01300 NURSI NG ADMI NI STRATI ON	0,020,271				13.
4.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 888, 285			14.
	01500 PHARMACY	-214, 261				15.
6. 00	01600 MEDICAL RECORDS & LIBRARY	-33,638				16.
7.00	01700 SOCIAL SERVICE	0	2, 575, 417			17.
7.01	01701 I NSERVI CE EDUCATI ON	-1, 159, 527	887, 309			17.
1. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	1, 566, 807			21.
2.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	-290, 731				22.
3.00	02300 PARAMED ED PRGM	-44, 861	216, 137			23.
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
	03000 ADULTS & PEDIATRICS	-3, 413, 660				30.
1.00	03100 I NTENSI VE CARE UNI T	-726				31.
0.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	-2, 320 -118, 733				40. 41.
3.00	04300 NURSERY	-436				41.
5.00	ANCI LLARY SERVI CE COST CENTERS	+30	332, 307			
0. 00	05000 OPERATI NG ROOM	-10, 192, 362	23, 096, 867			50.
2.00	05200 DELIVERY ROOM & LABOR ROOM	-372				52.
4.00	05400 RADI OLOGY-DI AGNOSTI C	-183, 419				54.
9.00	05900 CARDI AC CATHETERI ZATI ON	0	6, 049, 167			59.
0. 00	06000 LABORATORY	-858, 311	9, 765, 874			60.
5.00	06500 RESPI RATORY THERAPY	0	1, 767, 838			65.
6. 00	06600 PHYSI CAL THERAPY	-66, 647				66.
9.00	06900 ELECTROCARDI OLOGY	-75, 803				69.
0.00	07000 ELECTROENCEPHALOGRAPHY	-1, 463				70.
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0				71.
2.00 3.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	14, 027, 293			72. 73.
4.00	07400 RENAL DI ALYSI S		748, 297			73.
	03950 ANCI LLARY - OTHER	0				74.
	07697 CARDI AC REHABI LI TATI ON	0				76.
0	OUTPATI ENT SERVICE COST CENTERS	, j	2011/220			, 01
1.00	09100 EMERGENCY	-795, 334	5, 588, 196			91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.
3.00	04040 FAMILY PRACTICE	-100	2, 115, 355			93.
	OTHER REIMBURSABLE COST CENTERS					
6. 00	09600 DURABLE MEDICAL EQUIP-RENTED	-97, 255	322, 459			96.
	SPECIAL PURPOSE COST CENTERS	1				
	11300 INTEREST EXPENSE	0				113.
	11600 HOSPI CE	-200				116.
18.00		-54, 277, 427	269, 228, 540			118.
00.00	NONREI MBURSABLE COST CENTERS					100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0 3, 191, 770			190. 192.
	19200 PHYSI CI ANS' PRI VATE OFFI CES 07950 RENTAL SPACE		3, 191, 770 4, 048, 386			192. 194.
	07950 RENTAL SPACE 07951 FOUNDATION					194.
	07951 FOUNDATION 07952 RETAIL SERVICES		412, 377 132, 688			194. 194.
	07952 RELATE SERVICES		132, 688			194.
	07954 REID PHYSICIAN ASSOC.		97, 203, 142			194.
/ T. U4	07955 OTHER NRCC		97,203,142			194.
94 ∩⊑		0	1 0			
	07956 VACANT SPACE	0	0			194
94.06	07956 VACANT SPACE 07958 CAMBRI DGE RHC	0	0 1, 295, 235			194. 194.

	Financial Systems REID HOSPIT/ NTERS USED IN COST REPORT	AL & HEALTH CARE SER	CCN: 15-0048	In Lieu of Form CM Period: Worksheet M From 01/01/2017	
				To 12/31/2017 Date/Time F 5/7/2018 3:	
	Cost Center Description		CMS Code	Standard Label For	<u>57 piii</u>
				Non-Standard Codes	
			1.00	2.00	
	ENERAL SERVICE COST CENTERS			2.00	
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE		00100 00101		1.
	NEW CAP REL COSTS-MVBLE EQUIP		00200		2.
1	EMPLOYEE BENEFITS DEPARTMENT		00400		4.
1	NONPATIENT TELEPHONES		00540 00550	NONPATI ENT TELEPHONES DATA PROCESSI NG	5.
1	DATA PROCESSING PURCHASING RECEIVING AND STORES		00560	PURCHASING RECEIVING AND	5.
~			00570	STORES	
	ADMI TTI NG CASHI ERI NG/ACCOUNTS RECEI VABLE		00570 00580	ADMI TTI NG CASHI ERI NG/ACCOUNTS	5.
				RECEI VABLE	
	DTHER A&G DPERATION OF PLANT		00590 00700		5.
	AUNDRY & LINEN SERVICE		00800		8.
00	HOUSEKEEPI NG		00900		9.
	DI ETARY		01000		10
	CAFETERIA NURSING ADMINISTRATION		01100 01300		11
	CENTRAL SERVICES & SUPPLY		01400		14
. 00 F	PHARMACY		01500		15
	MEDICAL RECORDS & LIBRARY		01600		16
	SOCI AL SERVI CE NSERVI CE EDUCATI ON		01700		17    17
	&R SERVICES-SALARY & FRINGES APPRVD		02100		21
	&R SERVICES-OTHER PRGM. COSTS APPRVD		02200		22
	PARAMED ED PRGM		02300		23
	NPATI ENT ROUTI NE SERVI CE COST CENTERS		03000		30
	NTENSI VE CARE UNI T		03100		31
	SUBPROVIDER - IPF		04000		40
	SUBPROVIDER - IRF		04100 04300		41
	NCI LLARY SERVICE COST CENTERS		05000		
	DPERATING ROOM DELIVERY ROOM & LABOR ROOM		05200		50
	RADI OLOGY-DI AGNOSTI C		05400		54
	CARDI AC CATHETERI ZATI ON		05900		59
	LABORATORY RESPI RATORY THERAPY		06000 06500		60
	PHYSICAL THERAPY		06600		66
	ELECTROCARDI OLOGY		06900		69
	ELECTROENCEPHALOGRAPHY		07000		70
	MEDICAL SUPPLIES CHARGED TO PATIENTS		07100 07200		71
	DRUGS CHARGED TO PATIENTS		07300		73
	RENAL DI ALYSI S		07400		74
	ANCI LLARY - OTHER		03950		76
	CARDIAC REHABILITATION UTPATIENT SERVICE COST CENTERS		07697	CARDIAC REHABILITATION	76
	EMERGENCY		09100		91
	DBSERVATION BEDS (NON-DISTINCT PART)		09200		92
	FAMILY PRACTICE THER REIMBURSABLE COST CENTERS		04040	FAMILY PRACTICE	93
	DURABLE MEDICAL EQUIP-RENTED		09600		96
	PECIAL PURPOSE COST CENTERS				
	NTEREST EXPENSE IOSPI CE		11300 11600		113
	SUBTOTALS (SUM OF LINES 1 through 117)		11000		118
	IONREI MBURSABLE COST CENTERS				
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		19000		190
	PHYSICIANS' PRIVATE OFFICES		19200		192
	RENTAL SPACE FOUNDATI ON		07950 07951		194
	RETAIL SERVICES		07952		194
4.03 F	REID CONTRACTED SERVICES		07953		194
	REID PHYSICIAN ASSOC.		07954		194
	DTHER NRCC /ACANT SPACE		07955 07956		194
	CAMBRI DGE RHC		07958		194
	FOTAL (SUM OF LINES 118 through 199)		1		200

### Health Financial Systems RECLASSIFICATIONS

#### REID HOSPITAL & HEALTH CARE SERVICES

Provider CCN: 15-0048

					Тс	0 12/31/2017	Date/Time Prepare 5/7/2018 3:57 pm
	Cost Conton	Increases	Salary	Other			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
A - CA	PITAL EXPENSE RECLASS	0.00		0100			
	P REL COSTS-BLDG &	1.00	0	12, 516, 012			1.
FIXT DO NEW CA	P BLDG & FIXT -	1.01	0	5, 450, 251			2
OFFSIT		1.01	0	5, 450, 251			2
	P REL COSTS-BLDG &	1.00	o	11, 437			3.
FLXT							
DO NEW CA OFFSLT	P BLDG & FIXT -	1.01	0	238, 573			4
	P REL COSTS-BLDG &	1.00	o	42, 789			5
FLXT			5	12, 707			
	P BLDG & FIXT -	1.01	0	288, 673			6
0FFSI T	E	0.00	0	0			-
00		0.00	0	0 0			7.
		0.00	0	0			9
00		0.00	0	0			10
00		0.00	0	0			11.
00		0.00	0	0			12
00		0.00	0	0			13
00		0.00	0	0			14
00		0.00	0	0			15
00		0.00	0	0			16
00		0.00	0	0			17
00		0.00	0	0			18
00		0.00	0	0			19
00		0.00	0	0			20
00		0.00	0	0			21
00		0.00	0	0			22
00		0.00	0	0			23
00		0.00	0				24
B CA	FETERIA RECLASS		0	18, 547, 735			
DO CAFETE		11.00	2,017,343	2, 359, 115			1
			2,017,343	2, 359, 115			
C – LA	UNDRY RECLASS						
	ONTRACTED SERVICES	194.03	82, 095	101, 498			1
0			82, 095	101, 498			
D – NU	RSING VP RECLASS						
DO <u>NUR</u> SIN	G_ADMINISTRATION	13.00	<u>221, 7</u> 09				1
0			221, 709	0			
	CUPATIONAL MEDICINE REC						
DO OTHER		5.06	<u>170, 479</u>	232,085			1
TOTALS	1	22	170, 479	232, 085			
	PLANTABLE DEVICES RECLA DEV. CHARGED TO	72.00	0	14, 027, 293			1
PATIEN		12.00	U	14, 027, 293			1
00		0.00	0	0			2
00		0.00	o	0			3
00		0.00	o	0			4
00		0.00	0	0			5
0			0	14, 027, 293			
	TEREST RECLASS						
	P REL COSTS-BLDG &	1.00	0	7, 558, 166			1
FIXT_		+	+				
0	TEDN AND DECLOSIVE		0	7, 558, 166			
	TERN AND RESIDENT		1 501 //-	45 446			
	RVICES-SALARY &	21.00	1, 521, 667	45, 140			1
	<u>s apprvd</u>	+	1, 521, 667	45, 140			
K - 100	RKERS COMP RECLASS		1, 321, 007	45, 140			
	EE BENEFITS DEPARTMENT	4.00	0	934, 006			1
	EL DENELTIS DEL'ARTMENT	0.00	0	934,000			2
~ <u> </u>			— — — <del>o</del>	934,006			
L - RH	PA BENEFITS RECLASS						
	EE BENEFITS DEPARTMENT	4.00	0	11, 653, 725			1
			— — — <del>-</del>	11, 653, 725			
TOTALS							

# REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Provider CCN: 15-0048 Period: Error 01(01/2017)

-0048	Peri		worksneet
	From	01/01/2017	
	To	12/31/2017	Date/Time
			F /7 /0010 0

31/2017	Date/Time Prepared:
	F /7 /2010 2 F7

					10	5/7/2018 3	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
4 00	A - CAPITAL EXPENSE RECLASS	1.00		7 440			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 413			1.00
2.00	DATA PROCESSING	5.02	0	12, 157			2.00
3.00		5.04	0	15, 176			3.00
4.00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	0	155, 697	13		4.00
5.00	OTHER A&G	5.06	0	64, 794	10		5.00
6.00	OPERATION OF PLANT	7.00	0	24, 650			6.00
7.00	DI ETARY	10.00	0	260			7.00
8.00	PHARMACY	15.00	0	9, 038			8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8, 885			9.00
10.00	ADULTS & PEDIATRICS	30.00	0	16, 779	0		10.00
11.00	OPERATING ROOM	50.00	0	3, 119	0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	115, 792	0		12.00
13.00	LABORATORY	60.00	0	36, 921	0		13.00
14.00	RESPI RATORY THERAPY	65.00	0	416	0		14.00
15.00	PHYSI CAL THERAPY	66.00	0	207, 748			15.00
16.00	ELECTROCARDI OLOGY	69.00	0	204			16.00
17.00	CARDIAC REHABILITATION	76.97	0	37, 939			17.00
18.00	FAMILY PRACTICE	93.00	0	151, 644			18.00
19.00	DURABLE MEDI CAL EQUI P-RENTED	96.00	0	9, 511			19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5, 300, 161			20.00
21.00 22.00	RENTAL SPACE FOUNDATI ON	194.00 194.01	0	11, 910, 324 760			21.00 22.00
22.00	REID PHYSICIAN ASSOC.	194.01	0	453, 949			22.00
24.00	CAMBRI DGE RHC	194.04		4, 398			24.00
24.00				18, 547, 735			24.00
	B - CAFETERIA RECLASS	I		10,017,700			
1.00	DI ETARY	10.00	2,017,343	2, 359, 115	0		1.00
	0		2,017,343	2, 359, 115			
	C - LAUNDRY RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	82, 095	101, <mark>4</mark> 98	0		1.00
	0		82, 095	101, 498			
	D - NURSING VP RECLASS						
1.00	OTHER A&G	5.06	221, 709	0			1.00
			221, 709	0			
1 00	E - OCCUPATIONAL MEDICINE REC		470.470	000 005			
1.00	EMERGENCY	91.00	170, 479	232, 085			1.00
	F - IMPLANTABLE DEVICES RECLA	22	170, 479	232, 085			
1.00	NURSERY	43.00	o	2, 385	0		1.00
2.00	OPERATING ROOM	50.00	0	8, 502, 442			2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2, 358			3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 983			4.00
5.00	CARDI AC CATHETERI ZATI ON	59.00	0	5, 500, 125			5.00
				14,027,293			
	G - INTEREST RECLASS			· · ·	· · · · ·		
1.00	INTEREST EXPENSE	113.00	0	7, 558, 166	11		1.00
	0		0	7, 558, 166			
	J - INTERN AND RESIDENT	•			1		
1.00	I&R SERVICES-OTHER PRGM.	22.00	1, 521, 667	45, 140	0		1.00
	COSTS APPRVD		+				
			1, 521, 667	45, 140			
4 66	K - WORKERS COMP RECLASS	= c.1	-1	/ 22 23			
1.00	OTHER A&G	5.06	0	630, 331			1.00
2.00	REID_PHYSICIAN_ASSOC.	<u> </u>	Ŷ_				2.00
			0	934, 006			
1 00	L - RHPA BENEFITS RECLASS REID PHYSICIAN ASSOC.	104 04		11 652 725	0		1.00
1.00	TOTALS	<u> </u>	— — — <del>/</del>	<u>11, 653, 7</u> 25 11, 653, 725			1.00
500 00	Grand Total: Decreases		4, 013, 293	55, 458, 763			500.00
000.00		I I	., 510, 270	33, 100, 700	1		1 330. 00

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

Provi der CCN: 15-0048 Peri od: From 01/01/ To 12/31/

1/2017	Non-CMS Worksheet
1/2017	Date/Time Prepared:
	5/7/2018 3:57 pm

								5/7/2018 3:57	pm
	Cont Conton	Increase		Others	Coot Conton	Decre		Others	
	Cost Center 2.00	Line # 3.00	Salary 4.00	0ther 5.00	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	
	A - CAPITAL EXPENSE RE		4.00	5.00	0.00	7.00	8.00	9.00	
1.00	NEW CAP REL	1.00	0	12, 516, 012	EMPLOYEE BENEFITS	4.00	0	7, 413	1.00
2.00	COSTS-BLDG & FIXT NEW CAP BLDG & FIXT -	1.01	О	5, 450, 251	DEPARTMENT DATA PROCESSING	5.02	0	12, 157	2.00
3.00	OFFSITE NEW CAP REL	1.00	О	11, 437	ADMI TTI NG	5.04	0	15, 176	3.00
4.00	COSTS-BLDG & FIXT NEW CAP BLDG & FIXT -	1.01	О	238, 573	CASHI ERI NG/ACCOUNTS	5.05	0	155, 697	4.00
5.00	OFFSITE NEW CAP REL COSTS-BLDG & FIXT	1.00	О	42, 789	RECEI VABLE OTHER A&G	5.06	0	64, 794	5.00
6.00	NEW CAP BLDG & FIXT - OFFSITE	1.01	О	288, 673	OPERATION OF PLANT	7.00	0	24, 650	6.00
7.00		0.00	o	0	DI ETARY	10.00	0	260	7.00
8.00		0.00	0	0	PHARMACY	15.00	0	9, 038	8.00
9.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	8, 885	9.00
10.00		0.00	О	0	ADULTS & PEDIATRICS	30.00	0	16, 779	10.00
11.00		0.00	0		OPERATING ROOM	50.00	0	3, 119	11.00
12.00		0.00	0		RADI OLOGY-DI AGNOSTI C	54.00		115, 792	12.00
13.00		0.00	0		LABORATORY	60.00	0	36, 921	13.00
14.00		0.00	0		RESPI RATORY THERAPY	65.00		416	14.00
15.00		0.00	0	· · · · · · · · · · · · · · · · · · ·	PHYSI CAL THERAPY	66.00	0	207, 748	15.00
16.00		0.00	0		ELECTROCARDI OLOGY	69.00	0	204	16.00
17.00		0.00	0	0	CARDIAC	76.97	0	37, 939	17.00
18.00		0.00	0		REHABILITATION FAMILY PRACTICE	93.00		151, 644	18.00
19.00		0.00	0	U	DURABLE MEDICAL EQUIP-RENTED	96.00	0	9, 511	19.00
20.00		0.00	o	0	PHYSI CLANS' PRI VATE	192.00	0	5, 300, 161	20.00
21.00		0.00	0	0	RENTAL SPACE	194.00	0	11, 910, 324	21.00
22.00		0.00	0		FOUNDATION	194.01	0	760	22.00
23.00		0.00	0		REID PHYSICIAN ASSOC.	194.04	0	453, 949	23.00
24.00		0.00			CAMBRIDGE_RHC	<u>194</u> . <u>08</u>	0	4, 398	24.00
	0		0	18, 547, 735	0		0	18, 547, 735	
1.00	B - CAFETERI A RECLASS	11.00	2,017,343 2,017,343	<u>2, 359, 1</u> 15 2, 359, 115		10.00	<u>2,017,343</u> 2,017,343	<u>2, 359, 1</u> 15 2, 359, 115	1.00
	C - LAUNDRY RECLASS		270117010	2,007,110		1	2/01//010	2,007,110	
1.00	REID CONTRACTED SERVICES	194. 03	82, 095	101, 498	LAUNDRY & LINEN SERVICE	8.00	82, 095	101, 498	1.00
	0		82, 095	101, 498			82, 095	101, 498	
	D - NURSING VP RECLASS								
1.00	NURSI NG	13.00	221, 709	0	OTHER A&G	5.06	221, 709	0	1.00
	ADMI NI STRATI ON		221, 709	— — ō	0		221, 709	ō	
1.00	E - OCCUPATIONAL MEDIC OTHER A&G	5. 06	170, 479	222 095	EMERGENCY	91.00	170, 479	232, 085	1.00
1.00	TOTALS	5.00	170, 479	232, 085		91.00	170, 479	232,085	1.00
	F - IMPLANTABLE DEVICE	S RECLASS	170, 47 9	232,003	TOTALS	I	170,479	232,003	
1.00	I MPL. DEV. CHARGED TO	72.00	0	14, 027, 293	NURSERY	43.00	0	2, 385	1.00
2.00		0.00	о	0	OPERATING ROOM	50.00	0	8, 502, 442	2.00
3.00		0.00	0		DELIVERY ROOM & LABOR ROOM	52.00		2, 358	3.00
4.00		0.00	0	0	RADI OLOGY-DI AGNOSTI C	54.00	О	19, 983	4.00
5.00		0.00	ō		CARDIAC	59.00		5, 500, 125	5.00
					CATHETERI ZATI ON				
	0		0	14, 027, 293	0		0	14, 027, 293	
	G - INTEREST RECLASS	1 1				1			
1.00	NEW CAP REL	1.00	0	7, 558, 166	INTEREST EXPENSE	113.00	0	7, 558, 166	1.00
	COSTS-BLDG & FLXT		0	7, 558, 166	0			7, 558, 166	
4 95	J - INTERN AND RESIDEN	1 1	4 504	.= .			4 501 11		
1.00	I &R SERVICES-SALARY &	21.00	1, 521, 667	45, 140	I &R SERVI CES-OTHER	22.00	1, 521, 667	45, 140	1.00
	FRINGES APPRVD	$\vdash$ $+$	1, 521, 667	45, 140	PRGM. COSTS APPRVD	$\vdash$ $-$	1, 521, 667	45, 140	
	K - WORKERS COMP RECLA	SS	1, 521, 007	45, 140			1, 321, 007	45, 140	
1.00	EMPLOYEE BENEFITS	4.00	0	934, 006	OTHER A&G	5.06	0	630, 331	1.00
2.00		0.00	0	0	REID PHYSICIAN ASSOC.	194.04	0	303, 675	2.00
	0		ŏ	934,006			— — — <sub>0</sub>	934,006	
		. 1	1	.,			1		

Health Financial Systems REID HOSPITAL & H				ALTH CARE SERVICES		In Lie	u of Form CMS-	2552-10	
RECLASSI FI CATI ONS					Provider CCN: 15-0		Peri od:	Worksheet A-6	
				rom 01/01/2017					
						!	o 12/31/2017	Date/Time Pre 5/7/2018 3:57	epared: 7 pm
		ases			Decre	eases	57772018 3. 5.		
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	L - RHPA BENEFITS RECL	ASS							
1.00	EMPLOYEE BENEFITS	4.00	0	11, 653, 725	REID PHYSICIAN ASSOC.	194.04	0	11, 653, 725	1.00
	DEPARTMENT				L				
	TOTALS		0	11, 653, 725	TOTALS		0	11, 653, 725	
500.00	Grand Total:		4, 013, 293	55, 458, 763	Grand Total:		4, 013, 293	55, 458, 763	500.00
	Increases				Decreases				

#### REID HOSPITAL & HEALTH CARE SERVICES

Provi der CCN: 15-0048

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2017 Part I

					То	12/31/2017	Date/Time Prep 5/7/2018 3:57	
				Acqui si ti ons	S			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	13, 579, 037	898, 057		0	898, 057	0	1.00
2.00	Land Improvements	35, 550, 113	2, 674, 502		0	2, 674, 502	0	2.00
3.00	Buildings and Fixtures	280, 957, 511	11, 571, 594		0	11, 571, 594	0	3.00
4.00	Building Improvements	12, 344, 443	139, 657		0	139, 657	0	4.00
5.00	Fixed Equipment	2, 090, 615	13, 210		0	13, 210	0	5.00
6.00	Movable Equipment	171, 369, 690	2, 328, 107		0	2, 328, 107	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	515, 891, 409	17, 625, 127		0	17, 625, 127	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	515, 891, 409	17, 625, 127		0	17, 625, 127	0	10.00
		Endi ng Bal ance	Fully					
			Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	14, 477, 094	0					1.00
2.00	Land Improvements	38, 224, 615	0					2.00
3.00	Buildings and Fixtures	292, 529, 105	0					3.00
4.00	Building Improvements	12, 484, 100	0					4.00
5.00	Fixed Equipment	2, 103, 825	0					5.00
6.00	Movable Equipment	173, 697, 797	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	533 <mark>, 5</mark> 16, 536	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	533, 516, 536	0					10.00



Heal t	h Financial Systems REI	D HOSPI TAL & HEA	LTH CARE SERVI	I CES	In Lie	eu of Form CMS-:	2552-10
	ICILIATION OF CAPITAL COSTS CENTERS		Provider C	CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017		pared:
			S	SUMMARY OF CAP	ITAL		
	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 WO	RKSHEET A, COLUM	N 2, LINES 1 a	and 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	
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
	Cost Center Description	Capital-Relate d Costs (see instructions) 14.00	Total (1) (sur of cols. 9 through 14) 15.00	_			
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00 1.01 2.00 3.00	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0 0 0 0		0 0 0 0			1.00 1.01 2.00 3.00

Heal th	Fi nanci al	Systems		
RECONCI	LI LATION O	E CAPITAL	27200	ſ

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2017 Fo 12/31/2017		pared:
		COMP	UTATION 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)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS OF						
1.00	NEW CAP REL COSTS-BLDG & FIXT	359, 818, 739	0	359, 818, 739	0. 674428	0	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	173, 697, 797	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000	0	2.00
3.00	Total (sum of lines 1-2)	533, 516, 536	0	533, 516, 536			3.00
		ALLOCAT	ION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(	12, 516, 012	42, 789	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	(	5, 450, 251	288, 673	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	(	17, 966, 263	331, 462	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	I nterest 🗸 🗸	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate d Costs (see i nstructi ons)	of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	267, 568	0	11, 43	7 0	12, 837, 806	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE	0	0	238, 573	3 0	5, 977, 497	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(		Ű	2.00
3.00	Total (sum of lines 1-2)	267, 568	0	250, 010	0 0	18, 815, 303	3.00
			N				

### RELD HOSPITAL & HEALTH CARE SERVICES

S TO EXPENSES				Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Prep	
				10 12/31/2017		vared
			Expense Classification of To/From Which the Amount is		5/7/2018 3:57	
Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
stment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.
COSTS-BLDG & FIXT (chapter			FIXT	1.00	0	1.
estment income - NEW CAP 6 & FIXT - OFFSITE (chapter			NEW CAP BLDG & FIXT - OFFSITE	1.01	0	1.
estment income - NEW CAP COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
estment income - other apter 2)		0		0.00	0	3.
le, quantity, and time counts (chapter 8)		0		0.00	0	4
inds and rebates of enses (chapter 8)		0		0.00	0	5
al of provider space by diers (chapter 8)		0		0.00	0	6.
ephone services (pay ions excluded) (chapter		0		0.00	0	7.
evision and radio service apter 21)		0		0.00	0	8
ing lot (chapter 21) ider-based physician	A-8-2	0 -8, 94 <mark>3, 5</mark> 28		0.00	0	
ustment e of scrap, waste, etc.		0		0.00	0	11
upter 23) Ited organization Isactions (chapter 10)	A-8-1	-6, 753, 620	Ch		0	12
idry and linen service		0		0.00	0	13
eteria-employees and guests al of quarters to employee		-3, 023, 274 0	CAFETERI A	11.00 0.00	0 0	
others e of medical and surgical blies to other than		0		0.00	0	16
ents e of drugs to other than		0		0.00	0	17
ents e of medical records and	В	-33, 638	MEDICAL RECORDS & LIBRARY	16.00	0	18
racts sing and allied health ation (tuition, fees,	В	-44, 750	PARAMED ED PRGM	23.00	0	19
s, etc.) ling machines	в	-31, 221	ΠΙ ΕΤΔΡΥ	10.00	0	20
rest, finance or penalty ges (chapter 21)		0		0.00	0	
erest expense on Medicare payments and borrowings to	,	0		0.00	0	22
ny Medicare overpayments nstment for respiratory rapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
tation (chapter 14) Istment for physical Papy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24
tation (chapter 14) ization review - sicians' compensation		0	*** Cost Center Deleted ***	114.00		25
pter 21) reciation - NEW CAP REL				1.00	0	26
S-BLDG & FIXT reciation - NEW CAP BLDG &		0	NEW CAP BLDG & FIXT -	1.01	0	26
eciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2.00	0	27
physician Anesthetist				19.00		28
icians' assistant istment for occupational rapy costs in excess of	A-8-3	0		0.00		
ta i z i c i c i c i c i c i c i c i c i c i c	ation (chapter 14) zation review - cians' compensation ter 21) ciation - NEW CAP REL -BLDG & FIXT ciation - NEW CAP BLDG & - OFFSITE ciation - NEW CAP REL -MVBLE EQUIP hysician Anesthetist cians' assistant tment for occupational	ation (chapter 14) zation review - cians' compensation ter 21) ciation - NEW CAP REL -BLDG & FIXT ciation - NEW CAP BLDG & - OFFSITE ciation - NEW CAP REL -MVBLE EQUIP hysician Anesthetist cians' assistant tment for occupational A-8-3 by costs in excess of	ation (chapter 14) zation review - 0 cians' compensation ter 21) ciation - NEW CAP REL 0 BLDG & FIXT ciation - NEW CAP BLDG & 0 - OFFSITE ciation - NEW CAP REL 0 - MVBLE EQUIP hysician Anesthetist 0 cians' assistant 0 tment for occupational A-8-3 0 by costs in excess of	ation (chapter 14) zation review - cians' compensation ter 21)0ciation - NEW CAP REL - BLDG & FIXT ciation - NEW CAP BLDG & - OFFSITE ciation - NEW CAP REL0NEW CAP BLDG & FIXT ciation - NEW CAP REL - OFFSITE ciation - NEW CAP REL - OFFSITE0NEW CAP BLDG & FIXT OFFSITE ciation - NEW CAP REL - OFFSITE ciation - NEW CAP REL - OFFSITE O NEW CAP REL COSTS-MVBLE EQUIP O *** Cost Center Deleted *** O two costs in excess of	ation (chapter 14) zation review - cians' compensation ter 21) ciation - NEW CAP REL0*** Cost Center Deleted ***114.00BLDG & FIXT ciation - NEW CAP BLDG & FIXT0NEW CAP REL COSTS-BLDG & FIXT1.00Correlation - NEW CAP BLDG & FIXT0NEW CAP BLDG & FIXT - OFFSITE1.01Correlation - NEW CAP REL - OFFSITE0NEW CAP BLDG & FIXT - OFFSITE1.01Correlation - NEW CAP REL - OFFSITE0NEW CAP REL COSTS-MVBLE EQUIP2.00MVBLE EQUI P hysician Anesthetist cians' assistant ometh for occupational oy costs in excess ofA-8-30*** Cost Center Deleted ***0*** Cost Center Deleted ***67.00	ation (chapter 14) zation review - cians' compensation ter 21)0*** Cost Center Deleted ***114.000*** Cost Center Deleted ***114.000*** Cost Center Deleted ***114.000NEW CAP REL00NEW CAP REL COSTS-BLDG & FIXT1.000ONEW CAP REL COSTS-BLDG & FIXT1.000ONEW CAP BLDG & FIXT1.010ONEW CAP BLDG & FIXT - OFFSITE1.010ONEW CAP REL00NEW CAP REL0NEW CAP REL COSTS-MVBLE0EQUIP P Our P0*** Cost Center Deleted ***0*** Cost Center Deleted ***0

### RELD HOSPITAL & HEALTH CARE SERVICES

Heal th	Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVICES	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Prep	pared:
						5/7/2018 3:57	pm
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
30, 99	Hospice (non-distinct) (see	1.00	2.00	3.00 ADULTS & PEDIATRICS	4.00	5.00	30.99
30. 77	instructions)		0		30.00		30.77
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
	pathology costs in excess of						
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
52.00	Depreciation and Interest		0		0.00	Ĭ	52.00
33.00	MI SCELLANEOUS I NCOME	В	-581, 349	DI ETARY	10.00	0	33.00
	MI SCELLANEOUS I NCOME	В		EMPLOYEE BENEFITS DEPARTMENT			
	MI SCELLANEOUS I NCOME	В			5.02		
33.03	MI SCELLANEOUS I NCOME	В	-239	CASHI ERI NG/ACCOUNTS RECEI VABLE	5.05	0	33.03
33.04	MI SCELLANEOUS I NCOME	В	-850, 689	OTHER A&G	5.06	0	33.04
33.05	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00	0	33.05
33.06	MI SCELLANEOUS I NCOME	В	-418, 699	PURCHASING RECEIVING AND	5.03	0	33.06
33.07		В	214 241	STORES PHARMACY	15.00	0	33.07
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		INSERVICE EDUCATION	17.01		33.07
	MI SCELLANEOUS I NCOME	B		ADULTS & PEDIATRICS	30.00		33.09
	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66.00	0	33.10
	MI SCELLANEOUS I NCOME	В		OPERATI NG ROOM	50.00		33. 11
	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00		
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B		LABORATORY EMERGENCY	60.00 91.00		
	MI SCELLANEOUS I NCOME	B		DURABLE MEDICAL EQUI P-RENTEL			
33.16		В		NEW CAP REL COSTS-BLDG &	1.00		33.16
				FIXT			
33. 17	UNNECESSARY BORROWING	A	-4, 266, 585	NEW CAP REL COSTS-BLDG &	1.00	11	33.17
33. 18	SELF INSURANCE ADJUSTMENT	A	-11, 292, 854	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 18
	PATIENT ENTERTAINMENT SYSTEM	A		OTHER A&G	5.06		33.19
	COUNTRY CLUB DUES	A		OTHER A&G	5.06		
	AHA/IHA LOBBYING	A		OTHER A&G	5.06		33.21
	MARKETI NG/ADVERTI SI NG	AA		EMPLOYEE BENEFITS DEPARTMENT CASHIERING/ACCOUNTS	4.00 5.05		33.22 33.23
55.25	MARKETT NOT ADVERTISTING		-1, 752	RECEIVABLE	5.05	Ĭ	55.25
33.24	MARKETI NG/ADVERTI SI NG	A	-2, 035 <mark>, 5</mark> 04	OTHER A&G	5.06	0	33.24
	MARKETI NG/ADVERTI SI NG	A		DI ETARY	10.00		33.25
	MARKETI NG/ADVERTI SI NG	A		I NSERVI CE EDUCATI ON	17.01		
33.27	MARKETI NG/ADVERTI SI NG	A	-1, 532	▶&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	0	33.27
33. 28	MARKETI NG/ADVERTI SI NG	A	-13, 567	ADULTS & PEDIATRICS	30.00	0	33. 28
33.29	MARKETI NG/ADVERTI SI NG	A		SUBPROVIDER - IPF	40.00	0	33. 29
33.30	MARKETI NG/ADVERTI SI NG	A		SUBPROVIDER - IRF	41.00		
33. 31 33. 32	MARKETI NG/ADVERTI SI NG	A A		OPERATING ROOM	50.00 54.00		33.31 33.32
	MARKETI NG/ADVERTI SI NG MARKETI NG/ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C PHYSI CAL THERAPY	66.00		33.32
	MARKETI NG/ADVERTI SI NG	A		ELECTROENCEPHALOGRAPHY	70.00	-	33.34
33.35	MARKETING/ADVERTISING	A		EMERGENCY	91.00	0	33.35
	MARKETI NG/ADVERTI SI NG	А		DURABLE MEDICAL EQUIP-RENTED			33.36
	MARKETI NG/ADVERTI SI NG	A		HOSPICE	116.00		
33. 38 33. 39	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING	4.00 5.02		33.38 33.39
33.40	NON-ALLOWABLE EXPENSES	A		ADMI TTI NG	5.02		33.40
33.41	NON-ALLOWABLE EXPENSES	А		CASHI ERI NG/ACCOUNTS	5.05		33. 41
00.10			4 000 000			_	
33. 42 33. 43	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A	-1, 039, 001	OTHER A&G INSERVICE EDUCATION	5.06 17.01		
33.44	NON-ALLOWABLE EXPENSES	A		I&R SERVICES-OTHER PRGM.	22.00		
			.,	COSTS APPRVD		Ĭ	
33.45	NON-ALLOWABLE EXPENSES	Α		PARAMED ED PRGM	23.00		
	NON-ALLOWABLE EXPENSES	A		ADULTS & PEDIATRICS	30.00		33.46
	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		I NTENSI VE CARE UNI T SUBPROVI DER – I RF	31.00 41.00		33. 47 33. 48
33.48 33.49	NON-ALLOWABLE EXPENSES	A		NURSERY	41.00		1
33.50	NON-ALLOWABLE EXPENSES	A		OPERATI NG ROOM	50.00		33.50
33.51	NON-ALLOWABLE EXPENSES	A	-372	DELIVERY ROOM & LABOR ROOM	52.00	0	33. 51
33.52	NON-ALLOWABLE EXPENSES	A		PHYSI CAL THERAPY	66.00		33. 52
00 50	NON ALLOWADLE EVERICES						
33. 53 33. 54	NON-ALLOWABLE EXPENSES NON-ALLOWABLE EXPENSES	A A		EMERGENCY FAMILY PRACTICE	91.00 93.00		

#### REID HOSPITAL & HEALTH CARE SERVICES

In Lieu	l of	Form	CMS-2552-10					
Workshoot A_8								

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet A-8	
					To 12/31/2017		
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.55	NON-ALLOWABLE EXPENSES	А	-50	HOSPICE	116.00	0	33.55
33.56	HAF EXPENSE	А	-9, 340, 057	OTHER A&G	5.06	0	33.56
33.57	BOND REFUNDING - 2015 BONDS	А	401, 531	OTHER A&G	5.06	0	33.57
33.58	BOND REFUNDING - 2016 BONDS	А	7, 737	OTHER A&G	5.06	0	33.58
33.59	OCC MED - EMPLOYEE COST	А	-358, 151	EMERGENCY	91.00	0	33.59
50.00	TOTAL (sum of lines 1 thru 49)		-54, 277, 427				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	REID HOSPITAL & HE	ALTH CARE SERVICES	In Lie	eu of Form CMS-	2552-10
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 01/01/2017		
				To 12/31/2017		
					5/7/2018 3:57	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	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	18, 689, 372	25, 442, 992	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		0	18 689 372	25 442 992	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

1100								
				Related Organization(s) and/	or Home Office			
						1		
						1		
	Symbol (1)	Name	Percentage of	Name	Percentage of			
	- · · ·		Ownershi p		Ownershi p	1		
	1.00	2.00	3.00	4.00	5.00			
	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	A	REID 0/P SURGER	55.00	0.00 6.0	0
7.00			0.00	0.00 7.0	0
8.00			0.00	0.00 8.0	0
9.00			0.00	0.00 9.0	0
10.00			0.00	0.00 10.00	0
100.00	G. Other (financial or			100. 0	0
	non-financial) specify:				

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

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

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

 C. Provider has financial interest in corporation, partnership, or other organization.
 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

Health Financial Systems	RELD HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared:

						5/7/2018 3:57	/pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A	A RESULT OF TRAI	SACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:					
1.00	-6, 753, 620	0					1.00
2.00	0	0					2.00
3.00	0	0					3.00
4.00	0	0					4.00
4.01	0	0					4.01
4.02	0	0					4.02
5.00	-6, 753, 620						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

Tids not been posted to worksheet i	a, corumnis i and/or z, the amount arrowable shourd be murcated in corumn 4 of this part.	
Rel ated Organization(s)		
and/or Home Office		
Type of Business		
( 00		
6. 00		
B. INTERRELATIONSHIP TO RE	ATED 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

1 of model				
6.00				6.00
7.00				7.00
8.00				8.00
9.00				9.00
10.00				10.00
100.00				100.00

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

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

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

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

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

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

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

 Provider CCN: 15-0048
 Period:

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

PROVIDE	ER BASED PHISIC	TAN ADJUSTMENT		Provider	CCN: 15-0048	From 01/01/2017	7 WORKSheet A-8	5-2
						To 12/31/2017		epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER A&G	21, 525	21, 52	5	0 179,000	0 0	1.00
2.00	17.01	INSERVICE EDUCATION	294, 394	294, 39	4	0 179,000	0	2.00
3.00	22.00	I &R SERVICES-OTHER PRGM.	287, 444	287, 44	4	0 197, 500	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	3, 399, 260	3, 399, 26	0	0 179,000	0	4.00
5.00		SUBPROVIDER - IRF	116, 938	116, 93	8	0 179,000	0	5.00
6.00	50.00	OPERATING ROOM	3, 427, 227	3, 427, 22	7	0 246, 400	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	38, 240	38, 24	0	0 260, 300	0	7.00
8.00	60.00	LABORATORY	848, 386	848, 38	6	0 260, 300	0	8.00
9.00	69.00	ELECTROCARDI OLOGY	75, 803		3	0 179,000	0	9.00
10.00	91.00	EMERGENCY	434, 311	434, 31		0 179,000		10.00
200.00			8, 943, 528	8, 943, 52	8	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physi ci an Cost	
		I denti fi er	Limit	Unadjusted RC	E Memberships &		of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	OTHER A&G	0		0	0 0	0 0	1.00
2.00	17.01	I NSERVI CE EDUCATI ON	0		0	0 0	0	2.00
3.00	22.00	I &R SERVICES-OTHER PRGM. COSTS APPRVD	0		0	0 0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0		0	o  0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0		0	o  0	0	5.00
6.00	50.00	OPERATING ROOM	0		0	o  0	0	6.00
7.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	o  0	0	7.00
8.00	60.00	LABORATORY	0		0	ol o	0	8.00
9.00	69.00	ELECTROCARDI OLOGY	0		0	o  0	0	9.00
10.00	91.00	EMERGENCY	0		0	o  0	0	10.00
200.00			0		0	0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE		Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	1 <u>6. 0</u> 0	17.00	18.00	-	
1.00		OTHER A&G	0			0 21, 525		1.00
2.00		INSERVICE EDUCATION	0			0 294, 394		2.00
3.00		I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0		•	0 287, 444		3.00
4.00		ADULTS & PEDIATRICS	0			0 3, 399, 260		4.00
5.00		SUBPROVI DER – I RF	0			0 116, 938		5.00
6.00		OPERATING ROOM	0			0 3, 427, 227		6.00
7.00		RADI OLOGY-DI AGNOSTI C	0		-	0 38, 240		7.00
8.00		LABORATORY	0		-	0 848, 386		8.00
9.00		ELECTROCARDI OLOGY	0			0 75, 803		9.00
10.00	91.00	EMERGENCY	0			0 434, 311		10.00
200.00			0		0	0 8, 943, 528	,	200.00

	Financial Systems REID LLOCATION - GENERAL SERVICE COSTS	HOSPI TAL & HEAI	Provider C	Fr Tc		u of Form CMS-: Worksheet B Part I Date/Time Pre 5/7/2018 3:57	
			CAP	ITAL RELATED CO	STS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW CAP BLDG & FLXT - OFFSLTE	NEW MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	
		<u>col.7)</u> 0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE	12, 837, 806	12, 837, 806				1.00 1.01
2.00	00200 NEW CAP BEDG & FIXT - OFFSITE	5, 977, 497 0	C	5, 977, 497	0		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	29, 864, 026	46, 558		0	29, 919, 264	4.00
5.01	00540 NONPATI ENT TELEPHONES	269, 280	66, 252		0	46, 364	
5.02 5.03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	21, 675, 539 1, 263, 465	218, 365 272, 999		0	540, 460 162, 585	
5.04	00570 ADMI TTI NG	3, 164, 197	2, 512		0	397, 400	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	8, 141, 532	14, 217		0	565, 131	5.05
5.06 7.00	00590 OTHER A&G 00700 OPERATION OF PLANT	15, 009, 662 3, 375, 965	437, 636 3, 177, 747		0	1, 440, 763 453, 636	
8.00	00800 LAUNDRY & LINEN SERVICE	661, 168	215, 172		0	59, 040	1
9.00	00900 HOUSEKEEPI NG	2, 150, 016	118, 201		0	300, 529	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	447, 428 1, 779, 032	219, 237 172, 225		0	91, 189 385, 141	
	01300 NURSI NG ADMI NI STRATI ON	221, 709	34, 103		0	41, 259	
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 888, 285	146, 722	0	0	108, 311	14.00
		31, 031, 016	126, 836		0	686, 351	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 661, 280 2, 575, 417	61, 176 21, 648		0	574, 418 382, 121	1
	01701 I NSERVI CE EDUCATI ON	887, 309	181, 575		0	133, 391	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 566, 807	C		0	283, 176	
	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	210, 912 216, 137	0 18, 508	-	0	12, 023 39, 413	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	210, 137	18, 500	56, 157	0	37,413	23.00
30.00	03000 ADULTS & PEDI ATRI CS	19, 630, 699	1, 90 <mark>5,</mark> 692		0	3, 098, 871	30.00
	03100 I NTENSI VE CARE UNI T	5, 897, 204	428, 286		0	660, 716	1
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	4, 001, 849	389, 700 312, 214		0	657, 548 214, 065	
	04300 NURSERY	532, 387	46, 767		0	82, 095	
50.00	ANCI LLARY SERVICE COST CENTERS	23, 096, 867	845, 443	284, 080	0	240 271	50.00
	05200 DELIVERY ROOM & LABOR ROOM	882, 227	145, 065		0	240, 271 116, 456	
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 448, 815	1, 060, 249		0	1, 036, 034	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	6,049,167	236, 873		0	289, 602	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	9, 765, <mark>8</mark> 74 1, 767, <mark>83</mark> 8	243, 257 28, 730		0	618, 117 238, 820	
66.00	06600 PHYSI CAL THERAPY	5, 782, 749	141, 018		0	868, 954	
	06900 ELECTROCARDI OLOGY	1, 271, 330	122, 300		0	146, 143	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	276, 312	0	84, 458 0	0	36, 380 0	
	07200 I MPL. DEV. CHARGED TO PATIENT	14, 027, 293	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DI ALYSI S 03950 ANCI LLARY - 0THER	748, 297	25, 992	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	231, 225	78, 899		0	34, 087	1
	OUTPATIENT SERVICE COST CENTERS			-	-		
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 588, 196	397, 236	0	0	870, 397	91.00 92.00
	04040 FAMILY PRACTICE	2, 115, 355	155, 863	18, 380	0	341, 674	1
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	322, 459	30, 946	62, 323	0	6, 822	96.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	2, 568, 854	7, 763		о	221, 697	
118.00		269, 228, 540	12, 153, 982	2, 081, 781	0	16, 481, 450	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 191, 770	4, 344	u u u u u u u u u u u u u u u u u u u	0	0	192.00
	07950 RENTAL SPACE	4,048,386	0	412, 958	0		194.00
	07951 FOUNDATI ON 07952 RETAI L SERVI CES	412, 377 132, 688	3, 593 40, 819		0		194. 01 194. 02
	07953 REI D CONTRACTED SERVICES	183, 593	40, 819		0	15, 278	
194.03				2 054 010	0		
194.04	07954 RELD PHYSICIAN ASSOC.	97, 203, 142	601, 628		0	13, 183, 600	
194.04 194.05	07955 OTHER NRCC	97, 203, 142 0	9, 280	0	0	0	194.05
194.04 194.05 194.06		1		0	0 0 0	0	194. 05 194. 06

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eri od:	Worksheet B	
				rom 01/01/2017 o 12/31/2017		pared: _pm
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE		EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
201.00 Negative Cost Centers		0	C	0	0	201.00
202.00   TOTAL (sum lines 118 through 201)	375, 695, 731	12, 837, 806	5, 977, 497	0	29, 919, 264	202.00

Heal th	Fi nanci al	Systems	
COST A		CENEDAL	CED/

DST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0048 Pe Fr To	riod: om 01/01/2017 12/31/2017	Worksheet B Part I Date/Time Prepa 5/7/2018 3:57 p	ared
	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	pin
		5.01	5.02	5.03	5.04	5.05	
00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1			1. C
01 00 01 02 03 04 05 06 00 00	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	381, 896 40, 207 5, 339 15, 016 23, 524 19, 687 9, 677 1, 001	22, 498, 333 2, 345, 424 344, 915 275, 932 0 19, 709	4, 049, 812 6, 594 9, 198 22, 948 29, 953 851	3, 971, 517 0 0 0 0 0	9, 078, 498 0 0 0	1. 0 2. 0 4. 0 5. 0 5. 0 5. 0 5. 0 5. 0 7. 0 8. 0
00	00900 HOUSEKEEPING	1,001	29, 564		0	0	9.0
4.00 5.00 5.00 7.00 7.01 1.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 I NSERVI CE EDUCATI ON 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	14, 682 0 3, 003 1, 668 7, 174 11, 345 5, 673 7, 675 0 0	335, 061 (1 137, 966 118, 257 394, 189 827, 797 275, 932 1, 458, 499 0	0 3,993 461,584 321,195 6,147 1,571 6,271 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	10. 0 11. 0 13. 0 14. 0 15. 0 16. 0 17. 0 21. 0 22. 0
3.00	02300 PARAMED ED PRGM	501	98, 547	987	0	0	23.0
1.00	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	38, 039 8, 676 3, 670 5, 339 0	2, 345, 424 344, 915 147, 821 275, 932	138, 424 37, 757 19, 434	227, 443 41, 009 53, 627 16, 770 10, 698	93, 747 122, 592 38, 337	30. 0 31. 0 40. 0 41. 0 43. 0
0. 00	ANCI LLARY SERVI CE COST CENTERS	31, 533	857, 361	586, 651	807, 925	1, 846, 443	50. C
2.00	05200 DELIVERY ROOM & LABOR ROOM	7, 174	315, 351		37, 247		52.0
	05400 RADI OLOGY-DI AGNOSTI C	25, 526	1, 497, 918		621, 912		54.0
9.00	05900 CARDI AC CATHETERI ZATI ON	4, 838	98, 547		422, 071		59. (
0.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	10, 678	571, 574		396, 867		60. 65.
5.00 5.00	06600 PHYSI CAL THERAPY	1, 001 15, 016	118, 257		90, 301 81, 338		66.
	06900 ELECTROCARDI OLOGY	1, 502	482, 881		121, 113		69.
0. 00	07000 ELECTROENCEPHALOGRAPHY	1, 168	78, 838		12, 057		70.
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	C	0	701		71.
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS			0	133, 174 522, 376		
	07400 RENAL DIALYSIS	834	19, 709		4, 276		
	03950 ANCI LLARY - OTHER	0	C	0 0	0		76.
5. 97	07697 CARDI AC REHABI LI TATI ON	2,002	19, 709	3, 915	6, 081	13, 900	76.
I. 00	OUTPATIENT SERVICE COST CENTERS	13, 681	739, 104	146, 137	295, 668	675, 905	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	13,001	757, 10-	140,107	275,000		92.
8.00	04040 FAMILY PRACTICE	9, 510	384, 334	40, 851	36, 888	84, 328	93.
	OTHER REIMBURSABLE COST CENTERS	4 4 7 4	440.055	45.004	0 500	5 700	~ (
. 00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	4, 171	118, 257	15, 334	2, 529	5, 782	96.
3.00	11300 I NTEREST EXPENSE					1	113.
	11600 HOSPI CE	2, 169	29, 564		29, 446		
8.00		353, 700	16, 280, 000	3, 534, 317	3, 971, 517	9, 078, 498 1	118.
0 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o			0	01	190.
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 845	9, 855	0 0 2, 970	0		190. 192.
	07950 RENTAL SPACE	16, 183	,, 000		0		194.
	07951 FOUNDATI ON	1, 168	59, 128		0		194.
	07952 RETAIL SERVICES	0	354, 770		0		194.
	07953 REI D CONTRACTED SERVI CES	0	0	0	0		194.
	07954 REID PHYSICIAN ASSOC.	0	5, 794, 580	464, 674	0		194. 104
	07955 OTHER NRCC 07956 VACANT SPACE	0	0		0		194. 194.
	07958 CAMBRIDGE RHC		r c	9, 552	0		194. 194.
4.08 0.00			Ĺ	7,002	0		200.
)1. 00		о	C	0	0		201.
			22, 498, 333	4, 049, 812	3, 971, 517		

		HOSPI TAL & HEAI				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2017	Worksheet B Part I	
				T	0 12/31/2017	Date/Time Pre 5/7/2018 3:57	epared: 'pm
	Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		5A. 05	5.06	PLANT 7.00	LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00	00101 NEW CAP BLDG & FLXT - OFFSLTE 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSING						5.02
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5.03 5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00590 OTHER A&G	17, 359, 724	17, 359, 724				5.06
7.00	00700 OPERATION OF PLANT	7, 137, 208	345, 762				7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	956, 941	46, 359			2 070 072	8.00 9.00
	01000 DI ETARY	2, 663, 638 1, 158, 822	129, 040 56, 139			2, 870, 873 60, 184	1
	01100 CAFETERI A	2, 336, 398	113, 187			0	
	01300 NURSING ADMINISTRATION	442, 033	21, 414			149, 113	
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 724, 827	228, 894			5, 839	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	32, 566, 761 6, 269, 826	1, 577, 697 303, 742			0 9, 881	
	01700 SOCI AL SERVI CE	3, 262, 362	158, 045			16, 169	
	01701 I NSERVI CE EDUCATI ON	2, 674, 720	129, 577			35, 033	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 849, 983	89, 622			0	
	02200 I & R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	223, 707 432, 250	10, 837 20, 940			0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	432, 230	20, 940	55, 820	<u> </u>	0	23.00
	03000 ADULTS & PEDI ATRI CS	28, 041, 281	1, 358, 460			768, 469	30.00
	03100 I NTENSI VE CARE UNI T	7, 612, 977	368, 811			207, 051	
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	5, 414, 564 2, 230, 149	262, 309 108, 040			161, 240 94, 094	
	04300 NURSERY	718, 547	34, 810			3, 144	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	28, 596, 574	1, 385, 361			249, 495	
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C	1, 631, 496 17, 559, 942	79, 038 850, 691			43, 342 152, 931	
	05900 CARDI AC CATHETERI ZATI ON	8, 533, 049	413, 384			35, 931	
60.00	06000 LABORATORY	12, 561, 461	608, 540		0	130, 698	60.00
65.00	06500 RESPI RATORY THERAPY	2, 576, 044	124, 796			26, 050	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	9, 037, 371 2, 468, 718	437, 815 119, 597			20, 885 42, 892	
	07000 ELECTROENCEPHALOGRAPHY	521, 647	25, 271			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 303	112			24, 253	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	14, 464, 907	700, 752		0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 716, 541 815, 490	83, 158 39, 506		0	34, 134 37, 727	73.00 74.00
	03950 ANCI LLARY - OTHER	013,470	0			0	
76.97	07697 CARDI AC REHABI LI TATI ON	389, 818	18, 885	0	0	13, 025	76.97
01 00		0 726 224	400 747	274 271	144 050	220.054	01 00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	8, 726, 324	422, 747	274, 371	146, 059	230, 856	91.00 92.00
	04040 FAMILY PRACTICE	3, 187, 183	154, 403	4, 880	33, 901	38, 401	
	OTHER REIMBURSABLE COST CENTERS	I					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	568, 623	27, 547	45, 206	0	0	96.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	3, 014, 953	146, 059	0	0	27, 622	116.00
118.00		244, 449, 162	11, 001, 347	5, 316, 994	1, 151, 919	2, 618, 459	118.00
100.00	NONREI MBURSABLE COST CENTERS	0	0			0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 3, 273, 080	0 158, 564				190. 00 192. 00
	07950 RENTAL SPACE	4, 514, 460	218, 703				194.00
	07951 FOUNDATI ON	509, 715	24, 693				194.01
	07952 RETAIL SERVICES	549, 933	26, 642				194.02
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	198, 871 120, 304, 534	9, 634 5, 828, 290		-	0 250, 168	194.03 194.04
	07955 OTHER NRCC	9, 280	5, 828, 290				194.04
194.06	07956 VACANT SPACE	396, 712	19, 219	285, 166	0	0	194.06
	07958 CAMBRIDGE RHC	1, 489, 984	72, 182	0	0	0	194.08
200.00 201.00		0	0	_	_	^	200.00 201.00
201.00		375, 695, 731	0 17, 359, 724		1, 151, 919		
00		,,,	,,,	, .,,		_, 0, 0, 0, 0	

	Financial Systems         REID           LLOCATION - GENERAL SERVICE COSTS	HOSPI TAL & HEAL	Provi der C	CN: 15-0048 Pe Fr	riod: om 01/01/2017	u of Form CMS-2 Worksheet B Part I	
				То	12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: 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	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE						1.00 1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02 5.03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5.02 5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06 7.00	00590 OTHER A&G 00700 OPERATI ON OF PLANT						5.06
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 408, 101	0 E40 E41				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	2, 568, 541 3, 250	639, 365			13.00
	01400 CENTRAL SERVICES & SUPPLY	0	26, 090		5, 086, 991		14.00
15.00	01500 PHARMACY	0	82, 545	0	6, 707	34, 318, 532	
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	113, 062	0	0	0	
	01701 I NSERVI CE EDUCATI ON	0	17, 606	0	0	0	•
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	15, 741	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	1, 886	0	0	0	22.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	3, 831	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	906, 112	424, 923	274, 900	3, 312	3, 833	30.00
31.00	03100 I NTENSI VE CARE UNI T	131, 638	78, 660		4, 933	849	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	278, 821 91, 530	97, 603 28, 073		0	617 352	
43.00	04300 NURSERY	0	8, 532		0	0	
	ANCI LLARY SERVI CE COST CENTERS						
50.00 52.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM	0	28, 136 11, 972		723, 451 7, 074	123, 554 791	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	127, 018	82, 173	18, 024	571, 347	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	О	33, 588	21, 730	978, 397	373	•
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	100, 855	0 20, 590	323, 620	362	•
66.00	06600 PHYSI CAL THERAPY	0	31, 827	20, 590	1, 882 259	33, 011 433	1
	06900 ELECTROCARDI OLOGY	Ō	18, 192	0	0	207, 071	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	5, 448		0	0	•
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0 2, 753, 769	0	
	07300 DRUGS CHARGED TO PATIENTS	Ŏ	0	0	2, 100, 107	30, 202, 417	
	07400 RENAL DI ALYSI S	0	0	0	0	1, 160	
	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON	0	0 5, 503	0 3, 560	0	0	•
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	5, 505	3, 300	<u> </u>	0	/0. //
	09100 EMERGENCY	0	112, 453	72, 751	5, 890	20, 819	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	0	40 204	0	0	E 4 0	92.00
93.00	OTHER REIMBURSABLE COST CENTERS	0	49, 306	0	0	548	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 089	0	13, 688	112	96.00
	SPECIAL PURPOSE COST CENTERS			1 1			
	11300 I NTEREST EXPENSE 11600 HOSPI CE	0	29, 310	0	172	169, 425	113.00
118.00		1, 408, 101	1, 562, 533		4, 841, 178	31, 337, 074	•
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 RENTAL SPACE	0	0	0	0		192.00 194.00
	07951 FOUNDATI ON	0	5, 942	o	o		194.00
194.02	07952 RETAIL SERVICES	0	4, 858	0	0	0	194. 02
	07953 REID CONTRACTED SERVICES	0	4, 214		0		194.03
	07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	0	973, 612 0	0	245, 673 0	2, 902, 233 0	194.04
194 05	07956 VACANT SPACE	0	0	0	0		194.06
	UT950 VACANT SPACE	01	0			0	
194.06 194.08	07958 CAMBRI DGE RHC	Ő	17, 382	0	140		194. 08
194.06	07958 CAMBRIDGE RHC Cross Foot Adjustments	0	17, 382	0	140	79, 225	194. 08 200. 00 201. 00

57	TI ON - GENERAL SERVI CE COSTS		Provi der CCI		eriod: rom 01/01/2017 o 12/31/2017 INTERNS &	Worksheet B Part I Date/Time Pre 5/7/2018 3:57 RESIDENTS	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVI CES-SALAR Y & FRI NGES	SERVI CES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
	AL SERVICE COST CENTERS	1					1 1
01         00101           00         00200           00         00400           01         00540           02         00550           03         00560           04         00570           05         00580           06         00590           00         00700           00         00700           00         01000           00         01100           00         01300           00         01400           00         01500           00         01700           00         01700           00         01701           00         01701	<ul> <li>NEW CAP REL COSTS-BLDG &amp; FIXT</li> <li>NEW CAP BLDG &amp; FIXT - OFFSITE</li> <li>NEW CAP REL COSTS-MVBLE EQUIP</li> <li>EMPLOYEE BENEFITS DEPARTMENT</li> <li>NONPATIENT TELEPHONES</li> <li>DATA PROCESSING</li> <li>PURCHASING RECEIVING AND STORES</li> <li>ADMITTING</li> <li>CASHIERING/ACCOUNTS RECEIVABLE</li> <li>OTHER A&amp;G</li> <li>OPERATION OF PLANT</li> <li>LAUNDRY &amp; LINEN SERVICE</li> <li>HOUSEKEEPING</li> <li>DIETARY</li> <li>CAFETERIA</li> <li>NURSING ADMINISTRATION</li> <li>CENTRAL SERVICES &amp; SUPPLY</li> <li>PHARMACY</li> <li>MEDICAL RECORDS &amp; LIBRARY</li> <li>SOCIAL SERVICE</li> <li>IAR SERVICES-SALARY &amp; FRINGES APPRVD</li> </ul>	6, 710, 511 0 0 0	3, 441, 853 0 0	2, 969, 253 0			1.           1.           2.           4.           5.           5.           5.           5.           5.           5.           5.           10.           11.           13.           14.           15.           17.           21.
. 00 02300 I NPAT	I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM IENT ROUTINE SERVICE COST CENTERS	000	0	0 19, 487		236, 430	23.
	ADULTS & PEDIATRICS	384, 300		667, 691		174, 197	
	UINTENSIVE CARE UNIT	69, 290 90, 611		167, 147 141, 914	101, 099 0	12, 224 0	
	SUBPROVIDER - IRF	28, 336		41, 093	-	0	
	NURSERY	18, 076		8, 804	0	0	
	LARY SERVICE COST CENTERS				4 ( 0, 000		
	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	1, 365, 133 62, 934		43, 321 14, 528	160, 839 0	19, 448 0	
	RADI OLOGY-DI AGNOSTI C	1, 050, 817		178, 092	0	0	
	CARDI AC CATHETERI ZATI ON	713, 154		43, 584	0	0	
	LABORATORY	670, 569		121, 947	0	0	
	RESPI RATORY THERAPY	152, 577		59, 531	25, 275	3, 056	
		137, 433		132, 389		0	
	ELECTROCARDI OLOGY	204, 640 20, 373		27, 548 4, 894		8, 335 0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 184		4, 894 0		0	
	IMPL. DEV. CHARGED TO PATIENT	225, 018		0	-	0	
. 00 07300	DRUGS CHARGED TO PATIENTS	882, 635	0	0	0	0	73
	RENAL DIALYSIS	7, 225	0	4, 020		0	1
	ANCILLARY - OTHER	0	0	0	-	0	
	CARDIAC REHABILITATION	10, 274	<u> </u>	6, 729	0	0	76
	EMERGENCY	499, 577	1, 262, 280	159, 042	158, 542	19, 170	91
	OBSERVATION BEDS (NON-DISTINCT PART)						92
	FAMILY PRACTICE	62, 329	0	34, 146	0	0	93
	REIMBURSABLE COST CENTERS	1 070		44 750			1
	DURABLE MEDICAL EQUIP-RENTED	4, 273	0	11, 753	0	0	96
	INTEREST EXPENSE						113
6.0011600		49, 753	0	28, 051			116
B. 00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 710, 511		1, 915, 711	1, 955, 346	236, 430	118
	I MBURSABLE COST CENTERS	1					
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-	0			190
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192
	RENTAL SPACE			0 786	0		194 194
	RETAIL SERVICES		0	1, 595			194
	REID CONTRACTED SERVICES	0	0	1, 393			194
	REID PHYSICIAN ASSOC.	0	0	782, 363	-		194
	OTUED NDCC	0	0	235, 744	0	0	194
4. 05 07955		-					
4. 05 07955 4. 06 07956	VACANT SPACE	0	0	0	0		194.
4.0507955 4.0607956 4.0807958	VACANT SPACE CAMBRI DGE RHC	0	0	0 33, 054	0 0	0	194.
4. 05 07955 4. 06 07956	VACANT SPACE	000	0	0 33, 054 0	0	0 0	

	ncial Systems REID TION - GENERAL SERVICE COSTS	HOSPITAL & HEAL			eriod:	u of Form CMS-2552 Worksheet B
					om 01/01/2017	Part I Date/Time Prepare
	Cost Contor Description	PARAMED ED	Subtotal	Intern &	Total	5/7/2018 3:57 pm
	Cost Center Description	PARAMED ED	Subtotal	Residents Cost	TOTAL	
				& Post		
				Stepdown Adjustments		
		23.00	24.00	25.00	26.00	
	AL SERVICE COST CENTERS				1	
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE					1
	NEW CAP BLOG & FIXT - OFFSITE					2
	EMPLOYEE BENEFITS DEPARTMENT					4
	NONPATIENT TELEPHONES					5
	DATA PROCESSING					5
	PURCHASING RECEIVING AND STORES					5
	CASHI ERI NG/ACCOUNTS RECEI VABLE					5
	OTHER A&G					5
. 00 00700	OPERATION OF PLANT					7
	LAUNDRY & LINEN SERVICE					8
	HOUSEKEEPING					9
	DI ETARY CAFETERI A					10
	NURSING ADMINISTRATION					13
	CENTRAL SERVICES & SUPPLY					14
	PHARMACY					15
	MEDICAL RECORDS & LIBRARY					16
	SOCIAL SERVICE					17
	I &R SERVICE EDUCATION					21
	I &R SERVICES-OTHER PRGM. COSTS APPRVD					22
	PARAMED ED PRGM	510, 328				23
	I ENT ROUTI NE SERVI CE COST CENTERS					
1	ADULTS & PEDIATRICS	0	38, 155, 936		36, 541, 079	30
	SUBPROVIDER - IPF	0	9, 281, 589 6, 847, 448		9, 168, 266 6, 847, 448	31
	SUBPROVIDER - IRF	0	2, 889, 907		2, 889, 907	41
	NURSERY	0	829, 73	5 0	829, 735	43
	LARY SERVICE COST CENTERS		00 00 5 7	100.007	00.00(.070	
	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	33, 386, 566 2, 039, 144		33, 206, 279 2, 039, 144	50 52
	RADI OLOGY-DI AGNOSTI C	510, 328	21, 748, 708		21, 748, 708	54
	CARDI AC CATHETERI ZATI ON	0	10, 898, 156		10, 898, 156	59
	LABORATORY	0	14, 681, 600		14, 681, 600	60
		0	3, 069, 025		3, 040, 694	65
	PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	10, 463, 284 3, 172, 635		10, 463, 284 3, 095, 369	66
		0	646, 170		646, 170	70
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27, 852		27, 852	71
	IMPL. DEV. CHARGED TO PATIENT	0	18, 144, 446		18, 144, 446	72
	DRUGS CHARGED TO PATIENTS	0	32, 918, 885		32, 918, 885	73
	RENAL DI ALYSI S	0	923, 080		923, 080	74
	CARDIAC REHABILITATION	0	447, 794	-	447, 794	76
	TIENT SERVICE COST CENTERS	<u> </u>	,		,.,.,	
	EMERGENCY	0	12, 110, 881	-177, 712	11, 933, 169	91
	OBSERVATION BEDS (NON-DISTINCT PART)		0 5/5 005	0	0 5 ( 5 0 0 7	92
	PFAMILY PRACTICE REIMBURSABLE COST CENTERS	0	3, 565, 097	7 0	3, 565, 097	93
	DURABLE MEDICAL EQUIP-RENTED	0	672, 291	0	672, 291	96
	AL PURPOSE COST CENTERS	1 °L				
	INTEREST EXPENSE					113
116.00 11600		0 F10 220	3, 465, 345		3, 465, 345	116
18.00	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	510, 328	230, 385, 574	-2, 191, 776	228, 193, 798	118
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		ſ		n	190
	PHYSICIANS' PRIVATE OFFICES	0	3, 461, 235	5 0	3, 461, 235	190
94.0007950	RENTAL SPACE	0	5, 003, 292		5, 003, 292	194
	FOUNDATION	0	543, 618		543, 618	194
	RETAIL SERVICES	0	593, 515		593, 515	194
	REID CONTRACTED SERVICES	0	212, 719 132, 850, 830		212, 719 132, 850, 830	194 194
	OTHER NRCC		251, 884		251, 884	194
	VACANT SPACE	0	701, 097		701, 097	194
					1, 691, 967	194
	CAMBRIDGE RHC	0	1, 691, 967	· [ U	1,091,907	194
194.0807958 200.00	Cross Foot Adjustments	0	1, 691, 967 (		1, 091, 907	200
94. 08 07958		0 0 0 510, 328	1, 691, 967 ( ( 375, 695, 731	0 0	0 0 373, 503, 955	

Health Financial Systems

	D 1 1 00N 4E 0040		_
REID HOSPITAL & HEALTH	CARE SERVICES	In	

near th	RED HOSFITAL & HEALT	I CARL SERVI	UL3	TH LIEU UL I	01111 CM3-2552-10
COST AI	LLOCATION STATISTICS	Provider C	CN: 15-0048	Period: Works From 01/01/2017	sheet Non-CMS W
					Time Prepared:
					2018 3:57 pm
	Cost Center Description	·	Stati sti cs	Statistics Descri	ption
			Code		
			1.00	2.00	
	GENERAL SERVICE COST CENTERS				
	NEW CAP REL COSTS-BLDG & FIXT		1	SQUARE FEET	1.00
1.01	NEW CAP BLDG & FIXT - OFFSITE		3	SQUARE FEET	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT		S	GROSS SALARIES	4.00
5.01	NONPATI ENT TELEPHONES		5	PHONES	5. 01
5.02	DATA PROCESSING		6	TERMI NALS	5. 02
5.03	PURCHASING RECEIVING AND STORES		7	SUPPLY EXPENSE	5.03
5.04	ADMI TTI NG		С	TOTAL REVENUE	5. 04
5.05	CASHI ERI NG/ACCOUNTS RECEI VABLE		С	TOTAL REVENUE	5.05
5.06	OTHER A&G		-8	ACCUM. COST	5.06
7.00	OPERATION OF PLANT		20	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE		10	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING		11	HOURS OF SERVICE	9.00
10.00	DI ETARY		12	MEALS SERVED	10.00
11.00	CAFETERIA		13	MANHOURS	11.00
13.00	NURSI NG ADMI NI STRATI ON		14	DIRECT NURSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY		15	MED SUPPLIES	14.00
15.00	PHARMACY		16	DRUGS	15.00
16.00	MEDICAL RECORDS & LIBRARY		С	TOTAL REVENUE	16.00
17.00	SOCIAL SERVICE		17	TIME SPENT	17.00
17.01	I NSERVI CE EDUCATI ON		18	IN HOUSE ED	17.01
21.00	I &R SERVI CES-SALARY & FRI NGES APPRVD		21	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD		21	ASSIGNED TIME	22.00
23 00	PARAMED ED PRGM		19	TIME SPENT	23.00

Heal th	n Financial Systems REID	HOSPI TAL & HEAI	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0048 Pe	eriod: com 01/01/2017	Worksheet B Part II Date/Time Pre 5/7/2018 3:57	pared:
			CAP	ITAL RELATED CO	STS		
	Cost Center Description	Directly Assigned New Capital Related Costs		NEW CAP BLDG & FLXT - OFFSLTE	NEW MVBLE EQUI P	Subtotal	
		0	1.00	1.01	2.00	2A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			1			1.00
1.00	00100 NEW CAP REL COSTS-BEDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 793	46, 558		0	67, 031	
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	488 3, 916, 334	66, 252 218, 365		0	66, 740 4, 158, 461	
5.02	00560 PURCHASING RECEIVING AND STORES	15, 835	272, 999		0	288, 834	
5.04	00570 ADMI TTI NG	24, 679	2, 512		0	68, 074	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	85, 236	14, 217		0	276, 528	
5.06 7.00	00590 OTHER A&G 00700 OPERATI ON OF PLANT	81, 618 132, 079	437, 636 3, 177, 747		0	672, 350 3, 400, 056	
8.00	00800 LAUNDRY & LINEN SERVICE	99, 883	215, 172		0	3, 400, 050	
9.00	00900 HOUSEKEEPI NG	19, 471	118, 201	1	0	137, 672	
10.00	01000 DI ETARY	204, 941	219, 237		0	424, 178	
11.00 13.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON	0 41, 936	172, 225 34, 103		0	172, 225 76, 039	
14.00		758, 252	146, 722		0	904, 974	
15.00		330, 600	126, 836		0	457, 436	
16.00		49,097	61, 176		0	237, 936	
17.00 17.01	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	3, 564	21, 648 181, 575		0	25, 212 247, 996	
21.00		66, 421	161, 575		0	247, 998	1
22.00		Ő	0	Ő	0	0	1
23.00		3, 167	18, 508	58, 157	0	79, 832	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	420, 200	1 005 (02		0	2 225 001	1 20 00
30.00 31.00		430, 299 420, 681	1, 905, 692 428, 286		0	2, 335, 991 848, 967	
40.00		41, 163	389, 700		0	430, 863	
41.00		44, 885	312, 214		0	357, 099	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 591	46, 767	0	0	55, 358	43.00
50.00		946, 953	845, 443	284, 080	0	2, 076, 476	50.00
52.00		50, 979	145, 065		0	196, 044	
54.00		1, 239, 155	1, 060, 249		0	2, 334, 125	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	280, 796 436, 276	236, 873 243, 257	1	0	517, 669 679, 533	
65.00		43, 603	243, 237 28, 730		0	72, 333	
66.00	06600 PHYSI CAL THERAPY	87, 088	141, 018		0	1, 146, 379	
69.00		127, 771	122, 300	0	0	250, 071	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	23, 585 0	0	84, 458 0	0	108, 043 0	
72.00		0	0	0	0	0	
73.00		0	0	0	0	0	
74.00		3, 540	25, 992		0	29, 532	
76.00 76.97		19, 656	78, 899	0	0	0 98, 555	
	OUTPATIENT SERVICE COST CENTERS			-	-		
91.00		193, 612	397, 236	0	0		
92.00 93.00		26, 728	155, 863	18, 380	0	0 200, 971	
93.00	OTHER REIMBURSABLE COST CENTERS	20,720	155, 605	10, 300	0	200, 971	93.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	3, 203	30, 946	62, 323	0	96, 472	96.00
	SPECIAL PURPOSE COST CENTERS						
	0 11300  NTEREST_EXPENSE 0 11600 HOSPI CE	7,430	7, 763	0	0		113.00 116.00
118.00		10, 281, 388	12, 153, 982		0		
	NONREI MBURSABLE COST CENTERS			· · · · ·			
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	10000 DUVELCLANCE DDUVATE OFFLORO	102,063	4, 344		0	159, 703 552, 929	
192.00	0 19200 PHYSI CLANS' PRI VATE OFFI CES		$\cap$			JJZ, 727	1, 1, 1, 00
192.00 194.00	0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 07950 RENTAL SPACE 1 07951 FOUNDATI ON	139, 971 925	0 3, 593	412, 958 0	Ő	4, 518	194.01
192.00 194.00 194.0 194.0	0 07950 RENTAL SPACE 1 07951 FOUNDATI ON 2 07952 RETAI L SERVI CES	139, 971	0 3, 593 40, 819	0	0	40, 962	194.02
192.00 194.00 194.02 194.02 194.03	007950 RENTAL SPACE 107951 FOUNDATI ON 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES	139, 971 925 143 0	40, 819 0	0 0 0	0 0 0	40, 962 0	194. 02 194. 03
192.00 194.00 194.00 194.00 194.00 194.00	07950 RENTAL SPACE 107951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 407954 REID PHYSICIAN ASSOC.	139, 971 925 143 0 1, 488, 368	40, 819 0 601, 628	0 0 3, 056, 910	0 0 0 0	40, 962 0 5, 146, 906	194. 02 194. 03 194. 04
192.00 194.00 194.02 194.02 194.02 194.04 194.04	07950 RENTAL SPACE 107951 FOUNDATION 207952 RETAIL SERVICES 307953 REID CONTRACTED SERVICES 407954 REID PHYSICIAN ASSOC. 507955 OTHER NRCC	139, 971 925 143 0	40, 819 0 601, 628 9, 280	0 0 3, 056, 910 0		40, 962 0 5, 146, 906 9, 280	194. 02 194. 03 194. 04 194. 05
192.00 194.00 194.01 194.02 194.03 194.09 194.09 194.00 194.00	0 07950 RENTAL SPACE 1 07951 FOUNDATI ON 2 07952 RETAIL SERVICES 3 07953 REID CONTRACTED SERVICES 4 07954 REID PHYSICIAN ASSOC. 5 07955 OTHER NRCC 6 07956 VACANT SPACE 8 07958 CAMBRIDGE RHC	139, 971 925 143 0 1, 488, 368 0	40, 819 0 601, 628	0 0 3, 056, 910 0	0 0 0 0 0 0 0	40, 962 0 5, 146, 906 9, 280 396, 712 28, 310	194.02 194.03 194.04 194.05 194.06 194.08
192.00 194.00 194.02 194.02 194.02 194.04 194.03 194.03	0 07950 RENTAL SPACE 1 07951 FOUNDATION 2 07952 RETAIL SERVICES 3 07953 REID CONTRACTED SERVICES 4 07954 REID PHYSICIAN ASSOC. 5 07955 OTHER NRCC 6 07956 VACANT SPACE 8 07958 CAMBRIDGE RHC 0 Cross Foot Adjustments	139, 971 925 143 0 1, 488, 368 0 0	40, 819 0 601, 628 9, 280	0 0 3, 056, 910 0 372, 552 0		40, 962 0 5, 146, 906 9, 280 396, 712 28, 310 0	194. 02 194. 03 194. 04 194. 05 194. 06

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod: rom 01/01/2017	Worksheet B Part II	
				o 12/31/2017		
		CAP	ITAL RELATED CO	DSTS		
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 through 20	1) 12, 041, 168	12, 837, 806	5, 977, 497	0	30, 856, 471	202.00

Heal th	Fina	nci	al S	Syste	ems		
		0F	CAD		DEL	ATED	C

	TION OF CAPITAL RELATED COSTS	HOSPI TAL & HEAL	Provider CC	CN: 15-0048 P F T	eriod: rom 01/01/2017 o 12/31/2017	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/7/2018 3:57	pared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	ADMI TTI NG	
		4.00	5.01	5.02	5.03	5.04	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00 4. 00 5. 01 5. 02	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING	67, 031 104 1, 211	66, 844 7, 037	4, 166, 709			1. 01 2. 00 4. 00 5. 01 5. 02
5.02 5.03 5.04 5.05	00560 PURCHASI NG RECEIVING AND STORES 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE	364 890 1, 266	934 2, 628 4, 118	434, 374 63, 879 27, 377	724, 506 1, 180 1, 646	136, 651 0	5. 03 5. 04
5.06 7.00 8.00	00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 228 1, 016 132	3, 446 1, 694 175	51, 103 0 3, 650	4, 105 5, 359 152	0 0 0	7.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	673 204	175 2, 570	5, 475 62, 053	11, 508 9, 164	0	9. 00 10. 00
11.00 13.00 14.00 15.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	863 92 243 1, 538	0 526 292 1, 256	0 25, 551 21, 901 73, 004	0 714 82, 577 57, 461	0 0 0 0	13.00 14.00
16.00 17.00 17.01	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	1, 287 856 299	1, 986 993 1, 343	153, 309 51, 103 270, 115	1, 100 281 1, 122	0 0 0	16.00 17.00
21.00 22.00 23.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	635 27 88	0	270, 113 0 0 18, 251	0 138 177	0 0 0 0	21. 00 22. 00
30. 00 31. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 944 1, 481	6, 658 1, 519	434, 374 63, 879	г т г т	7, 843 1, 414	30.00
40. 00 41. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 473 480	642 934	27, 377 51, 103	6, 755 3, 477	1, 849 578	40.00 41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	184	0	0	3, 962	369	43.00
50.00 52.00 54.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI 0LOGY-DI AGNOSTI C	538 261 2, 322	5, 519 1, 256 4, 468	158, 784 58, 403 277, 416	7, 662	27, 564 1, 284 21, 445	52.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	649 1, 385	847 1, 869	18, 251 105, 856	83, 561 8, 559	14, 554 13, 685	59.00 60.00
65.00 66.00 69.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	535 1, 947 327	175 2, 628 263	21, 901 189, 811 89, 430	22, 303 3, 433 8, 333	3, 114 2, 805 4, 176	66.00
70.00 71.00 72.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	82 0 0	204 0 0	14, 601 0 0	871 0 0	416 24 4, 592	1
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	000	0 146 0	0 3, 650	0 1, 182		73.00 74.00
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	76	350	3, 650	700	210	76.97
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	1, 950 766	2, 395 1, 665	136, 883 71, 179		10, 195 <u>1, 272</u>	92.00
96. 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	15	730	21, 901	2, 743	87	96.00
		497 36, 928	380 61, 909	5, 475 3, 015, 069		1, 015 136, 651	113. 00 116. 00 118. 00
192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES	0 0	0 1, 898 2, 832	0 1, 825		0	190.00 192.00
194. 01 194. 02	07950 RENTAL SPACE 07951 FOUNDATION 07952 RETAIL SERVICES	74 46 34	2, 833 204 0	10, 951 65, 704	6, 607 40 205	0 0	194.00 194.01 194.02 194.03
194.04 194.05	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	34 29, 534 0	0 0	0 1, 073, 160 0	0 83, 130 0	0 0	194. 04 194. 05
194.08 200.00		0 415	0 0	0 0	0 1, 709	0	194.06 194.08 200.00
201.00 202.00		0 67, 031	0 66, 844	0 4, 166, 709	0 724, 506	0 136, 651	201. 00 202. 00

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

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CC	FI		Worksheet B Part II Date/Time Pre 5/7/2018 3:57	pared:
	Cost Center Description	CASHI ERI NG/ACC OUNTS RECEI VABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5.05	5.06	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00 5.01 5.02 5.03 5.04	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE	310, 935					1.01 2.00 4.00 5.01 5.02 5.03 5.04 5.04 5.05
	00590 OTHER A&G	0	734, 232				5.06
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	14, 624 1, 961	3, 422, 749 67, 979	389, 104		7.00 8.00
	00900 HOUSEKEEPING	0	5, 458		389, 104	196, 728	9.00
	01000 DI ETARY	0	2, 374	60, 815	0	4, 124	10.00
	01100 CAFETERI A	0	4, 787	54, 411	0	0	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	906 9, 681	10, 774 46, 354	0	10, 218 400	
	01500 PHARMACY	0	66, 729	38, 798	0	400	15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	12, 847	6, 404	0	677	16.00
	01700 SOCI AL SERVI CE	0	6, 685	2, 414	0	1, 108	17.00
	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	5, 481 3, 791	51, 374 0	0	2, 401 0	17.01 21.00
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	458	0	0	0	21.00
	02300 PARAMED ED PRGM	0	886	15, 470	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	17.04/	E7 457	505 0/0	444 504	50 ((4	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	17, 816 3, 212	57, 457 15, 599	595, 969 135, 308	116, 524 27, 177	52, 661 14, 188	30.00 31.00
	04000 SUBPROVI DER – I PF	4, 201	11, 094	123, 118	22, 787	11, 049	40.00
	04100 SUBPROVI DER – I RF	1, 314	4, 570	98, 637	11, 631	6, 448	41.00
		838	1, 472	14, 775	0	215	43.00
	ANCI LLARY SERVI CE COST CENTERS	63, 119	58, 594	223, 882	62,014	17, 097	50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 918	3, 343	45, 830	20, 302	2, 970	
	05400 RADI OLOGY-DI AGNOSTI C	48, 717	35, 980	242, 047	39, 917	10, 480	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	33, 062 31, 088	17, 484 25, 738	25, 312 74, 807	23, 519 0	2, 462 8, 956	
	06500 RESPI RATORY THERAPY	7,074	5, 278	6, 580	0	1, 785	
	06600 PHYSI CAL THERAPY	6, 371	18, 518		3, 271	1, 431	66.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	9, 487 944	5, 058 1, 069	3, 070 29, 760	0 1, 174	2, 939 0	69.00 70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	55	1,009	29,780	1, 174	1, 662	1
	07200 I MPL. DEV. CHARGED TO PATIENT	10, 432	29, 639	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	40, 920	3, 517	0	0		73.00
	07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER	335	1, 671 0	8, 212 0	0	2, 585 0	74.00 76.00
	07697 CARDI AC REHABI LI TATI ON	476	799	0	0	893	76.97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 161	17, 880	125, 498	49, 337	15, 819	91.00 92.00
	04040 FAMILY PRACTICE	2, 890	6, 531	2, 232	11, 451	2, 631	93.00
	OTHER REIMBURSABLE COST CENTERS						1
	09600 DURABLE MEDI CAL EQUI P-RENTED	198	1, 165	20, 678	0	0	96.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	2, 307	6, 178	0	0	1, 893	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	310, 935	465, 307	2, 432, 020	389, 104	179, 431	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	6, 707	13, 535	0		190.00
194.00	07950 RENTAL SPACE	0	9, 250	123, 559	0	0	194.00
	07951 FOUNDATION	0	1,044	1, 135	0		194.01
	07952 RETAIL SERVICES 07953 REID CONTRACTED SERVICES	0	1, 127 407	3, 770	0		194. 02 194. 03
		0	407 246, 505	715, 362	0	17, 143	
	07954 RELD PHYSICIAN ASSOC.				U U		
194. 04 194. 05	07955 OTHER NRCC	Ő	19	2, 932	0		194.05
194.04 194.05 194.06	07955 OTHER NRCC 07956 VACANT SPACE	0	813	130, 436	0	0	194.06
194. 04 194. 05 194. 06 194. 08	07955 OTHER NRCC 07956 VACANT SPACE 07958 CAMBRI DGE RHC	0 0 0			0 0 0	0	194. 06 194. 08
194.04 194.05 194.06	07955 OTHER NRCC 07956 VACANT SPACE 07958 CAMBRIDGE RHC Cross Foot Adjustments	0 0 0	813	130, 436	0 0 0 0	0 0	194.06

ALLUCATIO	N OF CAPITAL RELATED COSTS	HOSPI TAL & HEAI	Provider C	CN: 15-0048 Pe	In Lie eriod: fom 01/01/2017 12/31/2017	Worksheet B Part II Date/Time Pre 5/7/2018 3:57	epared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
0.51		10.00	11.00	13.00	14.00	15.00	
$\begin{array}{c ccccc} 1. & 00 & 00^{\circ} \\ 1. & 01 & 00^{\circ} \\ 2. & 00 & 00^{\circ} \\ 5. & 01 & 00^{\circ} \\ 5. & 01 & 00^{\circ} \\ 5. & 02 & 00^{\circ} \\ 5. & 03 & 00^{\circ} \\ 5. & 04 & 00^{\circ} \\ 5. & 05 & 00^{\circ} \\ 5. & 05 & 00^{\circ} \\ 5. & 06 & 00^{\circ} \\ 7. & 00 & 00^{\circ} \\ 7. & 00 & 00^{\circ} \\ 7. & 00 & 00^{\circ} \\ 8. & 00 & 00^{\circ} \\ 9. & 00 & 00^{\circ} \\ 10. & 00 & 01^{\circ} \\ 11. & 00 & 01^{\circ} \\ 13. & 00 & 01^{\circ} \\ 14. & 00 & 01^{\circ} \\ 15. & 00 & 01^{\circ} \\ 15. & 00 & 01^{\circ} \\ 16. & 00 & 01^{\circ} \\ 17. & 00 & 01^{\circ} \\ \end{array}$	VERAL SERVICE COST CENTERS 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 550 DATA PROCESSING 560 PURCHASING RECEIVING AND STORES 570 ADMITTING 580 CASHIERING/ACCOUNTS RECEIVABLE 590 OTHER A&G 700 OPERATION OF PLANT 300 LAUNDRY & LINEN SERVICE 500 HOUSEKEEPING 500 OUSEKEEPING 500 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 MOUSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 701 INSERVICE EDUCATION	565, 482 0 0 0 0 0 0	232, 286 294 2, 359 7, 465 10, 225 0 1, 592	125, 114 0 0 0 0	1, 068, 781 1, 409 0 0	705, 096 0 0	16. 00 17. 00
21.00     02 <sup>2</sup> 22.00     02 <sup>2</sup> 23.00     02 <sup>2</sup>	100 I &R SERVI CES-SALARY & FRI NGES APPRVD 200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD 300 PARAMED ED PRGM PATI ENT ROUTI NE SERVI CE COST CENTERS	0000	1, 424 171 346	0 0	0 0 0	0 0 0	21. 00 22. 00
30.00     030       31.00     03'       40.00     040       41.00     04'       43.00     04'	ATTENT ROTTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS IOO INTENSIVE CARE UNIT DOO SUBPROVIDER - IPF 100 SUBPROVIDER - IRF 300 NURSERY DILLARY SERVICE COST CENTERS	363, 887 52, 865 111, 972 36, 758 0	38, 428 7, 114 8, 827 2, 539 772	9, 958 12, 356 3, 554	696 1,036 0 0 0	79 17 13 7 0	31.00 40.00 41.00
50.00         050           52.00         052           54.00         053           59.00         054           60.00         066           65.00         064           60.00         066           70.00         077           71.00         077           73.00         073           74.00         033           76.00         033           76.00         034           70.00         076           70.00         033           76.00         034	DOO       OPERATI NG ROOM         200       DELI VERY ROOM & LABOR ROOM         200       DELI VERY ROOM & LABOR ROOM         400       RADI OLOGY-DI AGNOSTI C         200       CARDI AC CATHETERI ZATI ON         200       LABORATORY         500       RESPI RATORY THERAPY         500       PHYSI CAL THERAPY         200       ELECTROCARDI OLOGY         200       ELECTROENCEPHALOGRAPHY         100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         200       IMPL. DEV. CHARGED TO PATI ENTS         300       RENAL DI ALYSI S         350       ANCI LLARY - OTHER         369       CARDI AC REHABI LI TATI ON         7PATI ENT SERVICE COST CENTERS		2, 545 1, 083 11, 487 3, 038 9, 121 2, 878 9, 589 1, 645 493 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 516 16, 080 4, 252 0 4, 029 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	151, 998 1, 486 3, 787 205, 562 67, 993 395 54 0 0 578, 571 0 0 0 0	2, 538 16 11, 739 8 7 678 9 4, 254 0 0 0 620, 529 24 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52.00 54.00 59.00 60.00 65.00 66.00 69.00 70.00 71.00 72.00 73.00 74.00 76.00 76.97
92.00 092 93.00 040	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART) 240 FAMILY PRACTICE	0	10, 170 4, 459		1, 237 0	428	92.00
96.00 090 SPE	IER REIMBURSABLE COST CENTERS 500 DURABLE MEDICAL EQUIP-RENTED ECIAL PURPOSE COST CENTERS 300 INTEREST EXPENSE	0	99	0	2, 876	2	96. 00 113. 00
116. 00 110 118. 00	SOU HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	0 565, 482	2, 651 141, 312		36 1, 017, 136		116.00
190.00 192.00 192.00 194.00 074 194.01 074 194.02 076 194.03 076 194.04 076 194.05 076	AND MODISABLE COST CENTERS 2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2000 PHYSICIANS' PRIVATE OFFICES 200 PHYSICIANS' PRIVATE OFFICES 201 FOUNDATION 202 RETAIL SERVICES 203 REID CONTRACTED SERVICES 204 REID PHYSICIAN ASSOC. 205 OTHER NRCC 205 VACANT SPACE 205 CAMBRIDGE RHC Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 0 0	0 0 537 439 381 88,045 0 0 1,572	0 0 0 0 0 0 0 0 0 0	0 0 0 0 51, 616 0 29	0 0 0 59, 628 0 1, 628	190.00 192.00 194.00 194.01 194.03 194.03 194.04 194.05 194.06 194.08 200.00 201.00

alth Finai	ncial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	ln Li€	eu of Form CMS-	2552
LOCATION	OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/7/2018 3:57	
					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	SERVI CES-OTHER PRGM. COSTS	
		16.00	17.00	17.01	21.00	22.00	
	RAL SERVICE COST CENTERS	1					
	NEW CAP REL COSTS-BLDG & FIXT						1.
	NEW CAP BLDG & FIXT - OFFSITE NEW CAP REL COSTS-MVBLE EQUIP						1.
1	EMPLOYEE BENEFITS DEPARTMENT						4.
	NONPATIENT TELEPHONES						5.
	DATA PROCESSING						5.
	PURCHASING RECEIVING AND STORES						5.
							5.
	CASHI ERI NG/ACCOUNTS RECEI VABLE						5.
							5.
	OPERATION OF PLANT						
	D LAUNDRY & LINEN SERVICE HOUSEKEEPING						8
	DIETARY						9
	CAFETERIA						
							11
	NURSING ADMINISTRATION						13
	CENTRAL SERVICES & SUPPLY						14
	PHARMACY	105 771					15
	MEDICAL RECORDS & LIBRARY	425, 771	00 (50				16
	SOCIAL SERVICE	0	88, 652		_		17
	I I NSERVI CE EDUCATI ON	0	0	581, 72			17
	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0 5, 850		21
	I &R SERVICES-OTHER PRGM. COSTS APPRVD	0			0	794	
	PARAMED ED PRGM	0	0	3, 81	8		23
	TIENT ROUTINE SERVICE COST CENTERS			r	1	1	
	ADULTS & PEDIATRICS	24, 390		130, 81			30
00 03100	INTENSIVE CARE UNIT	4, 398	2, 569	32, 74	7		31
00 04000	SUBPROVIDER - IPF	5, 751	0	27, 80	3		40
00 04100	SUBPROVIDER - IRF	1, 798	0	8, 05	1		41
	NURSERY	1, 147	0	1, 72	5		43
	LARY SERVICE COST CENTERS				-1		
	OPERATING ROOM	86, 522	0				50
	DELIVERY ROOM & LABOR ROOM	3, 994					52
	RADI OLOGY-DI AGNOSTI C	66, 691	0	,			54
	CARDI AC CATHETERI ZATI ON	45, 261	0	8, 53			59
	LABORATORY	42, 558	0	- 1 -			60
	RESPI RATORY THERAPY	9, 683		11, 66			65
	PHYSI CAL THERAPY	8, 722	0				66
	ELECTROCARDI OLOGY	12, 988		5, 39			69
00 07000	ELECTROENCEPHALOGRAPHY	1, 293	0	95	9		70
00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	75	0	(	0		71
00 07200	DIMPL. DEV. CHARGED TO PATIENT	14, 281	0	(	0		72
00 07300	D DRUGS CHARGED TO PATIENTS	56, 017	0	(	0		73
00 07400	RENAL DIALYSIS	459	0	78	8		74
00 03950	ANCILLARY - OTHER	0	0	(	0		76
	7 CARDIAC REHABILITATION	652	0	1, 31	8		76
	ATIENT SERVICE COST CENTERS					1	
	EMERGENCY	31, 706	32, 513	31, 15	9		91
	OBSERVATION BEDS (NON-DISTINCT PART)						92
	FAMILY PRACTICE	3, 956	0	6, 69	0		93
	R REIMBURSABLE COST CENTERS	1		Г	1	1	4
	DURABLE MEDICAL EQUIP-RENTED	271	0	2, 30	3		96
	AL PURPOSE COST CENTERS	1	[	[	1	1	4
1	INTEREST EXPENSE						113
5. 00 11600		3, 158		5, 49			116
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	425, 771	88, 652	375, 31	9 0	0	118
NONRE	I MBURSABLE COST CENTERS						4
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190
. 00 1900	PHYSICIANS' PRIVATE OFFICES	0	0		0		192
). 00 19000 2. 00 19200			0		0		194
). 00 19000 2. 00 19200 4. 00 07950	RENTAL SPACE	0		1 15	4		194
). 00 19000 2. 00 19200 4. 00 07950	D RENTAL SPACE	0	0	15			
0. 00 19000 2. 00 19200 4. 00 07950 4. 01 07951		0	0	31:			1194
0.0019000 2.0019200 4.0007950 4.0107951 4.0207952	I FOUNDATI ON	0	0 0 0	31:			
), 00 1900( 2, 00 1920( 4, 00 0795( 4, 01 07952 4, 02 07952 4, 03 07953	I FOUNDATI ON 2 RETAI L SERVI CES		0 0 0	31:	2 0		194
0. 00 19000 2. 00 19200 4. 00 07950 4. 01 07950 4. 02 07952 4. 03 07953 4. 04 07954	I FOUNDATION 2 RETAIL SERVICES 3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC.			31: ( 153, 27)	2 0 6		194 194
0.00     19000       2.00     19200       4.00     07950       4.01     07951       4.02     07952       4.03     07953       4.04     07954       4.05     07955	I FOUNDATION 2 RETAIL SERVICES 3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC. 5 OTHER NRCC			31: ( 153, 27) 46, 18)	2 0 6		194 194 194
D. 00         19000           2. 00         19200           4. 00         07950           4. 01         07952           4. 02         07952           4. 03         07952           4. 04         07954           4. 05         07955           4. 05         07955	I FOUNDATION 2 RETAIL SERVICES 3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC. 5 OTHER NRCC 5 VACANT SPACE			31: ( 153, 27) 46, 18)	2 0 6 6 0		194 194 194 194
0. 00 19000 2. 00 19200 4. 00 07950 4. 01 0795 4. 02 07952 4. 03 07952 4. 04 07954 4. 05 07955 4. 06 07956 4. 08 07956	I FOUNDATION 2 RETAIL SERVICES 3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC. 5 OTHER NRCC 5 VACANT SPACE 3 CAMBRIDGE RHC		0 0 0 0 0 0	31: ( 153, 27) 46, 18)	2 0 6 6 0 6	794	194 194 194 194 194
0. 00 19000 2. 00 19200 4. 00 07950 4. 01 07951 4. 02 07952 4. 03 07953 4. 04 07954 4. 05 07955 4. 06 07956	I FOUNDATION 2 RETAIL SERVICES 3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC. 5 OTHER NRCC 5 VACANT SPACE			31: 153, 276 46, 186 6, 476	2 0 6 6 0		194 194 194 194 194 194 200 201

LLOCATION C	ICI AL SYSTEMS REID OF CAPITAL RELATED COSTS	HOSPI TAL & HEAL		CCN: 15-0048	<u>In Lie</u> Period: From 01/01/2017	Worksheet B Part II
					To 12/31/2017	
	Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		1 3777 2018 3: 37 pi
CENED		23.00	24.00	25.00	26.00	
.00         00100           .01         00101           .00         00200           .00         00400           .01         00540           .02         00550           .03         00560           .04         00570           .05         00580           .06         00590           .00         00700           .00         00700           .00         01100           1.00         01100           3.00         01300           4.00         01400           5.00         01500           6.00         01600           7.00         01700           7.00         01701           1.00         02100	AL SERVICE COST CENTERS 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 EDUCATION I &R SERVICES-SALARY & FRINGES APPRVD					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 2
2.00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD					2
	PARAMED ED PRGM	118, 956				2
0.00 03000	ADULTS & PEDIATRICS		4, 346, 60		0 4, 346, 607	
	I NTENSI VE CARE UNI T SUBPROVI DER – I PF		1, 248, 212 807, 930		0 1, 248, 212 0 807, 930	
	SUBPROVI DER – I RF		588, 978		0 588, 978	
	NURSERY		81, 89	7	0 81, 897	4
	LARY SERVICE COST CENTERS		3, 054, 190	0	0 3, 054, 190	5
	DELIVERY ROOM & LABOR ROOM		351, 72	7	0 351, 727	5
	RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON		3, 235, 48 1, 004, 030		0 3, 235, 487 0 1, 004, 030	
	LABORATORY		1, 095, 040		0 1,095,046	
	RESPI RATORY THERAPY		170, 404		0 170, 404	
	PHYSI CAL THERAPY ELECTROCARDI OLOGY		1, 686, 650		0 1, 686, 650	
	ELECTROEARDIOLOGT		397, 438 159, 909		0 397, 438 0 159, 909	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		1, 82 <sup>-</sup>	1	0 1, 821	
	IMPL. DEV. CHARGED TO PATIENT		637, 51		0 637, 515	
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS		741, 335 48, 731		0 741, 335 0 48, 731	
	ANCI LLARY - OTHER		(		0 0	1 1
	CARDI AC REHABI LI TATI ON		108, 874	4	0 108, 874	7
	TIENT SERVICE COST CENTERS EMERGENCY		1, 121, 559	9	0 1, 121, 559	9
	OBSERVATION BEDS (NON-DISTINCT PART)		.,		0	9
	FAMILY PRACTICE		324, 012	2	0 324, 012	9
	REIMBURSABLE COST CENTERS DURABLE MEDICAL EQUIP-RENTED		149, 540		0 149, 540	9
	AL PURPOSE COST CENTERS	<u> </u>	147, 340		0 147, 340	· · · · · · · · · · · · · · · · · · ·
3.0011300	INTEREST EXPENSE					11
6.0011600			63, 529		0 63, 529	
8.00	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	21, 425, 42	1	0 21, 425, 421	11
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		(	0	0 0	19
	PHYSICIANS' PRIVATE OFFICES		184, 199		0 184, 199	
	RENTAL SPACE FOUNDATI ON		695, 178		0 695, 178	
	RETAIL SERVICES		18, 65 112, 719		0 18, 657 0 112, 719	
4.0307953	REID CONTRACTED SERVICES		822		0 822	
94.0407954	REID PHYSICIAN ASSOC.		7, 664, 30	5	0 7, 664, 305	19
	OTHER NRCC		58, 41		0 58, 417	
	VACANT SPACE CAMBRI DGE RHC		527, 96 <sup>-</sup> 43, 192		0 527, 961 0 43, 192	
00.00	Cross Foot Adjustments	118, 956	125, 600		0 43, 192	
01.00	Negative Cost Centers	0	(	0	0 0	20
02.00	TOTAL (sum lines 118 through 201)	118, 956	30, 856, 47	11	0 30, 856, 471	20

RVI CES	2552-10			
CCN: 15-0048	Period: From 01/01/2017	Worksheet B-1		
	To 12/31/2017	Date/Time Pre 5/7/2018 3:57		
COSTS				

Cost Center Bescription         UPP Int HiLANE DOSIS         PUP INFERT         PUP INFERT </th <th></th> <th></th> <th></th> <th></th> <th></th> <th>5 12/31/2017</th> <th>5/7/2018 3: 57</th> <th></th>						5 12/31/2017	5/7/2018 3: 57	
HIL         HIL         HIL         HIL         HIL         HIL         BLREIT         BLREIT <td></td> <td></td> <td>CAP</td> <td>ITAL RELATED CO</td> <td>DSTS</td> <td></td> <td></td> <td></td>			CAP	ITAL RELATED CO	DSTS			
HIL         HIL         HIL         HIL         HIL         HIL         BLREIT         BLREIT <td></td> <td>Cast Capton Description</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		Cast Capton Description						
CSUMPE         FEET         CSUMPE         FEET         CSUMPE         DEPARTMENT         CHANGES           1-00         1-01         2:00         4:03         5:01           1-00         0000 RX8 CAP BLG.6 ETT.1 GF51 TE         0         2:05         1:00           1:00         0000 RX8 CAP BLG.6 ETT.1 GF51 TE         0         2:05         1:00           1:00         0000 RX8 CAP BLG.6 ETT.1 GF51 TE         0         2:05         1:00           1:00         0000 RX8 CAP BLG.6 ETT.1 GF51 TES         1:00         1:00         1:00         1:00           1:00 GS50 RATA RECORSTOR         0         0:0550 RATA RECORSTOR         1:00		cost center bescription						
COMARE FEED         COROSS SMLARE FS         SMLARE FS           1.00         1.01         2.00         4.03         5.01           1.00         0.0010 KBK CAP REL COST CENTERS         1.00         1.01         2.00         4.03         5.01           1.00         0.0010 KBK CAP REL COST-SHUE & EINT         739, 942         275, 456         1.00         1.00           0.0000 CBK CAP REL COST-CHERE BUT         2.000         4.00         1								
I.00         I.01         I.00         I.01         I.00         I.00         I.00         I.00           1.00         DITRN NRA LOW IL COST CENTERS         I.00         I.00 <td< td=""><td></td><td></td><td></td><td>(SQUARE FEET)</td><td></td><td></td><td></td><td></td></td<>				(SQUARE FEET)				
CENERAL SERVICE COST CATTERS           1.00         COTON MER CAM BLO SAFLING A FLAT         735.942           1.01         COTON MER CAM BLO SAFLING A FLAT         735.942           1.01         COTON MER CAM BLO SAFLING A FLAT         735.942           1.01         COTON MER CAM BLO SAFLING A FLAT         735.942           1.01         COTON MER CAM BLO SAFLING A FLAT         2.669           1.01         COTON MARK TELE SPEARTMENT         2.669           1.00         COSSO PURCHASING RECEIVER SAFLE         1.415           1.00         COSSO PURCHASING RECEIVER SAFLE         1.525           1.00         COSSO PURCHASING RECEIVER SAFLE         1.526           1.00         COSSO PURCHASING RECEIVER SAFLE         1.526           1.00         COSSO P				. ,				
1.00         00100         NEW CAP HEL COSTS BUILS & FLAT         735, 942         725, 946         1.00           2.00         00200         NEW CAP HILE A STAT.         01511         2         0         275, 946         1         2         0           2.00         00200         NEW CAP HILE A STAT.         01511         1         2         0         0         940, 140         2         2         5         0         1         1         1         0         1         0         1         0         1         0         1         0         1         0         1         0         1         0         0         1         0         1         0         0         1         0         0         1         0         0         1        <			1.00	1.01	2.00	4.00	5.01	
1.01         00101         LEW CAP BEL COST AWBLE COUP         275, 656         1         1.01           0.0000         DMANDER CAP BEL COST AWBLE COUP         2, 669         0         0         1, 00         1, 00         2, 00         0         0, 00, 00         DMANDER BEREFITS DEPARTMENT         2, 669         0         0         2, 00, 100         2, 209         5, 00         0         2, 00, 100         2, 209         5, 00         0         2, 00, 100         2, 00, 100         2, 209         5, 00         0         2, 00, 100         2, 209         5, 00         0         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 100         2, 00, 11, 100         1, 01, 4, 96         6         9, 00         0, 00, 000         1, 01, 4, 96         6         9, 00         0, 00, 000         1, 01, 4, 96         6         9, 00         1, 01, 4, 96         6         9, 00         1, 01, 4, 96         6         9, 00         1, 01, 4, 96         6         9, 00         1, 01, 4, 96         6         9, 00         1, 01, 4, 96         6         9, 00         1, 01, 100         11, 000, 1100, 010,	1 00		705 040		1			1 1 00
2.00         DO200         Lew Core         Description         2.00         Description         2.00         Description         2.00         Description         4.00           5.01         DD3-d0 (AMARTIN TITE PRONES)         3.740         G         0         2.49,140         2.735,144         4.00           5.01         DD3-d0 (AMARTIN TITE PRONES)         12.518         1.066         2.904,140         2.135,456         30         50           5.01         DD3-d0 (AMARTIN TITE PRONES)         12.518         1.066         3.036,771         141         5.05           5.06         DD3-d0 (DFERTI AN GOLDS)         FLE         1815         8.160         2.437,746         68         7.00           0.00000 (DFERTI AN GOLDS)         FLE         12.135         G         3.17,734         68         60           10.00         DD300 (DFERTI AN GOLDS)         FLE         17.33         G         2.009,580         101         100         11.00         DD300 (DFERTI AN GOLDS)         11.00         12.0170         181         13.00           11.00         DD300 (DFERTI AN GOLDS)         FLE ANST         1.953         G         2.009,580         101         100         12.0170         101         11.00         1.011,511,611								
4.00         00400         IMM_OVER BENNET IS DEPARTMENT         2,669         400         0         16,073,014         4.05           5.00         00500         INATE NOT TELEPRONES         3,778         0         0.29,91,199         2,441         5,02           5.00         00500         INATE NECESSI NG         12,518         1,095         0         2,904,199         2,441         5,03           5.00         00500         INATE NECESSI NG         12,518         1,095         0         2,904,199         2,441         5,03           5.00         00500         INERCASI IN, RECEIVING AND STORES         15,650         0         7,742,044         118         5,06           6.000500         OURTER ANG         6,776         0         1,614,916         6,800           0.00000         OURDINEY & LINE SERVICE         12,588         0         0         4,000         480,000         88,100           1.000         01000         DETARW         12,578         0         0         2,609,900         11,00           1.000         DETARM SERVICE         12,358         0         0         400,000         88,100         0         41,00         41,00         40,000         10,000         10,000				275,450				
5.01         00540 (NIMPAT INT TELEPHONES         3.788         0         0         249,140         2.289         5.01           00560 (NIRALISAIN RECEIVING AD STORES         15.680         0         0         173.664         35.55           00560 (NIRALISAIN RECEIVING AD STORES         15.680         0         0         21.64.64         35.55           00560 (NIRALISAIN RECEIVING AD STORES         15.680         0         2.18.64         10.55           00560 (NIRALISAIN RECEIVING AD STORES         15.680         0         2.18.64         10.55           00500 (OTHER AG)         0.0000 (OTHER AG)         11.61.64         7.00         0.0000 (OTHEAL G)         1.1.61.75         6         6.00           0.00000 (OTHEAL G)         0.0000 (OTHEAL G)         1.61.475         6         6.00         0         1.61.475         6         6.00           0.0000 (OTHEAL G)         1.41.64         1.50         5.50         0         1.61.75         1.11.81         5.00         1.01.75         5.00         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75         1.01.75			2,669	400		160, 773, 014		1
5.03         00560 PURCHASHING RECEIVING AND STORES         15,680         0         772,664         32         5.03           5.04         00570 DIFER AG         00580 CASHIER ING/ACCOUNTS RECTIVABLE         815         8,160         0         3.036,771         141         5.05           5.04         00570 DIFER AG         2,137,465         0         7,42,044         185         6         7,07         141,516         1,50         0         7,42,044         185         6         6         00500 DIFER AG         7,67         6         0         1,61,61         6         90         0         1,64,61         6         90         0         1,64,61         6         90         0         1,64,61         6         90         0         1,64,66         90         0         1,64,61         6         90         0         1,64,61         6         90         0         1,64,61         1,60         1,100         1,100,01         1,00         1,111 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
5.04         00570 (AUMI TINK OCOUNTS RECEI VARLE         144         1,884         0         2,135,450         90         5.04           5.00         00580 (CHER AGE CONTS RECEI VARLE         81,50         0         7,742,044         118         5.06           5.00         00580 (CHER AGE         25,088         7,055         0         7,742,044         118         5.06           5.00         00580 (LANILEY & LINEN SERVICE         12,335         0         0         1,40,016         68         00           10.00         00590 (MESIKE AGE         6,735         0         0         1,40,016         68         00           11.00         01100 (AFETERIA         1,837         0         0         2,666,860         11         10           13.00         01300 (ALSIGN (MISINK AGMINISTRATION         1,955         0         0         2,1709         118         13.00           14.00         01400 (CHATERIA ERCORDS & LIBRARY         2,507         5.883         0         2,665,355         14         17.00           17.00         01700 SILAL SERVICE         119,244         0         2,660         211,777         32         23.00           10.00         01000 ILSINEN KAGANTRICE         FRINKE KORDIN	5.02				0	2, 904, 199		5.02
5.05         00590 (ZASHLER) MG/ACQUMI'S RECEI VABLE         815         8,100         0         3,036,771         141         5.05           0.0700 (DFER TAG)         0700 (DFER TAG)         27,044         158         0         2,437,646         58         7.00         0         3,036,771         141         5.05           0.00000 (DER LARY)         0.0100 (DER LARY)         12,2356         0         0         1,164,916         6         9.00           0.000000 (DEL RAY)         6,777         0         0         1,164,916         6         9.00           0.00000 (DEL RAY)         7,271         0         2,255,079         10         14.00           1.1000 (DEL RAY)         7,271         0         0         3,668,177         41         10.00           1.000 (DEL CALE RECORDS & LIBRARY)         3,507         0         0         1,61,877         41         10.00           1.000 (DEC METICLAL SERVICE DUCATION         1,241         0         0         2,053,55         34         17.00           1.000 (DEC METICLAL RECORDS & LIBRARY)         1,241         0         0         1,64,668         22.00         20.01         16.62,002         23.00         23.00         23.00         23.00         23.00			15, 650		0	873, 664		
5.00         00500 [OTHER A&G         25.08         7.055         0         7.742.044         118         5.06           6.00         00600 [AUNDRY & LINEN SFRVICE         123.168         4.155         0         3.37.258         6.6         6.00           0.0000 [DEFARTI NO MUSSKEF]         12.588         0         0         1.000         1.4.916         6.00         6.00         1.000         1.4.916         6.00         6.00         1.000         2.000								
7. 00         0070C [DEREATION OF FLANT         112, 168         4, 158         0         2, 437, 646         58         7. 00           0. 00         0090C [HAUSEKEPI ING         6, 776         0         0         1, 614, 916         6, 8, 00           0. 00         0010C [LANDRY & LINN SERVICE         12, 356         0         0         1, 614, 916         6, 9, 00           0. 00         0110C [LARETERIA         9, 873         0         0         2, 069, 580         0         11, 00           0. 00         0100C [CARTERIA         9, 873         0         0         2, 089, 580         0         11, 00           0. 0110C [CARTERIA         9, 873         0         0         2, 083, 585         4, 11         0         3, 588, 517         4, 115, 00         3, 588, 517         4, 11         1, 12, 12, 12								
6. 00         00000 (LAUNDRY & LINEN SERVICE         12,335         0         0.377,256         6         8. 00           00. 00000 (DISEKEET NA         12,568         0         0.490,009         88         10.00           11.00         01000 (DIETARY         12,568         0         0.490,009         88         10.00           13.00         01300 (NURSING ADMINISTRATION         1.955         0         0.221,709         11.00           13.00         01500 (PHARAACY         8,471         0.0         0.0         3.681,157         4.315           17.00         10500 (PHARAACY         7.521         8.00         0.3681,157         4.315         1.435           17.00         110701 (INSERVICE FDICATION         10.9400         0         0         7.521,677         4.61         1.700           17.00         1108 SEVICES-SALARY & FRINCES APPRVD         0.0         0         0.520,692         2.80         0         2.100         2.200         0.2000 (IAS SEPICES COST CENTERS								
0         000000000000000000000000000000000000					0			1
10.00       01000       DI CAPETERIA       12.568       0       -4400.000       88       10.00         13.00       01300       NURS ADMINISTRATION       1.955       0       2.669,586       0       11.00         13.00       01300       NURSING ADMINISTRATION       1.955       0       0.221,709       18       13.00         14.00       01400       CHIRAL SERVICES & SUPPLY       8,411       0       0.582,019       10.14.00         15.00       01500       PHARMACY       7.271       0       0       3.686,157       43       15.00         10.00       01700 SOCIAL SERVICES ADDRY       1.244       0       0       2.553,355       34       17.00         22.00       02200 LAR SERVICES - OTHER PRCIM. COSTS ADDRYD       0.0       0       0       1.551,977       46       10.0       23.00       23					0			1
13.00       01300 NURSI NG ADMIN STRATION       1,955       0       0221,709       18       13.00         14.00       01400 CENTRAL SERVICES & SUPPLY       7,271       0       0       3,688,157       14.00         15.00       01500 PHARMACY       7,271       0       0       3,688,157       15.10         17.00       01700 SOCIAL SERVICE       1,241       0       0       2,053,355       34       17.00         17.01       01701 INSERVICE ENCORTION       1,0407       0       0       1,646,065       0       22.00         20.00       02200 PARAMED ED PRAM       FININGES APPRVD       0       0       0       64,606       0       22.00       0       22.00       0       22.00       0       22.00       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       0       1,652,002       22.81       0       0       1,652,002       22.81       0       0       1,503,138       0       0       1,501,102       10.00       10.00       10.00       10.00       10.00       1,502,140					0			1
14. 00       01400 CENTRAL SERVICES & SUPPLY       8, 411       0       0       582, 019       10       14. 00         15. 00       01500 PHARMACY       1       0       0       3, 688, 157       43       15. 00         16. 00       01000 MEDICAL RECORDS & LIBRARY       3, 507       58, 883       0       3, 688, 157       43       15. 00         17. 01       01701 INSERVICE EDUCATION       10, 409       0       0       1, 521, 667       0       2, 053, 355       34       17. 00         17. 01       01701 INSERVICE EDUCATION       10, 409       0       0       0       1, 521, 667       0       21. 00       22.00       23.00       23.00       23.00         17. 00       01701 INSERVICE COST CENTERS       109, 246       0       0       16, 652, 002       22.83       0.00         18.00       03100 INTENSIVE CARE UNIT       24, 552       0       0       3, 533, 338       22.40. 00       0       1, 510, 291       32.40. 00         10.00       0400 SUBPROVIDER - 1 FF       2.6861       0       0       1, 114       0       4.300         11. 00       04100 SUBPROVIDER - 1 FF       2.6861       0       0       1, 291, 114       199       5.00					0	2, 069, 580	0	11.00
15.00       01500       PLARMACY       7, 271       0       0       3, 686, 157       43       15.00         16.00       01700       SOCIAL SERVICE       1, 241       6, 883       0       0, 66, 78       68       16.00         17.00       01701       INSERVICE COST SALERARY       1, 241       6, 883       0       0, 66, 78       68       16.00         22.00       02200       1RAS SERVICES-SALERY & FRINCES APRVD       0       0       0       16.460       0       21.00       22.01       18.5 SERVICE       0       0       0       0.46.600       0       21.00       22.00       18.5 SERVICE       0       0       16.462       0       22.00       22.00       22.00       22.00       22.00       22.00       22.00       23.00       0       3.05.60.20       22.83       30.00       3.05.60.20       22.83       30.00       3.533.380       22       40.00       1.00       40.00       5.567.60.20       23.00       0       3.533.380       22       40.00       1.630.01       1.630.57.62.33       18.50       0       3.533.380       22       40.00       1.630.01       1.521.647       10.0       1.521.647       10.0       1.521.647       10.0       1.521.64					0			
16.00       01400       NEDICAL RECORDS & LIBRARY       3.507       5.883       0       3.086.678       66       16.00         17.00       01701       INSERVICE       FOUCAL SERVICE       1.241       0       0.205.355       34       17.00         17.00       01701       INSERVICE       FOUCAL INN       0.0409       0       716.787       46       17.01         17.00       01701       INSERVICE       FOUCAL SERVICE       0.0409       0       0       1.551.667       0.21.00         20.00       02200 IAR SERVICES-OTHER PROM. COSTS APPRVD       0       0       0.44.008       0       22.00         0.00       03100 INTENT KUT CARE UNIT       24.522       0       0       3.550.403       52       31.00         0.010       04000 SUBPROVIDER - IFF       17.888       0       0       1.56.201       32.28       30.00         0.010       04100 SUBPROVIDER - IFF       17.888       0       0       1.50.291       32.41.00       41.00       43.53.380       22.40.00       0       5.57.203       153.54.03       52.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00					Ŭ			1
17.00       01700       9C1AL SERVICE       1, 241       0       0       2, 053, 355       34       17.00         17.00       01701       INSERVICE       0, 469       0       0       76, 787       46       17.00         21.00       02200       IRS SERVICES-SALREY & FRINCES APPRVD       0       0       0       64,668       0       21.00         22.00       02200       IRS SERVICE COST CENTERS       0       0       16,652,002       228       0       0       30.00       3000       000       35,333,380       22       40.00       3,533,380       22       40.00       10.6,652,002       228       30.00       3,533,380       22       40.00       16,652,002       228       30.00       3,533,380       22       40.00       14.141       0       43.00       0.4300 NURSERV       2,681       0       0       1.5,67,203       153       54.00       25.57,203       153       55.00       55.67,203       153       55.00       26.00       0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00				, , , , , , , , , , , , , , , , , , ,	Ŭ			
17.00       101701       INSERVICE EDUCATION       10,409       0       716,787       46       17,00         21.00       02200       188 SERVICES-SALARY & FRINCES APPRVD       0       0       64,608       022,00         23.00       02200       188 SERVICE COST CENTERS					0			
121.00         02100         18.7 SERVICES-SALARY & FRINCES APPRVD         0         0         1,521,667         0         21.00         22.00           22.00         022300         18.8 SERVICES-SALARY & FRINCES APPRVD         0         0         0         44.608         0         21.00         22.00         23.00<					0			
22.00         02200   JAR SERVICES-OTHER PROM.         0         0         64, 608         0         22.00           100         03.00         02300 PRANUE DE PROM.         0.01         0.00         0.01<					0			
INPATI ENT NOUTINE SERVICE COST CENTERS         Instruction           00         02000 ADULTS & PEDIATRICS         109,246         0         0         10         16,652,002         228,30,00           01         00         00100 INTENSIVE CARE UNIT         24,552         0         0         3,533,380         22         40,00           04         00         04000 SUBPROVIDER - 1 RF         17,898         0         0         3,533,380         22         40,00           04         04300 NUBSERY         2,661         0         0         441,141         0         43,00           04300 NUBSERY         2,661         0         0         441,141         0         43,00           050.00 DELUVERY NOM & LABOR ROM         68,316         0         0         50,00         567,203         153         54,00           054.00 DELUVERY NOM & LABOR ROM         13,945         0         3,321,498         64         65,00           0600 OPERSPIRATORY THERAPY         1,647         0         1,283,318         66         65,00           0600 OPERSPIRATORY THERAPY         8,084         42,316         4,669,388         90         66,00           07000 ELECTROCARCHED TO PATIENTS         0         0         0	22.00		0	0	0			
30:00       03000       AULTS & PEDIATRICS       109, 246       0       0       16, 652, 002       228       30.00         30:00       03000       INTENSIVE CARE UNIT       24, 552       0       0       3, 550, 403       522       31.00         41:00       04100       SUBPROVIDER - IPF       2, 2340       0       0       3, 553, 380       52       41.00         41:00       04100       SUBPROVIDER - IFF       2, 681       0       0       41.141       0       43.00         ANCILLARY SERVICE COST CENTERS       2, 681       0       0       441, 141       0       43.00         ANCILLARY SERVICE COST CENTERS       2, 681       0       0       25.733       43       52.00         52.00       05200 DELIVERY ROM & LABOR ROM       48, 466       13, 691       0       1, 291, 114       189       50.00         54.00       05000 CARDIA CCATHETERIZATION       13, 579       0       0       1, 556, 196       29       59.00         65.00       065000 PENSICAT LHEAPY       1, 647       0       1, 283, 318       6       65.00         66.00       0600 PHYSICAT LHEAPY       1, 647       0       0       70.00       71.00       70.00	23.00	02300 PARAMED ED PRGM	1, 061	2, 680	0	211, 787	3	23.00
131.00       0X100  INTENSIVE CARE UNIT       24,552       0       0       3,550,403       52       31.00         04.00       040000 SUBPROVIDER - IPF       22,340       0       0       3,553,380       22       40.00         04.00       04000 SUBPROVIDER - IPF       22,340       0       0       3,553,380       22       40.00         043.00       00       000 SUBPROVIDER - IPF       26       0       0       41,141       0       43.00         043.00       00 SOD0 OPERATI NG ROM       48,466       13.091       0       1,291,114       189       50.00         50.00       05000 DELU CEN YOM & LABOR ROM       48,466       13.091       0       1,291,114       189       50.00         54.00       05400 RADI OLGY -DI AGNOSTIC       60,780       1,640       0       65,723       43.52.00         05.00       0500 CRESPI RATORY THERAPY       1,647       0       1,283,318       66.00       66.00         65.00       06000 RESPI RATORY THERAPY       8,084       42,316       0       4,669,388       90       66.00       670.00       70.00       70.00       72.00       77.00       70.00       72.00       77.00       72.00       72.00       72.00							-	
40.00       040000       SUBPROVI DER - 1 IPF       22, 340       0       0       3, 533, 380       22       40.00         41.00       041000       SUBPROVI DER - 1 IPF       2, 681       0       0       11       10       43.00         43.00       04300       NUSERRY       2, 681       0       0       141, 141       0       43.00         40.01       OMERCILLARY SERVICE COST CENTERS       0       0       1, 291, 114       189       50.00         50.00       DESCOO DELIVERY ROOM & LABOR ROOM       48, 466       13, 091       0       1, 291, 114       189       50.00         54.00       DSCOO CARDID LOCAPIDA CONTRC       60, 780       1, 600       0       5, 57, 203       153       54.00         59.00       DSSOO CLARDRATORY       13, 945       0       0       3, 533, 380       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       0       70.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       71.00       73.00       73.00       73.00       73.00       73.00       73.00       <								
11.00       04100       SUBPROVIDER - IRF       17,898       0       0       1,150,291       32       41.00         43.00       43.00       0       0       0       1,114       0       43.00         43.00       0       050.00       05000       0FERATING ROOM       48,466       13,091       0       1,291,114       189       50.00         50.00       05000       DELVICEY ROM & LABOR ROOM       48,466       10,091       0       5,57,203       153       54.00         50.00       05000       CARDIAC CATHETER IZATION       13,579       0       0       1,556,196       29       59.00         50.00       05000 RESPI RATORY THERAPY       1,647       0       0       3,231,498       64       60.00         66.00       06600 RESPI RATORY THERAPY       1,647       0       0       785,308       90       66.00         67.00       000 CELECTROCARDIAC GAPAHY       7       0       3,892       0       77.00       77.00         71.00       0100 MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       72.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00       78.00					Ŭ			
43.00       0       0       0       0       0       0       0       0       441,141       0       43.00         50.00       05000       0PERATING ROOM       68,316       0       0       1,291,114       189       50.00         52.00       05200       DELIVERY ROM & LABOR ROOM       60,780       1,660       0       625,783       43       52.00         54.00       05400 RADI OLGGY-DI AGNOSTIC       60,780       1,660       0       5,567,203       153       54.00         05000       OKADIAC CATHETERI ZATION       13,579       0       0       3,314,498       64       60.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       77.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>1</td>					-			1
ANCILLARY SERVICE COST CENTERS           0.00         05000         OPERATING ROM         48, 466         13, 091         0         1, 291, 114         189           52.00         05200         DELIVERY ROM & LABOR ROM         68, 316         0         0         625, 783         43         52.00           54.00         05400 RADI OLOCY-DI AGNOSTIC         60, 780         1, 600         5, 567, 203         153         54.00           05.00         05000 CARDIA CATHE TERI ZATION         13, 579         0         0         1, 560, 196         29         59.00           05.00         06500 RESPI RATORY THERAPY         1, 647         0         1, 233, 318         6         65.00           06.00         06000 ELECTROCADEDI LOCGY         70.01         0         0         785, 338         90         66.00           0.00         07000 ELECTROCADEDI LOCGY         70.01         0         0         0         70.00           0.00         07000 ELECTROCADEDI CLOGY         70.01         0         0         0         0         70.00           0.00         07000 ELECTROCADEND PATIENTS         0         0         0         0         70.00           0.00         07300 DRUGS CHARGED TO PATIENTS         0 </td <td></td> <td></td> <td></td> <td></td> <td>U U</td> <td></td> <td></td> <td></td>					U U			
52.00         05200         DELIVERY ROOM & LABOR ROOM         88 316         0         625,783         43         52.00           54.00         05400         RADIOLOGY-DIAGNOSTIC         60,780         1,600         0         5,567,203         153         54.00           059.00         05990         CARDIAC CATHETERIZATION         13,579         0         0         3,321,498         64         60.00           65.00         05000         RESPIRATORY THERAPY         13,945         0         0         3,321,498         64         60.00           66.00         06000         LABORATORY         8,084         42,316         0         4,669,388         90         64.00           67.00         07000         ELECTROCARDIAGRAPHY         7,011         0         785,308         9         69.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         71.00           72.00         7020         IPAL ENT STRAT         0         0         0         0         73.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         74.00         74.00         74.00         0 </td <td></td> <td></td> <td></td> <td></td> <td>-</td> <td>,</td> <td></td> <td></td>					-	,		
54.00       05400       RADIOLOGY-DIAGNOSTIC       60,780       1,600       0       5,57,203       153       54.00         59.00       05900       CARDIAC CATHETERIZATION       13,579       0       0       1,556,196       29       59.00         60.00       06500       LABORATORY       13,945       0       0       3,321,498       64       60.00         65.00       06500       RESPI RATORY THERAPY       1,647       0       1,283,318       6       65.00         66.00       06600       DECENCEPHALOGRAPHY       1,647       0       0       785,308       9       66.00         67.00       06000       ELECTROCARDIOLOGY       7,011       0       0       785,308       9       69.00         71.00       07100       MEDLAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07100       MEDLARY - OTHER       0       0       0       0       72.00         73.00       7030       07300       000       0       0       72.00       0       74.00       0       0       74.00       0       74.00       76.00       74.00       76.00       76.00       76.00								
59.00       05900       CARDIAC CATHETERIZATION       13, 574       0       1, 556, 196       29       59.00         60.00       06000       LABORATORY       13, 574       0       0       3, 321, 498       64       60.00         65.00       06500       RESPIRATORY THERAPY       1, 647       0       1, 283, 318       66       65.00         60.00       06000       LECTROENCEPHALOGRAPHY       8, 084       42, 316       0       4, 669, 388       90       66.00         70.00       OT000       ELECTROENCEPHALOGRAPHY       0       3, 892       0       70.00       71.00       0       0       0       0       71.00       0       0       0       0       71.00       0       0       0       0       71.00       0       0       0       0       0       72.00       72.00       72.00       0       0       0       72.00       72.00       72.00       0       0       0       0       73.00       0       0       0       0       0       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       74.00       75.00       74.00       76.00       <								
60.00       06000       LABORATORY       13,945       0       3,321,498       64       60.00         65.00       06500       RESPI RATORY THERAPY       1,647       0       0       1,283,318       6       65.00         60.00       06600       PHYSI CAL THERAPY       8,084       42,316       0       4,669,388       90       66.00         60.00       06000       ELECTROCABUIDLOGY       7,011       0       0       785,308       90       66.00         70.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       70.00         71.00       07100       REDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07400       RENAL DIALYSIS       1,490       0       0       0       74.00         74.00       07400 RENAL DIALYSIS       1,490       0       0       0       76.00         75.97       07407 CARDIA CREHABLITATION       4,523       0       0       183,169       22.07       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
65.00       06500       RESPI RATORY THERAPY       1, 647       0       1, 283, 318       6       65.00         66.00       06600       PHYSI CAL THERAPY       8, 084       42, 316       0       4, 669, 388       90       66.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       70.00       70.00       0       70.00       0       0       0       0       70.00       0       0       0       0       0       0       0       70.00       0       0       0       0       0       0       0       0       70.00       0       0       0       0       0       0       0       0       0       0       0       0       0       72.00       73.00       73.00       73.00       73.00       0       0       0       0       0       0       0       72.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       0       0       0       76.00       76.00       76.00       76.00       76.00					0			
66.00       06000       PHYSI CAL THERAPY       8,084       42,316       0       4,669,388       90       66.00         69.00       06900       ELECTROCARDIOLOGY       7,011       0       0785,308       9       66.00         70.00       7000       ELECTROCARDIOLOGY       7       0       0       70.00 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>1</td>					0			1
70.00       07000       ELECTROENCEPHALOGRAPHY       0       3, 892       0       195, 492       7       70.00         71.00       07100       MEDI CAL       SUPPLIES       CHARGED TO PATIENTS       0		•			0			
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       72.00         74.00       07400       RENAL DI ALYSI S       1,490       0       0       0       74.00         76.00       03950 ANCI LLARY - OTHER       0       0       0       0       76.00         76.97       07697       CARDI AC REHABILITATION       4,523       0       0       183,169       12       76.97         91.00       09100       EMERGENCY       22,772       0       0       4,677,140       82       91.00         92.00       09200       0BSERVATION BEDS (NON-DI STINCT PART)       2,872       0       36,661       25       92.00         93.00       04040 FAMILY PRACTICE       8,935       847       0       1,836,007       57       93.00         96.00       DURBABLE MEDI CAL EQUIP-RENTED       1,774       2,872       0       36,661       25       96.00         113.00       11300 <td>69.00</td> <td>06900 ELECTROCARDI OLOGY</td> <td>7, 011</td> <td>0</td> <td>0</td> <td>785, 308</td> <td>9</td> <td>69.00</td>	69.00	06900 ELECTROCARDI OLOGY	7, 011	0	0	785, 308	9	69.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSIS       1,490       0       0       0       0       74.00         03550       ANCILLARY - OTHER       0       0       0       0       0       74.00         076.07       07697       CARDIAC REHABILITATION       4,523       0       0       183,169       12       76.97         09100       DERERGENCY       22,772       0       0       4,677,140       82       91.00       92.00         92.00       09200       DBSERVATION BEDS (NON-DI STINCT PART)       28,935       847       0       1,836,007       57       93.00         040401       FAMILY PRACTICE       8,935       8477       0       1,836,007       57       93.00         95       DOFO       URRBLE MEDI CAL EQUI P-RENTED       1,774       2,872       0       36,661       25       96.00         SPECIAL PURPOSE COST CENTERS       113.00       11300       11300       113100       113100       1131.00       <			0	3, 892	0			1
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       73.00         74.00       07400       RENAL DI ALYSIS       1,490       0       0       0       574.00         76.00       03950       ANCILLARY - OTHER       0       0       0       0       0       76.00         76.97       07697       CARDI AC REHABILITATION       4,523       0       0       183,169       12       76.97         0UTPATI ENT SERVICE COST CENTERS			0	0	0	-	-	1
74.00       07400       RENAL DI ALYSI S       1,490       0       0       0       5       74.00         76.00       03950 ANCI LLARY - OTHER       0			-	-	-			
76.00         03950         ANCI LLARY - OTHER         0         0         0         0         76.00         92.00         93.00         76.00         76.00         94.00         76.00         93.00         76.00         93.00         93.00         76.00         93.00         93.00         93.00         93.00         93.00         94.00         96.00         96.00         96.00         96.00         96.00         96						0	-	
76. 97         07697         CARDIAC REHABILITATION         4, 523         0         183, 169         12         76. 97           017PATIENT SERVICE COST CENTERS			1,470	0	-	0		
91. 00       09100       EMERGENCY       22, 772       0       0       4, 677, 140       82       91. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       8, 935       847       0       1, 836, 007       57       93. 00         04040       FAMI LY PRACTI CE       8, 935       847       0       1, 836, 007       57       93. 00         07HER       REI MBURSABLE       COST CENTERS			4, 523	0	0	183, 169	-	
92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART) 04040       8,935       847       0       1,836,007       57       93.00         93.00       04040       FAMI LY PRACTI CE       8,935       847       0       1,836,007       57       93.00         07HER       REIMBURSABLE COST CENTERS		OUTPATIENT SERVICE COST CENTERS						
93.00       04040       FAMILY PRACTICE       8,935       847       0       1,836,007       57       93.00         OTHER REIMBURSABLE COST CENTERS       0       04040       FAMILY PRACTICE       93.00       0       36,661       25       96.00       09600       DURABLE MEDICAL EQUIP-RENTED       1,774       2,872       0       36,661       25       96.00       96.00       36,661       25       96.00       0       113.00       1NTEREST EXPENSE       113.00       11300       INTEREST EXPENSE       445       0       0       1,191,305       13       116.00         118.00       11600       HOSPICE       445       0       0       88,564,249       2,120       118.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       696,741       95,933       0       88,564,249       2,120       118.00         NONREI MBURSABLE COST CENTERS       190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       249       2,456       0       0       65       192.00         194.00       07950       RENTAL SPACE       0       19,030       0       7			22, 772	0	0	4, 677, 140	82	
OTHER         REI MBURSABLE         COST         CENTERS           96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED         1,774         2,872         0         36,661         25         96.00           SPECIAL         PURPOSE         COST         CENTERS         113.00         INTEREST         EXPENSE         113.00         11300         INTEREST         EXPENSE         113.00         113.00         1140.00         1000 FUE         113.00         113.00         113.00         113.00         113.00         1140.00         11600         HOSPI CE         445         0         0         1,191,305         13116.00           118.00         SUBTOTALS         (SUM OF LI NES 1 through 117)         696,741         95,933         0         88,564,249         2,120         118.00           NONREI MBURSABLE         COST         CENTERS         0         0         0         0         190.00 <td></td> <td></td> <td>0.005</td> <td></td> <td></td> <td>4 004 007</td> <td></td> <td></td>			0.005			4 004 007		
96. 00         09600         DURABLE         MEDI CAL         EQUI P-RENTED         1,774         2,872         0         36,661         25         96. 00           SPECI AL PURPOSE COST CENTERS           113. 00         11300         INTEREST EXPENSE         113.00         1,191,305         13         116.00           116. 00         11600         HOSPI CE         445         0         0         1,191,305         13         116.00           118. 00         SUBTOTALS (SUM OF LI NES 1 through 117)         696,741         95,933         0         88,564,249         2,120         118.00           NONREI MBURSABLE COST CENTERS           190. 00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00           192. 00         19200         PHYSI CI ANS' PRI VATE OFFI CES         249         2,456         0         0         65         192.00           194. 00         07950         RENTAL SPACE         0         19,030         0         97         194.01           194. 02         07952         RETAI L         SERVI CES         2,340         0         0         178,546         7         194.01           194. 03         079	93.00		8, 935	847	0	1, 836, 007	57	93.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           113.00         INTEREST EXPENSE           116.00         11600           116.00         INTEREST EXPENSE           118.00         SUBTOTALS (SUM OF LINES 1 through 117)           696,741         95,933           0         88,564,249         2,120           118.00         NONREI MBURSABLE COST CENTERS           190.00         IFT, FLOWER, COFFEE SHOP & CANTEEN         0           0         192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES           194.00         07950         RENTAL SPACE         0         0           194.01         07951         FOUNDATI ON         206         0         0           194.02         07952         RETAI L SERVICES         2, 340         0         0         110, 223         0           194.03         07953         REI D CONTRACTED SERVICES         2, 340         0         0         110, 223         0         194.02	96 00		1 77/	2 872	0	36 661	25	96 00
113.00       11300       INTEREST EXPENSE       113.00         116.00       11600       HOSPI CE       445       0       0       1, 191, 305       13       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       696, 741       95, 933       0       88, 564, 249       2, 120       118.00         NONREI MBURSABLE COST CENTERS         190.00       1975, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       192.00       192.00       PHYSI CI ANS' PRI VATE OFFI CES       249       2, 456       0       0       192.00       192.00       0       97, 194.01       01       194.01       07950       RENTAL SPACE       0       0       0       97, 194.01       194.01       194.02       07952       RETAI L SERVICES       2, 340       0       0       110, 223       0       194.02         194.03       07953       REI D CONTRACTED SERVICES       2, 340       0       0       110, 223       0       194.02         194.03       07953       REI D CONTRACTED SERVICES       0       0       0       110, 223       0       194.02	90.00		1,774	2,072	0	30,001	23	90.00
I18.00         SUBTOTALS (SUM OF LINES 1 through 117)         696, 741         95, 933         0         88, 564, 249         2, 120         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         249         2, 456         0         0         655         192.00           194.00         07950         RENTAL SPACE         0         19, 030         0         97         194.00           194.01         07951         FOUNDATI ON         206         0         0         178, 546         7         194.01           194.02         07952         RETAI L SERVICES         2, 340         0         0         110, 223         0         194.02           194.03         07953         REI D CONTRACTED SERVICES         2, 340         0         0         110, 223         0         194.03	113.0							113.00
NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         249         2,456         0         0         65         192.00           194.00         07950         RENTAL SPACE         0         19,030         0         0751         194.00           194.01         07951         FOUNDATI ON         206         0         0         178,546         7         194.00           194.02         07952         RETAI L SERVICES         2,340         0         0         110,223         0         194.02           194.03         07953         REI D CONTRACTED SERVICES         2,340         0         0         120.02         194.03	116.00		445	0	0	1, 191, 305	13	116.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       249       2, 456       0       0       65       192.00         194.00       07950       RENTAL SPACE       0       19, 030       0       0       97       194.00         194.01       07951       FOUNDATI ON       206       0       0       178, 546       7       194.01         194.02       07952       RETAI L SERVI CES       2, 340       0       0       110, 223       0       194.02         194.03       07953       REI D CONTRACTED SERVI CES       0       0       0       194.03	118.0		696, 741	95, 933	0	88, 564, 249	2, 120	118.00
192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       249       2,456       0       0       65       192.00         194.00       07950       RENTAL SPACE       0       19,030       0       0       97       194.00         194.01       07951       FOUNDATI ON       206       0       178,546       7       194.01         194.02       07952       RETAI L SERVI CES       2,340       0       0       110,223       0       194.02         194.03       07953       REI D CONTRACTED SERVI CES       0       0       82,095       0       194.03								1.00.00
194.00         07950         RENTAL SPACE         0         19,030         0         97         194.00           194.01         07951         FOUNDATI ON         206         0         178,546         7         194.01           194.02         07952         RETAIL SERVICES         2,340         0         0         110,223         0         194.02           194.03         07953         REI D CONTRACTED SERVICES         0         0         82,095         0         194.03								1
194.01       07951       FOUNDATI ON       206       0       178,546       7       194.01         194.02       07952       RETAIL SERVICES       2,340       0       0       110,223       0       194.02         194.03       07953       REI D CONTRACTED SERVICES       0       0       82,095       0       194.03						0		
194. 02       07952       RETAIL SERVICES       2, 340       0       0       110, 223       0       194. 02         194. 03       07953       REID CONTRACTED SERVICES       0       0       0       82, 095       0       194. 03			-		0	178 546		
194. 03 07953 REI D CONTRACTED SERVICES 0 0 0 82, 095 0 194. 03					o			
			0	0	0			1
194. 04         07954         REI D         PHYSI CI AN         ASSOC.         34, 489         140, 869         0         70, 842, 734         0         194. 04			34, 489	140, 869	0	70, 842, 734		
194. 05 07955 OTHER NRCC 532 0 0 0 0 194. 05					0	0		1
194. 06 07956 VACANT SPACE 1, 385 17, 168 0 0 0 194. 06			1, 385	17, 168	0	0		
194.08         07958         CAMBRIDGE         RHC         0         0         995, 167         0         194.08         200.00         200.00         200.00         0         995, 167         0         194.08         200.00         200.00         0         995, 167         0         194.08         200.00	194.0	SULVYSKU AMBRIDGE RHC		u ()	n O	995 167		
	200 0					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		200.00

Heal th Financial	Systems	RE
COST ALLOCATION	- STATI STI CAL	BASI S

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

COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Pre 5/7/2018 3:57	pared:
		CAPI	ITAL RELATED CO	OSTS		57772018 3. 57	
	Cost Center Description		NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)		EMPLOYEE BENEFITS ) DEPARTMENT (GROSS SALARIES)	NONPATI ENT TELEPHONES (PHONES)	
		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)	12, 837, 806	5, 977, 497		0 29, 919, 264	381, 896	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17. 444046	21. 700370	0.0000	0. 186096	166. 839668	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				67, 031	66, 844	204.00
205.00	Unit cost multiplier (Wkst. B, Part				0. 000417	29. 202272	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	ncial Systems REID TION - STATISTICAL BASIS		LTH CARE SERVIC Provider CC	N: 15-0048 P	eriod:	i of Form CMS-2 Worksheet B-1	2002 1
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	
	Cost Center Description	DATA	PURCHASI NG		CASHI ERI NG/ACC	5/7/2018 3:57 Reconciliation	pin
		PROCESSI NG (TERMI NALS)	RECEI VI NG AND STORES	(TOTAL REVENUE)	OUNTS RECEI VABLE		
		(TERWITINALS)	(SUPPLY	KEVENUE)	(TOTAL		
			EXPENSE)		REVENUE)	54.0/	
GENE	RAL SERVICE COST CENTERS	5.02	5.03	5.04	5.05	5A. 06	
1.00 0010	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP BLDG & FIXT - OFFSITE						1.01
	NEW CAP REL COSTS-MVBLE EQUIP						2.00 4.00
	NONPATIENT TELEPHONES						5.01
5.02 00550	DATA PROCESSING	2, 283					5.0
	PURCHASING RECEIVING AND STORES	238	9, 090, 876	701 5/0 000			5.0
	D ADMI TTI NG D CASHI ERI NG/ACCOUNTS RECEI VABLE	35	14, 802 20, 648	791, 568, 023 0	791, 568, 023		5.0 5.0
	OTHER A&G	28	51, 513	0	0	-17, 359, 724	5.0
	OPERATION OF PLANT	0	67, 237	0	0	0	7.0
	LAUNDRY & LINEN SERVICE	2	1, 911	0	0	0	8.0
	D HOUSEKEEPI NG D DI ETARY	34	144, 400 114, 988	0	0	0	9.0 10.0
	D CAFETERI A	0	0	0	-	0	11.0
	NURSI NG ADMI NI STRATI ON	14	8, 963	0	0	0	13.0
	CENTRAL SERVICES & SUPPLY	12	1, 036, 148	0	-	0	14.0
	D PHARMACY D MEDICAL RECORDS & LIBRARY	40	721, 008 13, 799	0	-	0	15.0 16.0
	SOCIAL SERVICE	28	3, 527	0	0	0	17.0
17.01 0170	I INSERVICE EDUCATION	148	14, 078	0	0	0	17.0
	I & R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.0
	I &R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM	0	1, 733 2, 216	0	-	0	22. 0 23. 0
		10	2,210	0	<u> </u>	0	23.0
30.00 0300	D ADULTS & PEDI ATRI CS	238	617, 697	45, 334, 465	45, 334, 465	0	30. 0
	DINTENSIVE CARE UNIT	35	310, 729	8, 173, 932		0	31.0
	SUBPROVIDER - IPF SUBPROVIDER - IRF	15 28	84, 755 43, 625	10, 689, 025		0	40.0 41.0
	NURSERY	0	43, 023	2, 132, 354		0	43.00
ANCI I	LARY SERVICE COST CENTERS						
	O OPERATING ROOM	87	1, 316, 887	160, 993, 723		0	50.0
	D DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	32 152	96, 140 927, 217	7, 424, 077 123, 961, 006		0	52.0 54.0
	CARDI AC CATHETERI ZATI ON	10	1, 048, 499	84, 128, 120		0	59.0
60.00 0600	LABORATORY	58	107, 400	79, 104, 494		0	60.0
		12	279, 848	17, 998, 985		0	65.0
	D PHYSI CAL THERAPY D ELECTROCARDI OLOGY	104	43, 081 104, 562	16, 212, 418 24, 140, 612		0	66. 0 69. 0
		8	10, 934	2, 403, 272		0	
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	139, 688	139, 688	0	71.0
	DIMPL. DEV. CHARGED TO PATIENT	0	0	26, 544, 582		0	72.0
	D DRUGS CHARGED TO PATIENTS		0 14, 832	104, 121, 148 852, 259		0	73.0 74.0
	ANCILLARY - OTHER	0	032	032, 237	032, 237	0	76.0
	7 CARDIAC REHABILITATION	2	8, 789	1, 211, 990	1, 211, 990	0	76.9
	ATIENT SERVICE COST CENTERS	75	220.044	E0 022 2E2	F0 022 252	0	
	DEMERGENCY DOBSERVATION BEDS (NON-DISTINCT PART)	75	328, 044	58, 933, 252	58, 933, 252	0	91.0 92.0
	FAMILY PRACTICE	39	91, 701	7, 352, 685	7, 352, 685	0	93.0
	R REIMBURSABLE COST CENTERS	Ĩ					
	DURABLE MEDICAL EQUIP-RENTED	12	34, 421	504, 126	504, 126	0	96.0
	AL PURPOSE COST CENTERS						113.00
116.00 1160		3	197, 870	5, 869, 145	5, 869, 145	0	116. 0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 652	7, 933, 710	791, 568, 023	791, 568, 023	-17, 359, 724	118. 0
	IMBURSABLE COST CENTERS	0				0	190. 0
	OGIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 6, 668	0	-		190. 0 192. 0
	RENTAL SPACE	0	82, 906	0	0		194.0
94.01 0795	1 FOUNDATI ON	6	498	0	0		194. 0
	2 RETAIL SERVICES	36	2, 568	0	0		194.0
	3 REID CONTRACTED SERVICES 4 REID PHYSICIAN ASSOC.	588	0 1, 043, 084	0	0		194.0 194.0
	5 OTHER NRCC	0	1, 043, 004	0	0		194.0
94.050795		1		-			194.0
194.060795	5 VACANT SPACE	0	0	0	U U		
194.060795 194.080795	B CAMBRI DGE RHC	0	0 21, 442	0	0	0	194. 0
194.060795		0	0 21, 442	0	0	0	

Health Fir	nancial Systems RELD	HOSPI TAL & HEA	ALTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/7/2018 3:57	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,	22, 498, 333	4, 049, 812	3, 971, 51	7 9, 078, 498		202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	9, 854. 723171	0. 445481	0.00501	7 0. 011469		203.00
204.00	Cost to be allocated (per Wkst. B,	4, 166, 709	724, 506	136, 65	1 310, 935		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1, 825. 102497	0. 079696	0.00017	3 0. 000393		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th	Fi nanci al	Systems	
COST A			1

Heal th	Financial Systems RELD	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
				F T	rom 01/01/2017 o 12/31/2017		
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/7/2018 3: 57 DI ETARY	pm
	Cost center beschiption	(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
		<b>`</b>	(SQUARE FEET)	(POUNDS OF	SERVICE)	. ,	
				LAUNDRY)			
	GENERAL SERVICE COST CENTERS	5.06	7.00	8.00	9.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1	1	1			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						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSING						5.02
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00590 OTHER A&G	358, 336, 007					5.06
7.00	00700 OPERATION OF PLANT	7, 137, 208	621, 066				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	956, 941					8.00
9.00	00900 HOUSEKEEPING	2,663,638			12, 784		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 158, 822 2, 336, 398			268 0		10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	442,033			664	0	
	01400 CENTRAL SERVICES & SUPPLY	4, 724, 827			26	-	
15.00	01500 PHARMACY	32, 566, 761	7, 040	0	0	0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	6, 269, 826			44	0	16.00
	01700 SOCIAL SERVICE	3, 262, 362			72		
17.01 21.00	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 674, 720 1, 849, 983			156 0		17.01 21.00
21.00	02200 I &R SERVICES-SALART & FRINGES APPRVD	223, 707			0		21.00
23.00	02300 PARAMED ED PRGM	432, 250		-	0	-	
	INPATIENT ROUTINE SERVICE COST CENTERS			-		-	1
30.00	03000 ADULTS & PEDI ATRI CS	28, 041, 281	108, 140	523, 091	3, 422	32, 758	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 612, 977			922		•
40.00	04000 SUBPROVIDER - IPF	5, 414, 564			718		•
41.00 43.00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 230, 149 718, 547			419 14		•
45.00	ANCI LLARY SERVI CE COST CENTERS	10,347	2,001	0		0	
50.00	05000 OPERATI NG ROOM	28, 596, 574	40, 624	278, 386	1, 111	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 631, 496			193		
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 559, 942			681	0	•
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	8, 533, 049 12, <mark>561,</mark> 461			160 582		59.00 60.00
65.00	06500 RESPIRATORY THERAPY	2, 576, 044			116		65.00
66.00	06600 PHYSI CAL THERAPY	9,037,371			93		66.00
69.00	06900 ELECTROCARDI OLOGY	2, 468, 718			191	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	521, 647			0	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	2, 303			108		
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	14, 464, 907 1, 716, 541		U U	152		72.00
	07400 RENAL DIALYSIS	815, 490		-	168		•
	03950 ANCI LLARY - OTHER	0	0		0		
76.97	07697 CARDI AC REHABI LI TATI ON	389, 818	0	0	58	0	76.97
	OUTPATIENT SERVICE COST CENTERS	0.70/.00/		0.01 170	1		
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 726, 324	22, 772	221, 478	1, 028	0	91.00
	04040 FAMILY PRACTICE	3, 187, 183	405	51, 406	171	0	92.00 93.00
<i>y</i> J. 00	OTHER REIMBURSABLE COST CENTERS	5,107,105	403	51,400	171	0	75.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	568, 623	3, 752	0	0	0	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	3,014,953			123		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	227, 089, 438	441, 296	1, 746, 721	11, 660	1 50, 906	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	3, 273, 080	-		0		192.00
	07950 RENTAL SPACE	4, 514, 460			0		194.00
	07951 FOUNDATION	509, 715			0		194.01
	07952 RETAIL SERVICES	549, 933			10		194.02
	07953 REID CONTRACTED SERVICES 07954 REID PHYSICIAN ASSOC.	198, 871 120, 304, 534		-	0 1, 114		194.03 194.04
	07954 REID PHYSICIAN ASSOC. 07955 OTHER NRCC	9, 280			i, 114 ∩		194.04
	07956 VACANT SPACE	396, 712			0		194.06
	07958 CAMBRI DGE RHC	1, 489, 984			0		194.08
200.00							200.00
201.00		47 050 55	7 .00		0 070 075		201.00
202.00		17, 359, 724	7, 482, 970	1, 151, 919	2, 870, 873	1, 408, 101	202.00
	Part I)		1	1		1	<u> </u>

Heal th Fi	nancial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	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. 048445	12. 048591	0. 65947	5 224. 567663	27.660806	203.00
204.00	Cost to be allocated (per Wkst. B,	734, 232	3, 422, 749	389, 10	4 196, 728	565, 482	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 002049	5. 511087	0. 22276	3 15. 388611	11. 108357	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

alth Financial Systems REID DST ALLOCATION - STATISTICAL BASIS	HUSPITAL & HEA	LTH CARE SERVI Provider C		In Lie Period:	u of Form CMS- Worksheet B-1	
ST ALLUCATION - STATISTICAL DASIS		Provider C		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	par
Cost Center Description	CAFETERI A (MANHOURS)	NURSI NG ADMI NI STRATI ON (DI RECT NURSI NG HRS)	CENTRAL SERVI CES & SUPPLY (MED SUPPLI ES	PHARMACY (DRUGS)	MEDI CAL RECORDS & LI BRARY (TOTAL REVENUE)	
	11.00	13.00	14.00	15.00	16.00	
GENERAL         SERVICE         COST         CENTERS           00         00100         NEW         CAP         REL         COSTS-BLDG & FIXT           01         00101         NEW         CAP         REL         COSTS-BLDG & FIXT           01         00101         NEW         CAP         REL         COSTS-BLDG & FIXT           00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           01         00540         NONPATIENT         TELEPHONES           02         00550         DATA         PROCESSING           03         00560         PURCHASING         RECEIVING         AND           04         00570         ADMITTING         O         O           05         00580         CASHI ERING/ACCOUNTS         RECEIVABLE         O           06         00590         OTHER         A&G         O         O         O         O           05         00580         CASHI ERING/ACCOUNTS         RECEIVABLE         O         O         O         O         O         O         O         O         O         O         O         D         D         EQUIN         D         EQUIN         O         EQUIN <t< td=""><td>3, 626, 352 4, 588 36, 835 116, 540 159, 624 0 24, 857 22, 224 2, 663 5, 409</td><td>1, 395, 298 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>19, 501, 92 25, 71</td><td>1</td><td>791, 568, 023 0 0 0 0 0 0</td><td>17 17 21 22</td></t<>	3, 626, 352 4, 588 36, 835 116, 540 159, 624 0 24, 857 22, 224 2, 663 5, 409	1, 395, 298 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 501, 92 25, 71	1	791, 568, 023 0 0 0 0 0 0	17 17 21 22
INPATI ENT ROUTI NE SERVI CE COST CENTERS           0.00         03000 ADULTS & PEDI ATRI CS           1.00         03100 INTENSI VE CARE UNI T           0.00         04000 SUBPROVI DER - I PF           1.00         04100 SUBPROVI DER - I RF           3.00         04300 NURSERY	599, 920 111, 055 137, 799 39, 634 12, 046	111, 055 137, 799 39, 634	18, 91		45, 334, 465 8, 173, 932 10, 689, 025 3, 342, 665 2, 132, 354	31 40 41
ANCI LLARY SERVI CE COST CENTERS						
0.00         05000         0PERATI NG ROOM           2.00         05200         DELI VERY ROOM & LABOR ROOM           1.00         05400         RADI OLOGY-DI AGNOSTIC           0.00         05900         CARDI AC CATHETERI ZATI ON           0.00         06000         LABORATORY           5.00         06500         RESPI RATORY THERAPY           0.00         06600         PHYSI CAL THERAPY           0.00         06600         ELECTROCARDI OLOGY           0.00         06900         ELECTROCARDI OLOGY           0.00         07000         ELECTROENCEPHALOGRAPHY           0.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           2.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS           3.00         07300         DRUGS CHARGED TO PATI ENTS           4.00         07400         RENAL DI ALYSI S           5.00         03950         ANCI LLARY - OTHER	39, 724 16, 902 179, 328 47, 421 142, 390 44, 934 149, 703 25, 684 7, 692 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16,902 179,328 47,421 0 44,934 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27, 11 69, 10 3, 750, 85 1, 240, 65 7, 21 99	9 677 0 489,073 9 319 7 310 4 28,257 2 371 0 177,253 0 0 0 0 0 0 0 25,853,284 0 993 0 0 0 0	160, 993, 723 7, 424, 077 123, 961, 006 84, 128, 120 79, 104, 494 17, 998, 985 16, 212, 418 24, 140, 612 2, 403, 272 139, 688 26, 544, 582 104, 121, 148 852, 259 0	52 54 59 60 65 66 70 71 72 73 74 74
5. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	7,770	7, 770		0 0	1, 211, 990	76
I. 00 09100 EMERGENCY	158, 765	158, 765	22, 58	0 17, 821	58, 933, 252	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3.00 04040 FAMILY PRACTICE	69, 612	C		0 469	7, 352, 685	92
OTHER REIMBURSABLE COST CENTERS 0.00 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	1, 538		52, 47	5 96	504, 126	
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 HOSPI CE 8. 00 SUBTOTALS (SUM OF LINES 1 through 117)	41, 381 2, 206, 038		65 18, 559, 55		5, 869, 145 791, 568, 023	
NONREI MBURSABLE COST CENTERS           20.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN           22.00         19200         PHYSI CI ANS' PRI VATE OFFI CES           24.00         07950         RENTAL SPACE           24.01         07951         FOUNDATI ON	0 0 0 8, 389	0		0 0 0 0 0 0 0 0	0 0	19( 192 194 194

24, 541

0

0

1, 374, 576

0

0

2, 484, 312

67, 817

0

0

537

941, 830

0 0 0

0 0

0 194.04 0 194.05

0 194.06

0 194.08 200. 00 201. 00

Cross Foot Adjustments

Negative Cost Centers

194.06 07956 VACANT SPACE

MCRI F32 - 14.2.164.1

200.00

201.00

194.08 07958 CAMBRI DGE RHC

194.03 07953 REID CONTRACTED SERVICES

194. 04 07954 REI D PHYSI CI AN ASSOC. 194. 05 07955 OTHER NRCC

Heal th F	inancial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COST ALL	LOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
			_		To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MANHOURS)	ADMI NI STRATI ON		(DRUGS)	RECORDS &	
				SUPPLY		LI BRARY	
				(MED_SUPPLIES)	)	(TOTAL	
			NURSING HRS)			REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B,	2, 568, 541	639, 365	5, 086, 99	1 34, 318, 532	6, 710, 511	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 708299					
204.00	Cost to be allocated (per Wkst. B,	232, 286	125, 114	1, 068, 78	1 705, 096	425, 771	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 064055	0, 089668	0. 05480	0. 024002	0. 000538	205 00
205.00	II)	0. 064055	0. 069000	0.054604	+ 0.024002	0.000538	205.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

In Lieu of Form CMS-2552-10 od: 01/01/2017 Worksheet B-1

COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2017	Worksheet B-1	
				o 12/31/2017	Date/Time Pre	pared:
			INTERNS &	RESI DENTS	5/7/2018 3:57	pm
Cost Center Description	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM.COSTS	PARAMED ED PRGM	
	(TIME SPENT)	(IN HOUSE ED)	(ASSI GNED	(ASSI GNED	(TIME SPENT)	
	17.00	17.01	TI ME)	TIME)	22.00	
GENERAL SERVICE COST CENTERS	17.00	17.01	21.00	22.00	23.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01   00101   NEW CAP BLDG & FLXT - OFFSLTE 2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSI NG						5.02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING						5.03 5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5.06 00590 OTHER A&G						5.06
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15. 00 01500 PHARMACY						15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00 01700 SOCIAL SERVICE	27, 466	· · · · · · · · · · · · · · · · · · ·				17.00
17.01 01701 INSERVICE EDUCATION 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0		851			17.01 21.00
22. 00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0		001	851		21.00
23. 00 02300 PARAMED ED PRGM	0	892			100	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1( 420	20 5(2	( )7	( )7	0	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	16, 438 796			627 44	0	
40. 00 04000 SUBPROVIDER - IPF	0			0	0	
41. 00 04100 SUBPROVI DER - I RF	0			0	0	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	403	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM	0	1, 983	70	70	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	159	· · · · · · · · · · · · · · · · · · ·		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	100	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	1, 995 5, 582		0	0	
65. 00 06500 RESPI RATORY THERAPY	0	2, 725		11	0	
66. 00 06600 PHYSI CAL THERAPY	0	6, 060		0	0	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 261 224		30 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	224		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 ANCI LLARY - 0THER	0	184		0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	308	0	0	0	1
OUTPATIENT SERVICE COST CENTERS	10.070					
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	10, 073	7, 280	69	69	0	91.00 92.00
93. 00 04040 FAMILY PRACTICE	0	1, 563	0	0	0	1
OTHER REI MBURSABLE COST CENTERS	1	-				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED SPECI AL PURPOSE COST CENTERS	0	538	0	0	0	96.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	1, 284			0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	27, 466	87, 690	851	851	100	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
192. 00 19000 PHYSI CLANS' PRI VATE OFFI CES	0		0	0		190.00
194.0007950 RENTAL SPACE	0	0	0	0	0	194.00
194. 01 07951 FOUNDATI ON	0	36		0		194.01
194. 02 07952 RETALL SERVICES 194. 03 07953 RELD CONTRACTED SERVICES	0	73		0		194. 02 194. 03
194. 04 07954 REID PHYSICIAN ASSOC.	0	35, 812	-	0		194.03
194. 05 07955 OTHER NRCC	0	10, 791		0	0	194. 05
194.0607956 VACANT SPACE	0		0	0		194.06
194.08 07958 CAMBRIDGE RHC 200.00 Cross Foot Adjustments	0	1, 513 l		0	0	194. 08 200. 00
201.00 Negative Cost Centers	1					201.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-0048

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/7/2018 3:57 pm INTERNS & RESIDENTS Cost Center Description SOCIAL SERVICE I NSERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED EDUCATI ON Y & FRINGES PRGM. COSTS PRGM (ASSI GNED (ASSI GNED (TIME SPENT) (TIME SPENT) (IN HOUSE ED) TIME) TIME) 17.00 17.01 21.00 22.00 23.00 3, 441, 853 202.00 Cost to be allocated (per Wkst. B, 2,969,253 1, 955, 346 236, 430 510, 328 202. 00 Part I) 203.00 21.846397 2, 297. 703878 277.826087 5, 103. 280000 203. 00 Unit cost multiplier (Wkst. B, Part I) 125. 313224 204.00 Cost to be allocated (per Wkst. B, 88,652 581, 723 5,850 794 118, 956 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 3. 227700 4. 280050 6.874266 0.933020 1, 189. 560000 205. 00 ||)206.00 NAHE adjustment amount to be allocated 0 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

In Lieu of Form CMS-2552-10

Worksheet B-1

Peri od:

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

	HUSFITAL & HLF					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/7/2018 3:57	pared:
					5/7/2018 3:57	pm
		Title	e XVIII	Hospi tal	PPS	
				Costs	·	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	36, 541, 079		36, 541, 0	79 0	36, 541, 079	30.00
31. 00 03100 I NTENSI VE CARE UNI T	9, 168, 266		9, 168, 20			•
40. 00 04000 SUBPROVI DER - I PF	6, 847, 448		6, 847, 44			•
41. 00 04100 SUBPROVI DER – I RF	2, 889, 907		2, 889, 90			
43. 00  04300  NURSERY	829, 735		829, 7			
ANCI LLARY SERVI CE COST CENTERS	029,733		027,7	55 0	829, 735	43.00
50. 00 05000 OPERATING ROOM	22 204 270		22.204.25	70	22.206.270	50.00
	33, 206, 279		33, 206, 2			
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2,039,144		2, 039, 14			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 748, 708		21, 748, 70			
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 898, 156		10, 898, 1			•
60. 00 06000 LABORATORY	14, 681, 600		14, 681, 60		,	
65. 00 06500 RESPI RATORY THERAPY	3, 040, 694					
66. 00 06600 PHYSI CAL THERAPY	10, 463, 284					
69. 00 06900 ELECTROCARDI OLOGY	3, 095, 369		3, 095, 36			
70.00 07000 ELECTROENCEPHALOGRAPHY	646, 170		646, 1			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 852		27, 8			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	18, 144, 446		18, 144, 44			
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 918, 885		32, 918, 88			
74.00 07400 RENAL DIALYSIS	923, 080		923, 08	30 0	923, 080	74.00
76. 00 03950 ANCI LLARY – OTHER	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	447, 794		447, 79	94 0	447, 794	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	11, 933, 169		11, 933, 10	59 0	11, 933, 169	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 425, 302		3, 425, 30	02	3, 425, 302	92.00
93.00 04040 FAMILY PRACTICE	3, 565, 097		3, 565, 04	97 0	3, 565, 097	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	672, 291		672, 29	91 0	672, 291	96.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	3, 465, 345		3, 465, 34	45	3, 465, 345	116.00
200.00 Subtotal (see instructions)	231, 619, 100	0	231, 619, 10	0 00	231, 619, 100	200.00
201.00 Less Observation Beds	3, 425, 302		3, 425, 30	02	3, 425, 302	201.00
202.00 Total (see instructions)	228, 193, 798	0	228, 193, 79	98 0	228, 193, 798	202.00
						•

## REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

		HUSPITAL & HEAL	_TH_CARE_SERVI	JES	In Lie	u of Form CMS-2	2552-
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2017	Worksheet C Part I	
					To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title	XVIII	Hospi tal	PPS	Pin
			Charges				
Со	st Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	IT ROUTINE SERVICE COST CENTERS						
	ULTS & PEDIATRICS	40, 867, 419		40, 867, 41			30. C
	ITENSI VE CARE UNI T	8, 173, 932		8, 173, 93			31. C
	IBPROVIDER – IPF	10, 689, 025		10, 689, 02			40. C
	IBPROVIDER – IRF	3, 342, 665		3, 342, 66			41. C
43.00 04300 NU		2, 132, 354		2, 132, 35	4		43. C
	RY SERVICE COST CENTERS						
	PERATING ROOM	54, 623, 305	106, 370, 418			0.000000	
	LIVERY ROOM & LABOR ROOM	6, 255, 601	1, 168, 476			0.000000	
	DI OLOGY-DI AGNOSTI C	18, 308, 552	105, 652, 454	123, 961, 00		0.000000	
	RDI AC CATHETERI ZATI ON	24, 128, 484	59, 999, 636			0.000000	
	BORATORY	26, 450, 560	52, 653, 934			0.000000	
	SPI RATORY THERAPY	14, 394, 651	3, 604, 334	17, 998, 98		0.000000	
	IYSI CAL THERAPY	5, 980, 114	10, 232, 304	16, 212, 41		0.000000	
	ECTROCARDI OLOGY	3, 505, 303	20, 635, 309	24, 140, 61		0.00000	
	ECTROENCEPHALOGRAPHY	79, 329	2, 323, 943	2, 403, 27		0.000000	
	DICAL SUPPLIES CHARGED TO PATIENTS	131, 369	8, 319	139, 68		0.000000	
	IPL. DEV. CHARGED TO PATIENT	15, 255, 449	11, 289, 133			0.000000	
	RUGS CHARGED TO PATIENTS	35, 193, 136	68, 928, 012	104, 121, 14		0.00000	
	NAL DIALYSIS	790, 735	61, 524	852, 25		0.000000	
	ICI LLARY - OTHER	0	0		0 0.000000	0.000000	
	RDIAC REHABILITATION	5, 197	1, 206, 793	1, 211, 99	0 0. 369470	0.00000	76.9
	ENT SERVICE COST CENTERS						
91.00 09100 EM		9, 482, 218	49, 451, 034			0.000000	
	SERVATION BEDS (NON-DISTINCT PART)	637, 894	3, 829, 152	4, 467, 04		0.000000	
	MILY PRACTICE	7,962	7, 344, 723	7, 352, 68	0. 484870	0.00000	93.0
	EIMBURSABLE COST CENTERS						
	IRABLE MEDI CAL EQUI P-RENTED	0	504 <mark>,</mark> 126	504, 12	1. 333577	0.00000	96.0
	PURPOSE COST CENTERS						
	ITEREST EXPENSE						113. (
116.0011600H0		2, 066, 653	<mark>3,</mark> 802, 49 <mark>2</mark>				116. (
	btotal (see instructions)	282, 501, 907	5 <mark>09, 06</mark> 6, 116	791, 568, 02	3		200. (
	ess Observation Beds otal (see instructions)	282, 501, 907	509, 066, 116				201.0
202.00 To				791, 568, 02			202. C

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared:
				5/7/2018 3:57 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41.00 04100 SUBPROVIDER - IRF				41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00 05000 OPERATING ROOM	0. 206258			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 208258			52.00
54. 00 05400 RADIOLOGY-DIAGNOSTIC	0. 274000			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 175448			59.00
60. 00 06000 LABORATORY	0. 129542			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 168937			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 645387			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 128222			69.00
70. 00 07000 ELECTROEARDFOLOGT	0. 268871			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199387			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 683546			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 316159			72.00
74. 00 07400 RENAL DIALYSIS	1. 083098			73.00
76. 00 03950 ANCI LLARY - OTHER	0. 000000			74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 369470			76.97
OUTPATIENT SERVICE COST CENTERS	0.007170			, 0. , ,
91. 00 09100 EMERGENCY	0. 202486			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 766794	•		92.00
93.00 04040 FAMILY PRACTICE	0. 484870			93.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 333577			96.00
SPECIAL PURPOSE COST CENTERS				
113.0011300 INTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00  Total (see instructions)				202.00

### REID HOSPITAL & HEALTH CARE SERVICES

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0048	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/7/2018 3:57	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00	4.00	5 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	36, 541, 079	1	36, 541, 0	79 0	36, 541, 079	20.00
31. 00 03100 I NTENSI VE CARE UNI T	9, 168, 266		9, 168, 20			
40. 00 04000 SUBPROVI DER - I PF	6, 847, 448		6, 847, 44			
40.00  04000  SUBPROVIDER - TPP 41.00  04100  SUBPROVIDER - TRF	2, 889, 907		2, 889, 90			
41. 00  04100 S0BPROVIDER - TRP 43. 00  04300 NURSERY	829, 735		829, 7			
ANCI LLARY SERVICE COST CENTERS	029,733		027,7	55 0	027,733	43.00
50. 00 05000 OPERATING ROOM	33, 206, 279	1	33, 206, 2	79 0	33, 206, 279	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 039, 144		2, 039, 14			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 748, 708		21, 748, 70			
59. 00 05900 CARDI AC CATHETERI ZATI ON	10, 898, 156		10, 898, 15			
60. 00 06000 LABORATORY	14, 681, 600		14, 681, 60			
65. 00 06500 RESPI RATORY THERAPY	3, 040, 694					
66. 00 06600 PHYSI CAL THERAPY	10, 463, 284					
69. 00 06900 ELECTROCARDI OLOGY	3, 095, 369		3, 095, 30			
70. 00 07000 ELECTROENCEPHALOGRAPHY	646, 170		646, 1			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	27,852		27, 8			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	18, 144, 446		18, 144, 44			
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 918, 885		32, 918, 88			
74. 00 07400 RENAL DIALYSIS	923, 080		923, 08			
	923,080		923,00			1
76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON	447, 794		447, 79		-	
OUTPATIENT SERVICE COST CENTERS	447, 794	1	447,7	74 0	447, 794	/0.9/
91. 00 09100 EMERGENCY	11, 933, 169	1	11, 933, 10	69 0	11, 933, 169	01 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 425, 302		3, 425, 30		3, 425, 302	
93. 00 04040 FAMILY PRACTICE	3, 565, 097		3, 565, 0			
OTHER REI MBURSABLE COST CENTERS	3, 303, 077		3, 303, 0	0	3, 303, 077	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	672, 291		672, 29	91 0	672, 291	96 00
SPECIAL PURPOSE COST CENTERS	012,271		072,2	, 1	072,271	/0.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 H0SPI CE	3, 465, 345		3, 465, 34	45	3, 465, 345	
200.00 Subtotal (see instructions)	231, 619, 100					
201.00 Less Observation Beds	3, 425, 302		3, 425, 30		3, 425, 302	
202.00 Total (see instructions)	228, 193, 798		228, 193, 79			
		' <b>_</b>	1	1	,	

### REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Ti †I	e XIX	Hospi tal	Cost	pili
		Charges			0031	
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	40, 867, 419		40, 867, 41	9		30.0
31.00 03100 INTENSIVE CARE UNIT	8, 173, 932		8, 173, 93	2		31.0
40. 00 04000 SUBPROVIDER - IPF	10, 689, 025		10, 689, 02	5		40.0
41.00 04100 SUBPROVIDER - IRF	3, 342, 665		3, 342, 66			41.0
43. 00 04300 NURSERY	2, 132, 354		2, 132, 35	4		43.0
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	54, 623, 305	106, 370, 418				
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 255, 601	1, 168, 476				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 308, 552	105, 652, 454				
59. 00 05900 CARDI AC CATHETERI ZATI ON	24, 128, 484	59, 999, 636				
60. 00 06000 LABORATORY	26, 450, 560	52, 653, 934	79, 104, 49	4 0. 185598		
65. 00 06500 RESPI RATORY THERAPY	14, 394, 651	3, 604, 334				
66. 00 06600 PHYSI CAL THERAPY	5, 980, 114	10, 232, 304				
69. 00 06900 ELECTROCARDI OLOGY	3, 505, 303	20, 635, 309				
70. 00 07000 ELECTROENCEPHALOGRAPHY	79, 329	2, 323, 943	2, 403, 27			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 369	8, 319	139, 68	8 0. 199387		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	15, 255, 449	11, 289, 133				
73.00 07300 DRUGS CHARGED TO PATIENTS	35, 193, 136	68, 928, 012				
74. 00 07400 RENAL DI ALYSI S	790, 735	61, 524	852, 25			
76.00 03950 ANCI LLARY - OTHER	0	0		0 0.000000		
76. 97 07697 CARDIAC REHABILITATION	5, 197	1, 206, 793	1, 211, 99	0.369470	0.00000	76. 9
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	9, 482, 218					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	637, 894	3, 829, 152				
93. 00 04040 FAMILY PRACTICE	7, 962	7, 344, 723	7, 352, 68	0. 484870	0.00000	93.0
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	504 <mark>, 1</mark> 26	504, 12	6 1.333577	0.000000	96. 0
SPECIAL PURPOSE COST CENTERS				_	1	4
113.00 11300 INTEREST EXPENSE						113.0
116. 00 11600 HOSPI CE	2, 066, 653					116.0
200.00 Subtotal (see instructions)	282, 501, 907	5 <mark>09, 06</mark> 6, 116	791, 568, 02	3		200. 0
201.00 Less Observation Beds	-					201.0
202.00  Total (see instructions)	282, 501, 907	509, 066, 116	791, 568, 02	3		202. 0

earth Financial Systems REI	D HUSPITAL & HEALT	H CARE SERVICES	In Lie	U OF FORM CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0048	Peri od:	Worksheet C
			From 01/01/2017	Part I
			To 12/31/2017	Date/Time Prepare
				5/7/2018 3:57 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
). 00 03000 ADULTS & PEDIATRICS				30
. 00 03100 INTENSIVE CARE UNIT				31
0. 00 04000 SUBPROVIDER - IPF				40
. 00 04100 SUBPROVIDER - IRF				41
. 00 04300 NURSERY				43
ANCI LLARY SERVI CE COST CENTERS				
	0.000000			
00 05000 OPERATING ROOM	0. 000000			50
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
0. 00 06000 LABORATORY	0. 000000			60
00 06500 RESPI RATORY THERAPY	0. 000000			65
. 00 06600 PHYSI CAL THERAPY	0. 000000			66
. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			
				70
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72
00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
. 00 07400 RENAL DIALYSIS	0. 000000			74
0. 00 03950 ANCI LLARY - OTHER	0. 000000			76
5. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76
OUTPATIENT SERVICE COST CENTERS				
. 00 09100 EMERGENCY	0.000000			91
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	•		92
3. 00 04040 FAMILY PRACTICE	0. 000000			93
OTHER REIMBURSABLE COST CENTERS	0.000000			///
	0. 000000			96
	0.000000			90
SPECIAL PURPOSE COST CENTERS				
3.00 11300 INTEREST EXPENSE				113
6. 00 11600 HOSPI CE				116
0.00 Subtotal (see instructions)				200
1.00 Less Observation Beds				201
2.00 Total (see instructions)				202
				1

		LTH CARE SERVI			u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (	COSTS	Provider C		Period: From 01/01/2017	Worksheet D	
				To 12/31/2017		narod
				10 12/31/2017	5/7/2018 3: 57	
		Title	XVIII	Hospi tal	PPS	-1
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 346, 607	0	4, 346, 60	33, 252	130.72	30.00
31.00 INTENSIVE CARE UNIT	1, 248, 212		1, 248, 21	2 4, 759	262.28	31.00
40. 00 SUBPROVIDER - IPF	807, 930	0	807, 93	0 10, 080	80.15	40.00
41.00 SUBPROVIDER – IRF	588, 978	0	588, 97	8 3, 152	186.86	41.00
43.00 NURSERY	81, 897		81, 89	7 1, 956	41.87	43.00
200.00 Total (lines 30 through 199)	7,073,624		7, 073, 62	4 53, 199		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
	0 0	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 ADULTS & PEDIATRICS	18, 507	2, 419, 235				30.00
31.00 INTENSIVE CARE UNIT	1, 756	460, 564				31.00
40. 00 SUBPROVIDER - IPF	6, 095	488, 514				40.00
41.00 SUBPROVIDER – IRF	1, 747	326, 444				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	28,105	3, 694, 757				200.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT,	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	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				1	-	
50.00 05000 OPERATING ROOM	3, 054, 190	160, 993, 723	0. 01897	1 34, 775, 595		
52.00 05200 DELIVERY ROOM & LABOR ROOM	351, 727	7, 424, 077	0. 04737	7 60, 018	2, 843	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 235, 487	123, 961, 006	0. 02610	17, 054, 856	445, 149	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,004,030	84, 128, 120	0. 01193	35 15, 184, 188	181, 223	59.00
60. 00 06000 LABORATORY	1, 095, 046			17, 374, 466	240, 515	60.00
65. 00 06500 RESPI RATORY THERAPY	170, 404	17, 998, 985	0. 00946	57 11, 103, 629	105, 118	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 686, 650	16, 212, 418	0. 10403	2, 130, 926	221, 689	66.00
69. 00 06900 ELECTROCARDI OLOGY	397, 438	24, 140, 612	0. 01646	2, 672, 226	43, 993	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	159, 909	2, 403, 272	0. 06653	59, 640	3, 968	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 821	139, 688	0. 01303	67, 511	880	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	637, 515	26, 544, 582	0. 02401	7 9, 988, 386	239, 891	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	741, 335	104, 121, 148	0. 00712	21, 080, 113	150, 090	73.00
74.00 07400 RENAL DIALYSIS	48, 731	852, 259	0. 05717	79 529, 613	30, 283	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	108, 874	1, 211, 990	0. 08983	3, 956	355	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	1, 121, 559	58, 933, 252	0.01903	8, 445, 674	160, 730	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	407, 443	4, 467, 046	0. 09121	1 605, 768	55, 253	92.00
93. 00 04040 FAMILY PRACTICE	324,012	7, 352, 685	0. 04406	7, 294		
OTHER REIMBURSABLE COST CENTERS						1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	149, 540	504, 126	0. 29663	32 0	0	96.00
200.00 Total (lines 50 through 199)	14, 695, 711	720, 493, 483		141, 143, 859	2, 542, 029	200.00
					•	•

	cial Systems IT OF INPATIENT ROUTINE SERVICE OTH	RELD HOSPITAL & HEAL			Period:	eu of Form CMS-: Worksheet D	2002-
	I OF INFAILENT ROUTINE SERVICE OF				From 01/01/2017 To 12/31/2017	Part III Date/Time Pre	pared
				XVIII	Hospi tal	5/7/2018 3:57 PPS	pm
	Cost Conton Decemination	Numerius and Cales and					
	Cost Center Description	Post-Stepdown	Nursing school	Post-Stepdown	Allied Health Cost	All Other Medical	
					COST		
		Adjustments 1A	1 00	Adjustments 2A	2.00	Education Cost	
		IA	1.00	ZA	2.00	3.00	
	I ENT ROUTI NE SERVI CE COST CENTERS				-		1
	ADULTS & PEDIATRICS	0	0		0 0		
	INTENSIVE CARE UNIT	0	0		0 0		
	SUBPROVIDER - IPF	0	0		0 0		
	SUBPROVIDER – IRF	0	0	(	0 0	0	
. 00 04300	NURSERY	0	0	(	0 0	0	43.0
0.00	Total (lines 30 through 199)	0	0	(	0 0	0	200. (
	Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	I npati ent	
		Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
		Amount (see	1 through 3,				
		instructions)	minus col. 4)				
		4.00	5.00	6.00	7.00	8.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS	I					
	ADULTS & PEDIATRICS	0	0	33, 25	2 0.00	18, 507	30. (
	INTENSIVE CARE UNIT		0	4, 75			
	SUBPROVIDER - IPF	0	0	10, 08			
	SUBPROVIDER - IRF	0	. 0	3, 15			
	NURSERY	0	0	1, 95			
0.00	Total (lines 30 through 199)		0				
0.00	Cost Center Description	I npati ent	PSA Adi . Al I	55, 17	7	28, 105	200.0
	cost center bescription		Other Medical				
			Education Cost				
			Education Cost				
		Cost (col. 7 x					
		col . 8)	12.00				
		9.00	13.00				
	I ENT ROUTI NE SERVI CE COST CENTERS						1
	ADULTS & PEDIATRICS	0	0				30.0
	I NTENSI VE CARE UNI T	0	0				31. (
	SUBPROVIDER - IPF	0	0				40.0
	SUBPROVI DER – I RF	0	0				41. (
	NURSERY	0	0				43.0
0.00	Total (lines 30 through 199)	0	0				200. (

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE ROUGH COSTS Cost Center Description ANCILLARY SERVICE COST CENTERS 00 05000 DEFEATING ROOM	Non Physician	Ti tl e	XVIII Nursing Schoo	Period: From 01/01/2017 To 12/31/2017 Hospital I Allied Health Post-Stepdown Adjustments 3A	Date/Time Pre 5/7/2018 3:57 PPS	pared: _pm
ANCI LLARY SERVI CE COST CENTERS	Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing Schoo	I Allied Health Post-Stepdown Adjustments	Allied Health	
ANCI LLARY SERVI CE COST CENTERS	Anesthetist Cost	Post-Stepdown Adjustments		Post-Stepdown Adjustments		
00 05000 OPERATI NG ROOM	Cost	Adjustments		Adjustments	3.00	
00 05000 OPERATI NG ROOM			2.00		3.00	
00 05000 OPERATI NG ROOM	1.00	2A C	2.00	3A	3.00	
00 05000 OPERATI NG ROOM	000000000000000000000000000000000000000	C	1			
	0	C				
	0		1	0 0	0	50.00
00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	510, 328	54.OC
00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
00 06000 LABORATORY	0	C		0 0	0	60. OC
00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
00 06600 PHYSI CAL THERAPY	0	) c		0 0	0	66.00
00 06900 ELECTROCARDI OLOGY	0	) c		0 0	0	69.00
00 07000 ELECTROENCEPHALOGRAPHY	0	) c		0 0	0	70.00
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	) c		0 0	0	71.00
00 07200 IMPL. DEV. CHARGED TO PATIENT	0	) c		0 0	0	72.00
00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
00 07400 RENAL DI ALYSI S	0			0 0	0	
00 03950 ANCI LLARY - OTHER	0			0 0	0	76.00
97 07697 CARDI AC REHABI LI TATI ON	0			0 0	0	
OUTPATIENT SERVICE COST CENTERS				- <u>-</u>		
00 09100 EMERGENCY	0		)	0 0	0	1 91. OC
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
00 04040 FAMILY PRACTICE	0	C C		0 0	0	
OTHER REIMBURSABLE COST CENTERS				· · · · ·		
00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	96.00
D. 00 Total (lines 50 through 199)	0			0 0	510, 328	

Heal th	Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2017 Fo 12/31/2017		pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 160, 993, 723	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	7, 424, 077	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	510, 328	510, 32	3 123, 961, 006	0.004117	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0 84, 128, 120	0.00000	59.00
60.00	06000 LABORATORY	0	0	(	79, 104, 494	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	0 17, 998, 985	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0 16, 212, 418	0.000000	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0	(	24, 140, 612	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	2, 403, 272	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		139, 688	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		26, 544, 582	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 104, 121, 148	0.000000	73.00
74.00	07400 RENAL DI ALYSI S	0	0		852, 259	0.000000	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	(	0 0	0.000000	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	(	1, 211, 990	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0	0	(	58, 933, 252	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		4, 467, 046		1
93.00	04040 FAMILY PRACTICE	0	0	(	7, 352, 685		1
	OTHER REIMBURSABLE COST CENTERS						1
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(	504, 126	0.00000	96.00
200.00	Total (lines 50 through 199)	0	510, 328	510, 32			200.00

Heal th	Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	I ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	VICE OTHER PASS	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/7/2018 3:57	pared: pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	34, 775, 595		0 33, 151, 234	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	60, 018		0 3, 897	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 004117	17, 054, 856	70, 21	5 39, 739, 963	163, 609	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	15, 184, 188		0 31, 015, 130	0	59.00
60.00	06000 LABORATORY	0. 000000	17, 374, 466		0 8, 751, 734	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	11, 103, 629		0 1, 758, 456	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 130, 926		0 13, 152	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	2, 672, 226		0 12, 574, 279	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	59, 640		0 994, 998	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	67, 511		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	9, 988, 386		0 5, 091, 412	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 080, 113		0 30, 456, 002	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	529, 613		0 37, 855	0	74.00
76.00	03950 ANCI LLARY - OTHER	0.000000	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0.000000	3, 956		0 597, 342	0	76.97
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	0.00000	8, 445, 674		0 18, 567, 823	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	605, 768		0 1, 080, 161	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	7, 294		0 1, 992, 185	0	93.00
	OTHER REIMBURSABLE COST CENTERS			•		•	1
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000	0		0 0	0	96.00
200.00	Total (lines 50 through 199)		141, 143, 859	70, 21	5 185, 825, 623	163, 609	200.00
	-						

Health Financial Systems REID	HOSPITAL & HEALTH	CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CC	CN: 15-0048	Period: From 01/01/2017	Worksheet D Part IV	
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	PSA Adj. Non PS	SA Adj. All		•		
		her Medical				
		ucation Cost				
	Cost					
	21.00	24.00				
ANCI LLARY SERVI CE 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	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				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						_
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93.00 04040 FAMILY PRACTICE	0	0				93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00   Total (lines 50 through 199)	0	0				200. 00

Health Financial Systems REID APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D HOSPITAL & HEA D VACCINE COST	Provider C		Peri od:	u of Form CMS- Worksheet D	2002-10
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Title	XVIII	Hospi tal	PPS	pili
			Charges	nospi tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	()	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 206258	33, 151, 234		0 0	6, 837, 707	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 274666	3, 897		0 0	1, 070	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 175448	39, 739, 963		0 0	6, 972, 297	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 129542	31, 015, 130		0 0	4, 017, 762	59.00
60. 00 06000 LABORATORY	0. 185598	8, 751, 734	2, 88	3 0	1, 624, 304	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 168937	1, 758, 456		0 0	297, 068	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 645387	13, 152		0 0	8, 488	66.00
69.00 06900 ELECTROCARDI OLOGY	0. 128222	12, 574, 279		0 0	1, 612, 299	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 268871	994, 998		0 0	267, 526	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199387	0		0 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 683546	5, 091, 412		0 0	3, 480, 214	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 316159			5 118, 668		
74.00 07400 RENAL DIALYSIS	1. 083098			0 0	41,001	
76.00 03950 ANCI LLARY - OTHER	0. 000000			0 0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 369470	597, 342		0 0	220, 700	76.97
OUTPATIENT SERVICE COST CENTERS					· · · ·	
91.00 09100 EMERGENCY	0. 202486	18, 567, 823		0 0	3, 759, 724	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 766794	1, 080, 161		0 0	828, 261	92.00
93.00 04040 FAMILY PRACTICE	0, 484870	1, 992, 185		0 0	965, 951	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 333577	0		0 0	0	96.00
200.00 Subtotal (see instructions)		185, 825, 623	3, 09	8 118, 668	40, 563, 311	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		185, 82 <mark>5,</mark> 623	3, 09	118, 668	40, 563, 311	202.00

RTIONMENT OF MEDICAL, OTHER HEALTH SERVICES /			CN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepa 5/7/2018 3:57 p	are om
		Titl∈	XVIII	Hospi tal	PPS	
	Cos					
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 SERVI CE COST CENTERS			1		r	<b>г</b> о
0 05000 OPERATING ROOM	0	0				50.
0 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.
0 05400 RADI OLOGY-DI AGNOSTI C 0 05900 CARDI AC CATHETERI ZATI ON	0	-				54.
	0	0				59.
	535	0				60.
	0	0				65. , ,
0 06600 PHYSI CAL THERAPY	0	0				66. ( )
	0	0				69. 70
0 07000 ELECTROENCEPHALOGRAPHY	0	0				70.
0 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
0 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				72.
0 07300 DRUGS CHARGED TO PATIENTS	68	37, 518	1			73.
0 07400 RENAL DIALYSIS	0	0				74.
0 03950 ANCI LLARY - OTHER	0	0				76.
07 07697 CARDI AC REHABI LI TATI ON	0	0				76.
OUTPATIENT SERVICE COST CENTERS			1			~ 1
	0	0				91.
0 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 93.
0 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS		U				93.
0 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.
00 Subtotal (see instructions)	603	37, 518				90. 00.
00 Less PBP Clinic Lab. Services-Progra		37, 310				00. 01.
Only Charges					20	JT.
00 Net Charges (line 200 - line 201)	603	37, 518			20	02.
ool [Net charges (The 200 - The 201)	1 003	57, 516			120	JZ.
		N				
	1					
	$\mathbf{O}$					

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		Peri od:	Worksheet D	
		Component	CCN: 15-S048	From 01/01/2017 To 12/31/2017	Part II	norod.
		component	CCN: 15-5048	10 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Title	× XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description		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	0.054.400	1 / 0 000 700	0.0400			
50. 00 05000 OPERATI NG ROOM	3, 054, 190				900	
52.00 05200 DELIVERY ROOM & LABOR ROOM	351, 727				0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 235, 487				13, 426	
59.00 05900 CARDI AC CATHETERI ZATI ON	1,004,030				24	
60. 00 06000 LABORATORY	1, 095, 046				10, 250	
65.00 06500 RESPI RATORY THERAPY	170, 404				4, 047	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 686, 650					
69.00 06900 ELECTROCARDI OLOGY	397, 438				592	
70. 00 07000 ELECTROENCEPHALOGRAPHY	159, 909				83	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 821	139, 688			0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	637, 515				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	741, 335				8, 266	
74.00 07400 RENAL DIALYSIS	48, 731	852, 259			1, 046	
76.00 03950 ANCI LLARY – OTHER	0	0	0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	108, 874	1, 211, 990	0. 08983	31 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	1, 121, 559				11, 336	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4, 467, 046			0	92.00
93. 00 04040 FAMILY PRACTICE	324, 012	7, <mark>352</mark> , 685	0. 04406	57 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	149, 540				0	
200.00  Total (lines 50 through 199)	14, 288, 268	720, 493, 483	I	3, 820, 147	78, 721	200. 00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S048	From 01/01/2017 To 12/31/2017		nared
		component	CON. 13 3040	10 12/31/2017	5/7/2018 3: 57	
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00	SA	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 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 0	510, 328	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	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	C	)	0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY	0	C	)	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	c		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	C		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						
91. 00 09100 EMERGENCY	0	C		0 0	U U	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
93. 00 04040 FAMILY PRACTICE	0	0		0 0	0	93.00
OTHER REI MBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		1	0	0	
200.00  Total (lines 50 through 199)	1 0	r o	1	0	510, 328	200.00

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	narod
			component	UCN. 15-3040	10 12/31/2017	5/7/2018 3: 57	pareu. pm
-			Title	e XVIII	Subprovider -	PPS	-
					I PF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,	J J	
		Education Cost	5	Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	(8	7)	
		4.00	F 00	4)	7.00	8,00	
	ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50,00	05000 OPERATI NG ROOM	0	0		0 160, 993, 723	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 7, 424, 077		
52.00	05400 RADI OLOGY-DI AGNOSTI C	0	510, 328	510, 32			
54.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	510, 526	510, 52	0 84, 128, 120		
60.00	06000 LABORATORY	0	0		0 79, 104, 494		
65.00	06500 RESPIRATORY THERAPY	0	0		0 17, 998, 985		
66.00	06600 PHYSI CAL THERAPY	0	0		0 16, 212, 418		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 24, 140, 612		
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2, 403, 272		•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 403, 272		
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 26, 544, 582		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 104, 121, 148		•
	07400 RENAL DI ALYSI S	0	0		0 852, 259		•
	03950 ANCI LLARY - OTHER	0	0		0 0	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	Ō		0 1, 211, 990		
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	I	0 58, 933, 252	0.00000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 4, 467, 046	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0		0 7, 352, 685	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS						]
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 504, 126	0.00000	96.00
200.00	Total (lines 50 through 199)	0	510, 328	510, 32	8 720, 493, 483		200.00

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C		Period:	Worksheet D	
THROUGH COSTS		Component (		From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	narod
		component	JON: 13-3040	10 12/31/2017	5/7/2018 3: 57	pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0. 000000	47, 437		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 004117	514, 372			13	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 029		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	740, 411		0 314	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	427, 491		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	276, 364		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	35, 947		0 84	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 244		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 160, 930		0 668	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	18, 285		0 0	0	74.00
76. 00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	0. 000000	595, 637		0 3, 918	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
93.00 04040 FAMILY PRACTICE	0. 000000	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		3, 820, 147	2, 11	8 8, 079	13	200. 00

MCRIF32 - 14.2.164.1

Health Financial Systems REID	HOSPI TAL & HEAL	TH CARE SERVICE	S	In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider CCN	: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component CC	N. 15 5049	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	narod
		component co	N. 15-5046	10 12/31/2017	5/7/2018 3: 57	pareu. 7 pm
		Title >	XVI I I	Subprovider -	PPS	
				I PF		
Cost Center Description		PSA Adj. All				
		Other Medical				
		ducation Cost				
	Cost	24.00				
ANCI LLARY SERVI CE COST CENTERS	21.00	24.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60, 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				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						
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
93. 00 04040 FAMILY PRACTICE	0	0				93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
200.00  Total (lines 50 through 199)	0	0				200. 00

Health Financial Systems REII APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D HOSPITAL & HEA D VACCINE COST	Provider C	CN: 15-0048	Period: From 01/01/2017	u of Form CMS- Worksheet D Part V	
		•	CCN: 15-SO48	To 12/31/2017		
		Title	e XVIII	Subprovider - IPF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 206258			0 0	0	1 00.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 274666	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 175448	3, 095		0 0	543	54.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 129542	0		0 0	0	59.0
50. 00 06000 LABORATORY	0. 185598	314		0 0	58	60.0
55. 00 06500 RESPI RATORY THERAPY	0. 168937	0		0 0	0	
6. 00 06600 PHYSI CAL THERAPY	0. 645387	0		0 0	0	66.0
9. 00 06900 ELECTROCARDI OLOGY	0. 128222	84		0 0	11	69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	0. 268871	0		0 0	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199387	0		0 0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 683546	0		0 0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 316159	668		0 4, 953	211	73.0
4.00 07400 RENAL DIALYSIS	1.083098	0		0 0	0	74.0
76. 00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 369470	0		0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS						1
01.00 09100 EMERGENCY	0. 202486	3, 918		0 0	793	91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 766794	0		0 0	0	92.0
93.00 04040 FAMILY PRACTICE	0. 484870	0		0 0	0	93.0
OTHER REIMBURSABLE COST CENTERS						
06. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 333577	0		0 0	0	96.0
200.00 Subtotal (see instructions)		8, 079		0 4, 953	1, 616	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.0
Only Charges						
202.00 Net Charges (line 200 - line 201)		8, 079		0 4, 953	1, 616	202.00

Health Financial Systems REID	HOSPITAL & HEALTH	I CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Period: From 01/01/2017	Worksheet D Part V	
		Component	CCN: 15-SO48	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	epared: / pm
		Title	e XVIII	Subprovider - IPF	PPS	
	Costs				1	
Cost Center Description	Cost	Cost				
		Reimbursed ervices Not				
		Subject To				
	Ded. & Coins. De	d. & Coins.				
		see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	-		1			
50. 00 O5000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				54.00 59.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 566				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				76.97
OUTPATIENT SERVICE COST CENTERS			1			
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 93. 00 04040 FAMILY PRACTICE	0	0				92.00
073. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0	0				93.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0				96.00
200.00 Subtotal (see instructions)	0	1, 566				200.00
201.00 Less PBP Clinic Lab. Services-Program	Ő	1,000				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	1, 566				202.00
▼						

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period:	Worksheet D	
		Component		From 01/01/2017 To 12/31/2017		narod
		component	CCN. 15-1046	10 12/31/2017	5/7/2018 3: 57	
		Title	× 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	2 054 100	1(0 000 700	0.01007	1 45.0(2	870	
50.00 05000 OPERATING ROOM	3, 054, 190					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	351, 727				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 235, 487					
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,004,030					
	1,095,046					
65. 00 06500 RESPI RATORY THERAPY	170, 404					
66.00 06600 PHYSI CAL THERAPY	1, 686, 650					
69. 00 06900 ELECTROCARDI OLOGY	397, 438					
70. 00 07000 ELECTROENCEPHALOGRAPHY	159, 909					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	1, 821	139, 688			•	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	637, 515					
73. 00 07300 DRUGS CHARGED TO PATIENTS	741, 335					•
74. 00 07400 RENAL DI ALYSI S	48, 731	852, 259				74.00
76.00 03950 ANCI LLARY - OTHER	0	0	0.00000		° °	
76. 97 07697 CARDI AC REHABI LI TATI ON	108, 874	1, 211, 990	0. 08983	1 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	4 404 550	50,000,050	0.01000	4 5 5 ( 0	10/	0.1 0.0
91.00 09100 EMERGENCY	1, 121, 559					
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	4, 467, 046			0	
93. 00 04040 FAMILY PRACTICE	324, 012	7, 352, 685	0. 04406	/ 0	0	93.00
	140 540	E04 104	0.00((2	2 0		04 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	149, 540				Ű	
200.00   Total (lines 50 through 199)	14, 288, 268	720, 493, 483	1	2, 261, 826	156, 585	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	VICE OTHER PAS	S Provider C	CN: 15-0048	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T048	From 01/01/2017 To 12/31/2017		pared:
					5/7/2018 3:57	
		Titl€	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description				Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown Adjustments		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00	JA	3.00	
50. 00 05000 OPERATING ROOM	0	(	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	510, 328	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0.07020	59.00
60, 00 06000 LABORATORY	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	l c		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c c		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C		0 0	0	74.00
76. 00 03950 ANCI LLARY – OTHER	0	C	)	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C	)	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
93. 00 04040 FAMILY PRACTICE	0	C	)	0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS	-		1	-	-	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	0	
200.00  Total (lines 50 through 199)	0	r C	P	0 0	510, 328	200.00

Heal th	Financial Systems RELD	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	6 Provider C		Peri od:	Worksheet D	
THROUG	H COSTS		Composite		From 01/01/2017	Part IV	
			component	CCN: 15-T048	Го 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title	XVIII	Subprovider -	PPS	
					I RF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
		4.00	F 00	4)	7.00	0.00	
		4.00	5.00	6.00	7.00	8.00	
F0 00	ANCI LLARY SERVICE COST CENTERS		0		1(0 000 700	0.000000	
50.00	05000 OPERATING ROOM	0	0		160, 993, 723		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	540.00	7, 424, 077		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	510, 328	510, 32			1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 84, 128, 120		
60.00	06000 LABORATORY	0	0		79, 104, 494		
65.00	06500 RESPI RATORY THERAPY	0	0		17, 998, 985		
66.00	06600 PHYSI CAL THERAPY	0	0		16, 212, 418		
69.00	06900 ELECTROCARDI OLOGY	0	0		24, 140, 612		
	07000 ELECTROENCEPHALOGRAPHY	0	0		2, 403, 272		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		139, 688		
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		26, 544, 582		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 104, 121, 148		
	07400 RENAL DIALYSIS	0	0		0 852, 259		
	03950 ANCI LLARY – OTHER	0	0		0 0	0.00000	•
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		1, 211, 990	0.00000	76.97
	OUTPATIENT SERVICE COST CENTERS			1			
91.00	09100 EMERGENCY	0	0		58, 933, 252		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		4, 467, 046		
93.00	04040 FAMILY PRACTICE	0	0		7, 352, 685	0.00000	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	-		504, 126		
200.00	Total (lines 50 through 199)	0	510, 328	510, 32	3 720, 493, 483		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	RVICE OTHER PASS	Provider C	CN: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T048	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	norod.
		component	JUN. 13-1040	10 12/31/2017	5/7/2018 3: 57	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	45, 863		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 004117	63, 196		50 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	174		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	206, 946		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	177, 220		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 404, 879		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	4, 536		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	671		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 130		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	338, 156		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	11, 493		0 0	0	74.00
76. 00 03950 ANCI LLARY – OTHER	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			_		_	
91.00 09100 EMERGENCY	0. 000000	5, 562		0 160	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
93.00 04040 FAMILY PRACTICE	0. 000000	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0		
200.00 Total (lines 50 through 199)		2, 261, 826	20	50 160	0	200.00

Health Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVICE	S	In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CCN	: 15-0048	Peri od:	Worksheet D	
THROUGH COSTS		Component CC	N· 15_T048	From 01/01/2017 To 12/31/2017	Part IV	narod
		component co	N. 15 1040	10 12/31/2017	Date/Time Pre 5/7/2018 3:57	pm cu.
		Title >	KVI I I	Subprovider -	PPS	<u> </u>
				I RF		
Cost Center Description		PSA Adj. All Other Medical				
		ducation Cost				
	Cost					
	21.00	24.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o				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	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				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						
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	-0	0				92.00
93. 00 04040 FAMILY PRACTICE	0	0				93.00
OTHER REI MBURSABLE COST CENTERS 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED						96.00
	0	0				200.00
200.00  Total (lines 50 through 199)	l VI	U				1200. OU

MCRIF32 - 14.2.164.1

APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	'	CCN: 15-T048	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title	× XVIII	Subprovider - IRF	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	
	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	0. 206258	0		0 0	0	
2.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 274666	0		0 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 175448	0		0 0	0	54.00
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 129542	0		0 0	0	59.00
0.00	D6000 LABORATORY	0. 185598	0		0 0	0	60.00
5.00	06500 RESPI RATORY THERAPY	0. 168937	0		0 0	0	65.00
6.00	D6600 PHYSI CAL THERAPY	0. 645387	0		0 0	0	
9.00	D6900 ELECTROCARDI OLOGY	0. 128222	0		0 0	0	69.00
0.00	07000 ELECTROENCEPHALOGRAPHY	0. 268871	0		0 0	0	70.00
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199387	0		0 0	0	71.00
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 683546	0		0 0	0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 316159	0		0 192	0	73.00
4.00	07400 RENAL DIALYSIS	1. 083098	0		0 0	0	74.00
6.00	03950 ANCI LLARY - OTHER	0.00000	0		0 0	0	76.00
6.97	07697 CARDI AC REHABI LI TATI ON	0. 369470	0		0 0	0	76.9
	DUTPATIENT SERVICE COST CENTERS			_			
1.00	09100 EMERGENCY	0. 202486	160		0 0	32	91.00
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 766794	0		0 0	0	92.00
	D4040 FAMILY PRACTICE	0. 484870	0		0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1. 333577	0		0 0	0	96.00
00.00	Subtotal (see instructions)		160		0 192	32	200.00
01.00	Less PBP Clinic Lab. Services-Program				0 0	l	201.00
	Only Charges					1	
202.00	Net Charges (line 200 - line 201)		160		0 192	32	202.00

	D HOSPITAL & HEALTI	H CARE SERVI	CES	In Lie	u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C	CN: 15-0048	Period: From 01/01/2017	Worksheet D Part V	
		Component	CCN: 15-T048	To 12/31/2017	Date/Time Pre	epared:
		Title	e XVIII	Subprovider -	5/7/2018 3:5 PPS	/ pm
	Conto			I RF		
Cost Center Description	Costs	Cost	-			
		Reimbursed				
		ervices Not				
		Subject To				
		d. & Coins.				
	(see inst.) ( 6.00	<u>(see inst.)</u> 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	<u> </u>			
0.00 05000 OPERATING ROOM	0	C	)			50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	C				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	•			54.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.0
D. 00 06000 LABORATORY	0	C	•			60. C
5. 00 06500 RESPI RATORY THERAPY	0	C	1			65.0
5. 00 06600 PHYSI CAL THERAPY	0	C	1			66.0
2. 00 06900 ELECTROCARDI OLOGY 0. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	•			69. C
1. 00 07100 ELECTROENCEPHALOGRAPHY 1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	1			71.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		•			72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	61				73.0
4. 00 07400 RENAL DIALYSIS	0	C				74.0
6. 00 03950 ANCI LLARY - OTHER	0	Ċ	•			76.0
6. 97 07697 CARDI AC REHABI LI TATI ON	0	C				76.9
OUTPATIENT SERVICE COST CENTERS						
1.00 09100 EMERGENCY	0	C				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.0
3. 00 04040 FAMILY PRACTICE	0	C	)			93.0
OTHER REIMBURSABLE COST CENTERS 6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	C	N.			96.0
00.00 Subtotal (see instructions)	0	61				200.0
01.00 Less PBP Clinic Lab. Services-Program	0	01				200.0
Only Charges	Ŭ					201.0
02.00 Net Charges (line 200 - line 201)	0	61				202.0

	HOSPI TAL & HEA				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2017 To 12/31/2017		narodi
				10 12/31/2017	5/7/2018 3:57	pareu. pm
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
···· F···		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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 206258	0	1, 248, 51	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 274666	0	86, 78	9 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 175448	0	2, 092, 71	8 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 129542	0	340, 85	7 0	0	59.00
60. 00 06000 LABORATORY	0. 185598	0	1, 055, 16	5 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 168937	l o	82, 94	o o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 645387		579, 57		0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 128222		222, 64		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0, 268871	0	38, 53		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 199387	0	6		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 683546		112, 20		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 316159		1, 305, 83		0	1
74. 00 07400 RENAL DI ALYSI S	1. 083098		2,09		0	
76. 00 03950 ANCI LLARY - OTHER	0. 000000		_,	0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 369470		6, 06	5 0	0	
OUTPATIENT SERVICE COST CENTERS			-,		-	
91.00 09100 EMERGENCY	0. 202486	0	1, 774, 35	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART)	0. 766794				0	
93.00 04040 FAMILY PRACTICE	0. 484870		124, 30		0	
OTHER REIMBURSABLE COST CENTERS			121,00	,		1 101 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 333577	0		0 0	0	96.00
200.00 Subtotal (see instructions)		0	9, 261, 65	•	0	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ŭ	,,201,00	0 0	Ū	200.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	9, 261, 65	4 0	0	202.00
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	., 0	Ŭ	

alth Financial Systems REID PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	HOSPITAL & HEAI		CCN: 15-0048	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet D Part V Date/Time Pre 5/7/2018 3:57	epare
		Tit	le XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
. 00 05000 OPERATING ROOM	257, 517		0			50.
. 00 05200 DELIVERY ROOM & LABOR ROOM	23, 838		ol			52.
00 05400 RADI OLOGY-DI AGNOSTI C	367, 163		0			54.
00 05900 CARDI AC CATHETERI ZATI ON	44, 155		ol			59.
00 06000 LABORATORY	195, 837		0			60.
00 06500 RESPIRATORY THERAPY	14,012		0			65.
00 06600 PHYSI CAL THERAPY	374, 053					66.
	28, 548					69.
00 07000 ELECTROENCEPHALOGRAPHY	10, 360					70.
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	13					71.
. 00 07200 I MPL. DEV. CHARGED TO PATIENT	76, 700		o			72.
00 07300 DRUGS CHARGED TO PATIENTS	412, 851		0			73.
. 00 07400 RENAL DIALYSIS	2, 264		0			74.
. 00 03950 ANCI LLARY - OTHER	0		0			76.
. 97 07697 CARDIAC REHABILITATION	2, 241		0			76.
OUTPATIENT SERVICE COST CENTERS						
. 00 09100 EMERGENCY	359, 282		0			91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	144, 918		0			92.
. 00 04040 FAMILY PRACTICE	60, 273		o			93.
OTHER REIMBURSABLE COST CENTERS						
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0			96.
0.00 Subtotal (see instructions)	2, 374, 025		ol			200.
1.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						
2.00 Net Charges (line 200 - line 201)	2, 374, 025		ol			202.
		N	0			
	1					
V						

REI D	HOSPI	TAL	&	HEALTH	CARE	SERVI	CES

	Financial Systems REID HOSPITAL & HEALTH			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/7/2018 3:57	pared:
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days			33, 252	1.00
2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			33, 252	
3.00	Private room days (excluding swing-bed and observation bed day		rivate room days	55, 252	
5.00	do not complete this line.	ys). It you have only pr	rvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		30, 135	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	
	reporting period				
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		01 6 11		
. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	- 31 OF THE COST	0	7.00
3.00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	and the cost	0	8.00
3. 00	reporting period (if calendar year, enter 0 on this line)	in days) at ter becember t	ST OF THE COST	0	0.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	18, 507	9.00
	newborn days)		,		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en				10.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	only (including privat	te room days)	0	12.00
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	Y only (including privat	to room dave)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar ye			0	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14.00
15.00	Total nursery days (title V or XIX only)		uujo)	0	
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				1
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.00
	reporting period				
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of 1	the cost	0.00	20.00
1 00	reporting period			24 541 070	21 0
21.00 22.00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting portion (line)	36, 541, 079 0	
22.00	5 x line 17)		ing period (ine	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line 6	0	23.00
	x line 18)		51 (		
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.00
	x line 20)			0	
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 36, 541, 079	
11.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			30, 341, 079	27.00
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private and and the	fforontial (1)	0	
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	TTerential (line	36, 541, 079	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
38.00	Adjusted general inpatient routine service cost per diem (see			1, 098. 91	38.00
				20, 337, 527	
39.00	Program general inpatient routine service cost (line 9 x line				
39.00 40.00	Medically necessary private room cost applicable to the Progra	-		20,007,027	

RELD HOSPI	TAL &	HEALTH	CARE	SERVI CE	ĒS

COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costli	Total npatient Days	col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00 0.0	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.0	0	0	42.00
	INTENSIVE CARE UNIT	9, 168, 266	4, 759	1, 926. 5	1, 756	3, 382, 952	43.00
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
	SURGI CAL I NTENSI VE CARE UNI T						45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			35, 241, 786	48.00
	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	<u> </u>				58, 962, 265	
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	2, 879, 799	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	2, 612, 244	51.00
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud medical education costs (line 49 minus line §	ding capital rela	ated, non-phy	sician anesth	etist, and	5, 492, 043 53, 470, 222	
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55.00 56.00
	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period e	nding 1996, u	pdated and co	mpounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines	s 55, 59 or 60 e	nter the less	er of 50% of		0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less than		(lines 54 x	6 <mark>0)</mark> , or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	listi ucti olis)				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tio <mark>ns)</mark>			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
65.00	instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decembe	r 31 of the c	ost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through I	December 31 o	f the cost re	porting period	0	67.00
68.00	(line 13 x line 20)	e costs <mark>a</mark> fter <mark>D</mark> e	cember 31 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient ( PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service c	ost (line 37)			70.00
	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71.00 72.00
73.00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.00
	Total Program general inpatient routine servi	•					74.00
75.00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	costs (from W	orksheet B, P	art II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			78.00 79.00
80.00	Total Program routine service costs for compa	· · ·		·	us line 79)		80.00
	Inpatient routine service cost per diem limit						81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82.00 83.00
	Program inpatient ancillary services (see ins		,				84.00
	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.00
	Total observation bed days (see instructions)	)				3, 117	87.00
	Adjusted general inpatient routine cost per o	•	line 2)			1, 098. 91 3 425 302	
07.00	Observation bed cost (line 87 x line 88) (see	= instructions)				3, 425, 302	07.00

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: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 346, 607	36, 541, 079	0. 11895	1 3, 425, 302	407, 443	90.00
91.00 Nursing School cost	0	36, 541, 079	0.00000	3, 425, 302	0	91.00
92.00 Allied health cost	0	36, 541, 079	0.00000	3, 425, 302	0	92.00
93.00 All other Medical Education	0	36, 541, 079	0.00000	3, 425, 302	0	93.00

th Financial Systems REID HOSPITAL & HEAL PUTATION OF INPATIENT OPERATING COST	TH CARE SERVICES Provider CCN: 15-0048	Period:	u of Form CMS-2 Worksheet D-1	
CUTATION OF INPATIENT OPERATING COST		From 01/01/2017		
	Component CCN: 15-S048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Subprovider -	PPS	
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
0 Inpatient days (including private room days and swing-bed days	ays, excluding newborn)		10, 080	1.
0 Inpatient days (including private room days, excluding swing		····	10, 080	
0 Private room days (excluding swing-bed and observation bed do not complete this line.	days). If you have only pr	rivate room days,	0	3.
0 Semi-private room days (excluding swing-bed and observation			10, 080	4.
0 Total swing-bed SNF type inpatient days (including private reporting period	room days) through Decembe	er 31 of the cost	0	5.
0 Total swing-bed SNF type inpatient days (including private i	room days) after December	31 of the cost	0	6.
reporting period (if calendar year, enter 0 on this line)			_	_
0 Total swing-bed NF type inpatient days (including private reporting period	oom days) through December	- 31 of the cost	0	7.
0 Total swing-bed NF type inpatient days (including private re	oom days) after December 3	31 of the cost	0	8.
reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Dreamon (avaluding	, owing had and	6, 095	9.
0 Total inpatient days including private room days applicable newborn days)	to the Program (excluding	j swing-bed and	0, 095	9.
00 Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10.
through December 31 of the cost reporting period (see instru- Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.
December 31 of the cost reporting period (if calendar year,	enter 0 on this line)	3 ,	0	
00 Swing-bed NF type inpatient days applicable to titles V or 3	XIX only (including privat	e room days)	0	12
through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or 2	XIX only (including privat	e room days)	0	13.
after December 31 of the cost reporting period (if calendar	year, enter 0 on this lir	ne)		
00 Medically necessary private room days applicable to the Prop 00 Total nursery days (title V or XIX only)	gram (excluding swing-bed	days)	0	
00 Nursery days (title V or XIX only)			0	
SWING BED ADJUSTMENT	in an thursuch Dependence 01 a		0.00	1 1 7
00 Medicare rate for swing-bed SNF services applicable to servi reporting period	ices through December 31 c	or the cost	0.00	
00 Medicare rate for swing-bed SNF services applicable to servi reporting period	ices after December 31 of	the cost	0.00	18.
00 Medicaid rate for swing-bed NF services applicable to servi	ces through December 31 of	the cost	0.00	19
reporting period Medicaid rate for swing-bed NE services applicable to service	ces after December 31 of t	he cost	0.00	20.
reporting period			( 047 440	01
00 Total general inpatient routine service cost (see instruction 00 Swing-bed cost applicable to SNF type services through Decem		ing period (line	6, 847, 448 0	
5 x line 17)			-	
00 Swing-bed cost applicable to SNF type services after Decembric x line 18)	er 31 of the cost reportir	ng period (line 6	0	23
00 Swing-bed cost applicable to NF type services through Decem	ber 31 of the cost reporti	ng period (line	0	24
7 x line 19) 00 Swing-bed cost applicable to NF type services after December	r 21 of the cost reporting	poriod (line 9	0	25
x line 20)			0	25
00 Total swing-bed cost (see instructions)			0	
00 General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	t (IThe 21 minus IThe 26)		6, 847, 448	27.
00 General inpatient routine service charges (excluding swing-	bed and observation bed ch	narges)	0	
00 Private room charges (excluding swing-bed charges)			0	
00  Semi-private room charges (excluding swing-bed charges) 00  General inpatient routine service cost/charge ratio (line 2'	7 ÷ line 28)		0 0. 000000	
00 Average private room per diem charge (line 29 ÷ line 3)			0.00	
00 Average semi-private room per diem charge (line 30 ÷ line 4)	-	ations)	0.00	
00 Average per diem private room charge differential (line 32 m 00 Average per diem private room cost differential (line 34 x			0.00 0.00	
00 Private room cost differential adjustment (line 3 x line 35	)		0	36.
00 General inpatient routine service cost net of swing-bed cos 27 minus line 36)	t and private room cost di	fferential (line	6, 847, 448	37.
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A		-	(70.51	
00 Adjusted general inpatient routine service cost per diem (so 00 Program general inpatient routine service cost (line 9 x lin			679. 31 4, 140, 394	
00 Medically necessary private room cost applicable to the Prog			4, 140, 374	
00 Total Program general inpatient routine service cost (line	$30 \pm 100 (10)$		4, 140, 394	1 11

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COMPLET	TLON OF		005043

REID HOSPITAL & HEALTH	CARE	SERVI CES
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Heal th	Financial Systems REID	HOSPI TAL & HEALT	TH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
	ATION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	
			Component	CCN: 15 CO40	From 01/01/2017	Data /Tima Dra	nored.
			Component	CCN: 15-S048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title	e XVIII	Subprovider -	PPS	pm
					I PF		
	Cost Center Description	Total	Total	Average Per	5	Program Cost	
		Inpatient Cost Ir	npatient Days		÷	(col. 3 x col.	
		1.00		col . 2)		4)	
42.00		1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (	0 00	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.0	0 00	0	43.00
44.00	CORONARY CARE UNIT	Ŭ	0	0.0	,0	Ĭ	44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description	L.					
	·					1.00	
48.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 000, 686	48.00
49.00	Total Program inpatient costs (sum of lines			ns)		5, 141, 080	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from	ı Wkst. D, sur	n of Parts I and	488, 514	50.00
	111)						
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	80, 839	51.00
E2 00	and IV)	EQ and E1				F/0 050	E2 00
52.00	Total Program excludable cost (sum of lines		atod as		notict and	569, 353	
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ateu, non-phy	sician anestr	ierist, and	4, 571, 727	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operat	ing cost and targ	get amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	J				0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period er	nding 1996, ι	updated and co	ompounded by the	0.00	59.00
	market basket						
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61.00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that		(lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see	instructions)					
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	63.00
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Decem	how 21 of the		ng pariod (Cao	0	44.00
64.00	instructions) (title XVIII only)			cost reporti	ng period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after December	r 31 of the c	ost reporting	n period (See	0	65.00
00.00	instructions) (title XVIII only)			lost reporting	, period (bee	Ŭ	00.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 6	5)(title XVII	l onlv). For	0	66.00
	CAH (see instructions)				<i>Ji</i>		
67.00	Title V or XIX swing-bed NF inpatient routin	e costs thro <mark>ugh</mark> [	December 31 c	of the cost re	eporting period	0	67.00
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of	the cost repo	orting period	0	68.00
	(line 13 x line 20)						
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER N				<u></u>		70.00
70.00 71.00	Skilled nursing facility/other nursing facil						70.00
72.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line			<i>∠)</i>			71.00
72.00	Medically necessary private room cost applic		(line 14 v li	ne 35)			72.00
74.00	Total Program general inpatient routine serv	0	•				74.00
75.00	Capital -related cost allocated to inpatient				Part II. column		75.00
	26, line 45)			2	cor aiiir		
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78.00
79.00	Aggregate charges to beneficiaries for exces						79.00
80.00	Total Program routine service costs for comp		st limitatior	ı (line 78 mir	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I	· · · · · · · · · · · · · · · · · · ·					82.00
83.00	Reasonable inpatient routine service costs (		)				83.00
84.00	Program inpatient ancillary services (see in		- >				84.00
85.00	Utilization review - physician compensation						85.00
86.00	Total Program inpatient operating costs (sum		bugn 85)			L	86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PAS						07 00
	Total observation bed days (see instructions					0	
87.00	Adjusted general inpationt routing cost par	diam (lina 27 - I	lino 21			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			0.00	89.00

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
		Component (		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
		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	807, 930	6, 847, 448	0. 11799	0 0	0	90.00
91.00 Nursing School cost	0	6, 847, 448	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 847, 448	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 847, 448	0.00000	0 0	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	Worksheet D-1	2002-10
		Component CCN: 15-TO48	From 01/01/2017 To 12/31/2017	Date/Time Prej 5/7/2018 3:57	pared:
		Title XVIII	Subprovider - IRF	PPS	piii
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 152	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	ivate room days,	3, 152 3, 152 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		r 31 of the cost	3, 152 0	4.00 5.00
6.00	Total swing-bed SNF type inpatient days (including private ro 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 reporting period	m days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	1, 747	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oom days)	0	10. 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, ea	nly (including private r	oom days) after	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI. through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	14.00 15.00
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0.00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s <mark>thr</mark> ough D <mark>ec</mark> ember 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NE services applicable to services reporting period	s after December 31 of t	he cost	0.00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through Decemb		ing pariod (line	2, 889, 907 0	21.00 22.00
	Swing-bed cost applicable to SNF type services after December Swing-bed cost applicable to SNF type services after December		0.1	0	23.00
	Swing-bed cost applicable to NF type services through December Swing-bed cost applicable to NF type services through December			0	24.00
	7 x line 19) Swing-bed cost applicable to NF type services after December :			0	
26.00	x line 20) Total swing-bed cost (see instructions)	of the cost reporting		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 889, 907	
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)		J .	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 min	, ,	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line) and the set of the set	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 889, 907	36.00 37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38.00	Adjusted general inpatient routine service cost per diem (see			916.85	
39.00	Program general inpatient routine service cost (line 9 x line			1, 601, 737	
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 601, 737	41.00

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REID HOSPITAL & HEALT	H CARE SERVICES
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	Financial Systems REIE	) HOSPITAL & HEALT	TH CARE SERVICE	<u>-</u> S	In Lie	eu of Form CMS-	2552-1
	ATION OF INPATIENT OPERATING COST		Provider CCN		Peri od:	Worksheet D-1	
			Component CC	N. 15 TO40	From 01/01/2017	Data /Tima Dra	norod.
			Component CC	N: 15-1048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title	XVIII	Subprovider -	PPS	
					I RF		
	Cost Center Description	Total		Average Per	5	Program Cost	
		Inpatient CostIr	npatient DaysD		÷	(col. 3 x col.	
		1.00	2.00	<u>col. 2)</u>	4.00	4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	42.0
+2.00	Intensive Care Type Inpatient Hospital Units		U	0.	00 0	0	42.0
13.00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.0
44.00	CORONARY CARE UNI T						44.0
45.00	BURN INTENSIVE CARE UNIT					1	45.0
46.00	SURGICAL INTENSIVE CARE UNIT					ĺ	46.0
47.00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description						
10.00			1.1 000)			1.00	10.0
18.00 19.00	Program inpatient ancillary service cost (W			-)		1, 118, 996	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(Se	e instruction:	s)		2, 720, 733	49.0
50.00	Pass through costs applicable to Program in	patient routine se	ervices (from )		m of Parts L and	326, 444	50.0
	)					020,	00.0
51.00	Pass through costs applicable to Program in	patient ancillary	services (from	n Wkst. D,	sum of Parts II	156, 845	51.0
	and IV)						
52.00	Total Program excludable cost (sum of lines					483, 289	
53.00	Total Program inpatient operating cost exclu		ated, non-physi	cian anest	netist, and	2, 237, 444	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				l	-
54.00	Program di scharges					0	54.0
5.00	Target amount per discharge					0.00	
6.00	Target amount (line 54 x line 55)					0	
7.00	Difference between adjusted inpatient opera	ting cost and targ	get amount (li	ne 56 minus	line 53)	0	57.0
8.00	Bonus payment (see instructions)					0	58.0
9.00	Lesser of lines 53/54 or 55 from the cost r	eporting period er	nding 1996, up	dated and c	ompounded by the	0.00	59. C
	market basket						
50.00	Lesser of lines 53/54 or 55 from prior year					0.00	
51.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that						61.0
	amount (line 56), otherwise enter zero (see		(THICS ST A O	<i>y</i> ), 01 1% 0	i the target		
52.00	Relief payment (see instructions)					0	62.0
3.00	Allowable Inpatient cost plus incentive payr	nent (see instruct	tio <mark>ns)</mark>			0	63. C
	PROGRAM INPATIENT ROUTINE SWING BED COST						
54.00	Medicare swing-bed SNF inpatient routine cos	sts through Decemb	per 31 of the o	cost report	ing period (See	0	64.0
5.00	instructions)(title XVLL only) Medicare swing-bed SNF inpatient routine cos	ts after Decombor	c 21 of the co	st roportin	a pariod (Soo	0	65. C
5.00	instructions) (title XVIII only)	sts after beceniber	STOT THE CO.	st reporting	g period (see	0	05.0
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	4 plus line 65	)(title XVI	ll only). For	0	66. C
	CAH (see instructions)				··· ··· ))) · · ···	-	
57.00	Title V or XIX swing-bed NF inpatient routin	ne costs thro <mark>ugh</mark> [	December 31 of	the cost r	eporting period	0	67.0
	(line 12 x line 19)						
58.00	Title V or XIX swing-bed NF inpatient routin	ne costs after Dec	cember 31 of th	ne cost rep	orting period	0	68. C
0.00	(line 13 x line 20)	multime esets (1)	na (7 i lina i	(0)			1
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. C
0.00	Skilled nursing facility/other nursing facil				)		70.0
1.00	Adjusted general inpatient routine service of			•	,	1	71.0
2.00	Program routine service cost (line 9 x line		· · · · · · · · · · · · · · · · · · ·			1	72.0
3.00	Medically necessary private room cost applic		(line 14 x line	ə 35)		1	73.0
4.00	Total Program general inpatient routine serv					1	74.0
5.00	Capital-related cost allocated to inpatient	routine service o	costs (from Wo	rksheet B,	Part II, column	1	75.0
4 00	26, line 45) Der diem eenitel related eeste (line 75 , li	no 2)				1	-, ,
6.00 7.00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line					1	76.0
8.00	Inpatient routine service cost (line 74 min					1	78.0
9.00	Aggregate charges to beneficiaries for exce		ovider records	)		1	79.0
0.00	Total Program routine service costs for com				nus line 79)	1	80.0
1.00	Inpatient routine service cost per diem limi				/	1	81. (
2.00	Inpatient routine service cost limitation (						82.
3.00	Reasonable inpatient routine service costs		)			1	83. (
4.00	Program inpatient ancillary services (see in					1	84.0
35.00	Utilization review - physician compensation						85.0
	Total Program inpatient operating costs (sur		ough 85)			L	86.0
86.00							
	PART IV - COMPUTATION OF OBSERVATION BED PAS					<u> </u>	07 0
36.00 37.00 38.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions Adjusted general inpatient routine cost per	5)	ine 2)			0.00	

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
		Component (	CCN: 15-T048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		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	588, 978	2, 889, 907	0. 20380	05 0	0	90.00
91.00 Nursing School cost	0	2, 889, 907	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 889, 907	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 889, 907	0.00000	0 0	0	93.00

REI D	HOSPI	TAL	&	HEALTH	CARE	SERVI	CES

	Financial Systems REID HOSPITAL & HEALT ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	naro
			10 12/31/2017	5/7/2018 3:57	
		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 day			33, 252	
00	Inpatient days (including private room days, excluding swing-			33, 252	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	ped davs)		30, 135	4
00	Total swing-bed SNF type inpatient days (including private ro	5 /	er 31 of the cost	0	
	reporting period			_	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om davs) through December	- 31 of the cost	0	7
	reporting period			Ũ	·
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			770	
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	770	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private i	room days)	0	10
	through December 31 of the cost reporting period (see instruct		5 1		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
. 00	through December 31 of the cost reporting period	A only (The during priva	te room days)	0	12
. 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			0	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 1, 956	
	Nursery days (title V or XIX only)			50	
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (	of the cost	0.00	] 17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	and often December 21 of	the east	0.00	18
. 00	reporting period	Les aller becember 31 of	the cost	0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	15)		36, 541, 079	21
00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportion	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			Ũ	
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
00	x line 20)			0	26
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		36, 541, 079	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				1
	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	
. 00	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
00 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 36, 541, 079	
	27 minus line 36)	privato room cost u		33, 511, 077	"
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 000 01	1
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	-		1, 098. 91 846, 161	
	Medically necessary private room cost applicable to the Progr			040, 101 0	1
0. 00				0	1 70

RELD HOSPITAL	&	HEALTH	CARE	SERVI CES	

COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		eriod: rom 01/01/2017	Worksheet D-1	
					o 12/31/2017		
				e XIX	Hospi tal	5/7/2018 3: 57 Cost	pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
			1	col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	829, 735	1, 956	424.20	50	21, 210	42.00
42 00	Intensive Care Type Inpatient Hospital Units	0 1/0 2//	4, 759	1 00/ 51	100	235, 034	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	9, 168, 266	4, 759	1, 926. 51	122	235, 034	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
	Program inpatient ancillary service cost (Wks			20)		1, 269, 694	
49.00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48)(s	see instruction	15)		2, 372, 099	49.00
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst D sum	of Parts L and	0	50.00
00.00				intot. D, Suin		Ű	00.00
51.00	Pass through costs applicable to Program inpa	atient ancillary	services (fro	om Wkst. D, su	m of Parts II	0	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines 5		. 🔶 .			0	52.00
53.00	Total Program inpatient operating cost exclud		ated, non-phys	sician anesthe	tist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	DZ)					
54.00	Program di scharges					0	54.00
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operati	ng cost and tar	get amount (li	ine 56 minus I	ine 53)	0	57.00
58.00	Bonus payment (see instructions)	J.	0		ŕ	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting p <mark>eri</mark> od e	ending 1996, u	odated and com	pounded by the	0.00	59.00
(0.00	market basket					0.00	(0.00
60.00 61.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				he emount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see i				the target		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tio <mark>ns)</mark>			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Decem	iber 31 of the	cost reportin	g period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decembe	or 31 of the cu	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)	is arter becchibe		bat reporting		l l	05.00
66.00	Total Medicare swing-bed SNF inpatient routir	ne co <mark>sts (li</mark> ne 6	4 plus line 6	5)(title XVIII	only). For	0	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 of	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after De	combor 21 of	the cost roper	ting pariod	0	68.00
00.00	(line 13 x line 20)			the cost repor	ting period		00.00
69.00	Total title V or XIX swing-bed NF inpatient 1	outine costs (I	ine 67 + line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service co	ost (line 37)			70.00
	Adjusted general inpatient routine service co		ne 70 ÷ line 2	2)			71.00
72.00	Program routine service cost (line 9 x line 7			>			72.00
73.00	Medically necessary private room cost applica	U	•	ne 35)			73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•		arkeboot P. Do	rt II column		74.00 75.00
75.00	26, line 45)	outine service	COSTS (TION W	JIKSHEEL D, Pa	ILII, COLUMNI		75.00
76.00	Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
77.00	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00	Aggregate charges to beneficiaries for excess	s costs (from pr	ovider records	s)			79.00
80.00	Total Program routine service costs for compa	arison to the co	ost limitation	(line 78 minu	s line 79)		80.00
81.00	Inpatient routine service cost per diem limit	tation					81.00
82.00	Inpatient routine service cost limitation (li						82.00
	Reasonable inpatient routine service costs (s		5)				83.00
84.00	Program inpatient ancillary services (see ins		<b>`</b>				84.00
	Utilization review - physician compensation (						85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86.00
87.00	Total observation bed days (see instructions)					3, 117	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)			1, 098. 91	
89.00	Observation bed cost (line 87 x line 88) (see					3, 425, 302	89.00

Health Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				Fom 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: 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	4, 346, 607	36, 541, 079	0. 11895	1 3, 425, 302	407, 443	90.00
91.00 Nursing School cost	0	36, 541, 079	0.00000	3, 425, 302	0	91.00
92.00 Allied health cost	0	36, 541, 079	0.00000	3, 425, 302	0	92.00
93.00 All other Medical Education	0	36, 541, 079	0.00000	3, 425, 302	0	93.00

	FINANCIAI SYSTEMS REID HUSPITAL & HEALT			U OF FORM CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-S048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/7/2018 3:57	pared:
		Title XIX	Subprovider - IPF	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 day			10, 080	1.00
2.00	Inpatient days (including private room days, excluding swing-			10, 080	2.00
3.00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	Tvate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		10, 080	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			_	
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 roo	m dave) after December 2	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	in days) at ter becenber 3	or of the cost	0	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	0	9.00
	newborn days)	0 . 0	, j		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
44 00	through December 31 of the cost reporting period (see instruc			0	11.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		coom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	ing (the daring pir var	ie room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)				15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			50	16.00
17.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17.00
17.00	reporting period	es thi dugh becchiber st e		0.00	
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
10.00	reporting period			0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	is through December 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
	reporting period				
	Total general inpatient routine service cost (see instruction			6, 847, 448	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.00
~~ ~~	5 x line 17)			0	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.00
24 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
21.00	$7 \times 1 \text{ ine } 19$		ng period (rine	0	21.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 847, 448	27.00
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	a and observation bed ci	lai yes)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		CTIONS)		34.00
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)			0.00	35.00 36.00
36.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 847, 448	
57.00	27 minus line 36)			0,01,140	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				]
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			679.31	38.00
	Program general inpatient routine service cost (line 9 x line			0	39.00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	. ,		0	40.00
<del>4</del> 1.00	In the service cost (TTHE 39	T THE 40)	I	0	41.0

Heal th	Fi nanci a	I Systems	
OOUDUT			

RELD HOSPITAL	&	HEALTH	CARE	SERVI CES

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEA		CES CN: 15-0048	In Lie Period:	eu of Form CMS- Worksheet D-	
OMPUT	ATTON OF INPATIENT OPERATING COST		Provider C	CN: 15-0048	Period: From 01/01/2017		I
			Component	CCN: 15-S048	To 12/31/2017	Date/Time Pre	
				le XIX	Subprovider -	5/7/2018 3:5 Cost	/pm
				e XIX	I PF	0031	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	.
		1.00	2.00	<u>col.2</u> )	4.00	4)	_
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	0 42
. 00	Intensive Care Type Inpatient Hospital Units		(	<u>η 0.0</u>	0		5 42
8. 00	INTENSIVE CARE UNIT	0	(	0.0	0 00	(	J 43
. 00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00				<u> </u>			47
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	. line 200)				0 48
. 00	Total Program inpatient costs (sum of lines			ons)		70	
	PASS THROUGH COST ADJUSTMENTS	Q , , ,					
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sun	n of Parts I and	(	J 50
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fi	om Wkst. D, s	sum of Parts II	(	D 51
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	J 52
3.00	Total Program inpatient operating cost exclu	,	lated. non-phy	vsician anestł	netist, and		5 52 5 53
	medical education costs (line 49 minus line		i drod, non prij		lotrot, and		
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					(	
6.00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)		
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	onding 1006 i	indated and co	omnounded by the		
. 00	market basket	por tring period	enuring 1990, t		inpounded by the	0.00	5 57
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the r	narket basket		0.00	0 60
I. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of	the amount by	0	D 61
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	<sup>*</sup> the target		
	amount (line 56), otherwise enter zero (see	instructions)					
2.00	Relief payment (see instructions)						0 62 0 63
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	ctrons)			<u> </u>	2 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	(	5 64
	instructions) (title XVIII only)			,			-
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reportinț	) period (See	(	0 65
	instructions)(title XVIII only)						_
b. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	(	) 66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	December 21	of the cost r	porting ported		0 67
. 00	(line 12 x line 19)	e costs through	December 31 (	JI THE COST IS	sporting period		5 67
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	ortina period	(	D 68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient					(	D 69
	PART III - SKILLED NURSING FACILITY, OTHER N					1	_
). 00	Skilled nursing facility/other nursing facil	3		. ,	1		70
. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /U ÷ line	∠)			71
. 00	Medically necessary private room cost applic		(line 14 v li	no 35)			73
. 00 . 00	Total Program general inpatient routine serv	0	•				74
. 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	Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu		novidor				78
. 00	Aggregate charges to beneficiaries for exces				aus lino 70)		79
. 00 . 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		UST IT MITATION	i (iine /ơ mìr	ius i i ne 79)		80
. 00	Inpatient routine service cost per drem rimi		)				82
. 00	Reasonable inpatient routine service costs (		· .				83
. 00	Program inpatient ancillary services (see in		- /				84
5.00	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum	•					86
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
7.00	Total observation bed days (see instructions					(	
	Adjusted general inpatient routine cost per	aiem (line 27 ÷	line 2)			0.00	D  88
. 00 . 00	Observation bed cost (line 87 x line 88) (se	o instruction=					2 89

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2017	Worksheet D-1	
		Component (		To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
			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	807, 930	6, 847, 448	0. 11799	0 0	0	90.00
91.00 Nursing School cost	0	6, 847, 448	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	6, 847, 448	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 847, 448	0.00000	0 0	0	93.00

Component CD: 15-1044         [Free Bill/BI2/BI207] 12/31/2017         Inter/Time Properties (2008) 32/31/2017           Cest Center Description         Itile XIX         Subgroup of er- Ist         Cost           Aut T- ALL PROVINEE COMPARTS         1.00         1.00         1.00           Ave T- ALL PROVINEE COMPARTS         1.00         1.00         1.01         1.00           Ave T- ALL PROVINEE COMPARTS         1.00         1.01		FINANCIAL SYSTEMS REID HUSPITAL & HEALTH			U OT FORM CMS-2	
THE MX         Subgroot der -         Cost           IBP         IDP	COMPUT	ATTON OF INPATTENT OPERATING COST	Provider CCN: 15-0048 Component CCN: 15-T048			pared:
Cost Center Description         1.00           PMT LET DATE         1.00           INAT LET DATE         1.00           Lob Impatient days (including pervate room days, and swing-bed days, excluding sextp bed and newtorm days).         3.152         1.00           2:00 Impatient days (including pervate room days, excluding sextp bed and newtorm days).         3.152         2.00           0:00 DF vice trans days (including pervate room days, excluding sextp bed and newtorm days).         3.152         2.00           0:00 Train pervation (including pervate room days) (including private room days).         3.152         2.00           0:00 Train pervation (including private room days).         100 (including pervater room days).         3.152         2.00           0:00 Train pervation (including private room days).         100 (including private room days).         0.00         0.0			Title XIX			_p
MART 1 - ALL PROVIDER CARPORENTS           INPARTING MASS.         Inparticul days (including private room days and sking-bad days, excluding membern days).         3,152         1,00           Inparticul days (including private room days, and sking-bad days, excluding membern days).         3,152         1,00           1.00         Inparticul days (including private room days, and bad membern days).         3,152         1,00           0.00         Finite International State S		Cost Center Description	L		1.00	
1.00       Inpatient days (including private room days and sking-bed days, excluding newborn)       3,152       1.00         2.00       Inpatient days (including private room days, and sking-bed days)       3,152       2.00         3.00       Private room days, (excluding swing-bed and observation bed days). If you have noly private room days, or total swing-bed dy observation bed days)       3,152       4.00         5.00       Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if call-adar-year, enter 0 on this line).       0       7.00         7.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if call-adar-year, enter 0 on this line).       0       7.00         7.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if call-adar-year, enter 0 on this line).       0       0         0.00       Total swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and 0       0       0         1.00       Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if call-adar year, enter 0 on this line)       0       1.00         1.00       Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if Call-adar year, enter 0 on this line)       0       <					1.00	
2.00       Injustient days (including private room days, excluding swing-bed and networm days).       3, 152       2, 00         3.00       Private room days (excluding swing-bed and observation bed days).       17 you have only private room days.       3, 00         5.00       Traperting period.       Type inputient days (including private room days).       4, 00         5.00       Tradit sing-bed SK type inputient days (including private room days).       17 out only the cost reporting period.       0, 00         7.00       Total sing-bed SK type inputient days (including private room days).       17 out only the cost reporting period.       0, 00         0.00       Total sing-bed SK type inputient days (including private room days).       17 out only sing-bed SK type inputient days applicable to the Program.       0, 00         0.00       Total sing-bed SK type inputient days applicable to the set on this line).       0, 00       0, 00         0.00       Sking-bed SK type inputient days applicable to the set on this line).       0, 10, 00       0, 00         0.00       Sking-bed SK type inputient days applicable to the set on this line).       0, 10, 00       10, 00         0.00       Sking-bed SK type inputient days applicable to the set on this line).       0, 10, 00       10, 00         0.00       Sking-bed SK type inputient days applicable to the set on this line).       0, 10, 00       10, 00					0.450	
4.00       Seel _private room days (excluding swing-bed and observation bed days)       3,152       4,00         5.00       Total swing-bed SM* type Inpatient days (including private room days) after December 31 of the cost       0       5,00         7.00       Total swing-bed SM* type Inpatient days (including private room days) after December 31 of the cost       0       6,00         8.00       Total swing-bed M* type inpatient days (including private room days) after December 31 of the cost       0       7,00         9.00       Total swing-bed M* type inpatient days (including private room days) after December 31 of the cost       0       0         9.00       Total swing-bed SM* type inpatient days applicable to the Norgam (oxcluding swing-bed and oxs)       0       0         9.00       Total inpatient days applicable to the Norgam (oxcluding swing-bed and oxs)       0       0       0         9.00       Total inpatient days applicable to the Norgam (oxcluding swing-bed and oxs)       0       1       0         9.00       Swing-bed M* type Inpatient days applicable to the Norgam (oxcluding swing-bed ask)       0       1       0         10.00       Swing-bed M* type Inpatient days applicable to the Norgam (oxcluding swing-bed ask)       0       1       0         11.00       Swing-bed M* type Inpatient days applicable to the Norgam (oxcluding swing-bed ask)       0       1       0	2.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day	ped and newborn days)	ivate room days,	3, 152	1.00 2.00 3.00
0.00       Total swing-bed SNF type Inpatient days (Including private room days) after becember 31 of the cost reporting period (Ir calendar year, enter 0 on this line)       0.00         0.00       Total swing-bed NF type Inpatient days (Including private room days) after becember 31 of the cost reporting period       0.00         0.00       Total swing-bed NF type Inpatient days (Including private room days) after becember 31 of the cost reporting period       0.00         0.00       Total inpatient days applicable to the Program (excluding swing-bed and newborn days)       0.00         0.01       Dising-bed SNF type Inpatient days applicable to the Program (excluding private room days)       0.00         0.01       Dising-bed SNF type Inpatient days applicable to the XNI only (Including private room days)       0.00         1.00       Swing-bed MF type Inpatient days applicable to thits VII and VII only ding private room days)       0.10.00         1.00       Swing-bed MF type Inpatient days applicable to thits VII and VII only dincluding private room days)       0.10.00         1.00       Swing-bed MF type Inpatient days applicable to the Program (excluding swing-bed days)       0.14.00         1.00       Madically necessary private room days applicable to the Program (excluding swing-bed days)       0.14.00         1.00       Madically necessary private room days applicable to services after December 31 of the cost       0.00         1.00       Madicare rate for swing-bed SNF services applica		Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost		4.00 5.00
7.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       7.00         8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost       0       8.00         9.00       Total inpatient days including private room days applicable to the Program (excluding private room days) through December 31 of the cost reporting period (ise instructions)       0       0.00         10.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       11.00         10.00       Swing-bed WF type inpatient days applicable to the Swing-bed mays)       0       12.00         10.00       Swing-bed WF type inpatient days applicable to the Swing-bed mays)       0       12.00         11.00       Swing-bed WF type inpatient days applicable to the Program (excluding private room days)       0       12.00         12.00       Swing-bed WF type inpatient days applicable to the Program (excluding swing-bed days)       0       14.00         13.00       Non-serv days (ittle V or XIX only)       19.06       15.00         14.00       Medicare rate for swing-bed SWF services applicable to services frough December 31 of the cost       0.00       17.00         15.00       Non-services applicable to Services frough December 31 of the cost       0.00       19.	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00       <	7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00
9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       0       9.00         10.00       Swing-bed SNF Type inpatient days applicable to title XVIII only (including private room days) after to cost reporting period (icalendar year enter 0 on this line)       0       10.00         11.00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (icalendar year, enter 0 on this line)       0       10.00         12.00       Ming-bed NF type inpatient days applicable to title SV or XIX only (including private room days)       0       12.00         13.00       Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       5.01       16.00         15.00       Total nursery days (title V or XIX only)       5.01       16.00         10.00       Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       16.00         11.00       Medicar rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       17.00         12.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       10.00       10.00       10.00	8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.00
10. 00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0       10. 00         11. 00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0       10. 00         12. 00       Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)       0       10. 00         13. 00       Swing-bed SMF type inpatient days applicable to title SV or XIX only (including private room days)       0       10. 00         14. 00       Medically necessary private room days applicable to titles V or XIX only (including private room days)       0       14. 00         14. 00       Medical ty necessary private room days applicable to titles V or XIX only (including private room days)       0       14. 00         14. 00       Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost       0. 00       17. 00         17. 00       Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost       0. 00       18. 00         18. 00       Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost       0. 00       19. 00         19. 00       Medicare rate for swing-bed NE services applicable to services after December 31 of the cost       0. 00       19. 00         10. 00       Medicare rate for swing-bed NE services after December 31 o	9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	0	9.00
11:00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       11.00         12:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       0       12.00         13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       0       13.00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         16:00       Total nursery days (title V or XIX only)       50       16.00         17:00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost       0.00       18.00         18:00       Medicare rate for swing-bed NF services applicable to services for up December 31 of the cost       0.00       19.00         19:00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       10.00         10:00       Total af rate for swing-bed NF services applicable to services after December 31 of the cost       0.00       0.00         10:00       Total af arte for swing-bed NF services after December 31 of the cost reporting period (line 5 x line 17)       2.80       0.00	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if called and year, enter 0 on this line)       0       12.00         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if called and year, enter 0 on this line)       0       13.00         14.00       Wedically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       .50       16.00         16.00       Nursery days (title V or XIX only)       .50       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       19.00         20.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)       2.889,007       2.00         20.00       Swing-bed cost (see instructions)       2.889,007       2.00       2.00         20.00       Swing-bed cost septice cost cost after December 31 of the cost reporting period (line 6 x line 20)       2.00       2.00       2.00       2.00       2.00 </td <td>11.00</td> <td>Swing-bed SNF type inpatient days applicable to title XVIII o</td> <td>nly (including private r</td> <td>oom days) after</td> <td>0</td> <td>11.00</td>	11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11.00
13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar, year, enter 0 on this line)       0       13.00         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       50       16.00       16.00         15.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       18.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       18.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       20.00         21.00       Total general inpatient routine service cost (see instructions)       2.889,007       2.809,007         22.00       Swing-bed cost applicable to SF type services after December 31 of the cost reporting period (line 6 x line 20)       2.889,007         22.00       Swing-bed cost (see instructions)       2.889,007       2.00         23.00       Swing-bed cost (see instructions)       0.	12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       55         16.00       Nursery days (title V or XIX only)       50         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost       0.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         19.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         21.00       Total general inpatient routine service cost (see instructions)       2.889,907         21.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 13)       2.889,907         22.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       2.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)       2.00         24.00       Swing-bed cost (see instructions)       2.889,907       21.00         25.00       Swing-bed cost sepi cost net of swing-bed cost (line 21 minus line	13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
16.00       Nursery days (title V or XIX only)       50       16.00         SWING BED ADJUSTIONT       50       16.00         17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00         18.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         19.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         21.00       Total general inpatient routine service cost (see instructions)       2.889,907         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x ine 10)       2.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x ine 20)       2.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x ine 20)       2.00         25.00       Swing-bed cost seplicable to NF type services after December 31 of the cost reporting period (line 6 x ine 20)       2.00         26.00       Total swing-bed cost (		Medically necessary private room days applicable to the Progra				14.00
17.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0.00       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       0.00       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       0.00       19.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       0.00       19.00         21.00       Total general inpatient routine service cost (see instructions)       2.889,907       21.00         22.00       Swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line x line 18)       0       24.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 18)       0       25.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       2889,907         26.00       Total swing-bed cost (see instructions)       2.889,907       2.00         26.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       0         27.00       Swing-bed cost applicable to NF type servic		Nursery days (title V or XIX only)				
18.00Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost0.0018.0019.00Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost0.0019.0020.00Medicaid rate for swing-bed NE services applicable to services after December 31 of the cost0.0020.0020.00Medicaid rate for swing-bed NE service cost (see instructions)2.889,90721.0021.00Total general inpatient routine service cost (see instructions)2.889,90721.0023.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)2.80023.0024.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)24.0024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)28.0028.0026.00Total swing-bed cost (see instructions)028.0028.0028.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)28.0028.0028.00General inpatient routine service charges (excluding swing-bed charges)00020.00Swing-bed rout appeired (line 3 + line 3)0.00000031.0030.00Average private room charge (line 29 + line 3)0.0030.0031.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)0.0031.00General inpatient rou	17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17.00
19.00Medicaid "ate for swing-bed NF services applicable to services through December 31 of the cost reporting period0.0019.0020.00Medicaid rate for swing-bed NE services applicable to services after December 31 of the cost reporting period0.0020.0021.00Total general inpatient routine service cost (see instructions) S x line 17)2.889,90721.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 19)024.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)024.0026.00Total swing-bed cost (see instructions) x line 20)0026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT PRIVATE ROOM DIFFERENTIAL ADJUSTMENT PRIVATE ROOM perivate room charges (excluding swing-bed charges) 000020.00Semi-private room charges (excluding swing-bed charges) 0000031.00General inpatient routine service cost/charge ratio (line 32 + line 33) 0000032.00Average perivate room charge differential (line 32 + line 31) 0000032.00Converage service cost differential (line 34 x line 35) 0000033.00Average perivate room cost differential (	18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
20.00       Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line feedback of the cost reporting period (line feedback of the cost reporting period (line feedback of the cost applicable to SNF type services after December 31 of the cost reporting period (line feedback of the cost applicable to SNF type services after December 31 of the cost reporting period (line feedback of the cost applicable to SNF type services after December 31 of the cost reporting period (line feedback of the cost applicable to SNF type services after December 31 of the cost reporting period (line feedback of the top)       22.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line feedback of the top)       23.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line feedback of the top)       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line feedback of the top)       24.00         26.00       Total swing-bed cost (see instructions)       0       26.00         27.00       General inpatient routine service cost net of swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       28.00         29.00       Average perivate room per diem charge (line 30 + line 3)       0.00       29.00         30.00       Average perive onom peri diem charge (line 30 + line 3)       0	19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
22.00       Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)       0       22.00         23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 7 x line 18)       0       24.00         24.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)       0       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 20)       0       25.00         26.00       Total swing-bed cost (see instructions)       0       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       2,889,907       27.00         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       00.00000       31.00         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average per diem private room cost differential (line 34 x line 31)       0.00       32.00       30.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00	20. 00	Medicaid rate for swing-bed NE services applicable to services	s <mark>a</mark> fter December 31 of t	he cost	0.00	20. 00
23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0         26.00       Total swing-bed cost (see instructions)       0       25.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       2,889,907       27.00         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       0       29.00         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average per idem private room cost differential (line 32 minus line 33) (see instructions)       0.00       32.00         33.00       Average per diem private room cost differential (line 3 x line 35)       0       34.00         34.00       Private room cost differential di ustamet (line 3 x line 35)       0       37.00         36.00       Private room cost differential di ustenet (see instructions)       0		Swing-bed cost applicable to SNF type services through December		ing period (line		21. 00 22. 00
7 x line 19)       25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       25.00         26.00       Total swing-bed cost (see instructions)       0       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       2,889,907       27.00         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       29.00         30.00       Semi-private room charges (excluding swing-bed charges)       0       00       00.00000         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       30.00         32.00       Average private room per diem charge (line 29 + line 3)       0.000000       30.00         32.00       Average per diem private room cost differential (line 32 minus line 33) (see instructions)       0.00       32.00         33.00       Average per diem private room cost di fferential (line 34 x line 31)       0.00       35.00         36.00       Private room cost di fferential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost per diem (see instructions)       916.85       38.00	23.00	5	31 of the cost reportin	g period (line 6	0	23. 00
x line 20)26.00Total swing-bed cost (see instructions)026.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,889,90727.00PRIVATE ROM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.00029.0030.00Semi-private room charges (excluding swing-bed charges)029.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room cost differential (line 32 minus line 33) (see instructions)0.0034.0034.00Average per diem private room cost differential (line 3 x line 31)0.0035.0036.00Private room cost differential dijustment (line 3 x line 35)036.0037.00General inpatient routine service cost per diem (see instructions)36.0037.00General inpatient routine service cost per diem (see instructions)916.8538.00Adjusted general inpatient routine service cost per diem (see instructions)916.8539.00Program general inpatient routine service cost per diem (see instructions)916.8539.00Program general inpatient routine service cost per diem (see instructions)039.00Program general inpatient routine service cost per diem (see instructions)916.85<	24.00		r 31 of the cost reporti	ng period (line	0	24.00
27. 00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,889,90727. 00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029. 00Private room charges (excluding swing-bed charges)029.0030. 00Semi-private room charges (excluding swing-bed charges)030.0031. 00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032. 00Average private room per diem charge (line 30 ÷ line 4)0.0032.0033. 00Average per diem private room cost differential (line 34 x line 31)0.0035.0036. 00Private room cost differential (line 3 x line 35)036.0037. 00General inpatient routine service cost per diem (see instructions)036.0037. 00PRORAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS916.8538.0038. 00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0039. 00Program general inpatient routine service cost per diem (see instructions)916.8538.0040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)00.90.0040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)00.40.00	25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
28.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.0029.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)00.00000032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0032.0034.00Average per diem private room cost differential (line 3 x line 35)0.0034.0035.00Average per diem private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost per diem (see instructions)036.0038.00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0039.00Program general inpatient routine service cost per diem (see instructions)039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)039.00			(line 21 minus line 26)			26. 00 27. 00
29.00Private room charges (excluding swing-bed charges)029.0030.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average per diem private room charge differential (line 30 ÷ line 4)0.0033.0034.00Average per diem private room cost differential (line 34 x line 31)0.0034.0035.00Average per diem private room cost differential (line 3 x line 35)0.0036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20 × line 30)36.0037.00Part II - HOSPITAL AND SUBPROVIDERS ONLY0.0036.00900Program general inpatient routine service cost per diem (see instructions)916.8538.0039.00Program general inpatient routine service cost (line 9 x line 38)039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	~~ ~~					
30.00Semi-private room charges (excluding swing-bed charges)030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room cost differential (line 34 × line 31)0.0034.0035.00Average per diem private room cost differential (line 3 × line 35)0.0035.0036.00Private room cost differential adjustment (line 3 × line 35)0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 90737.0038.00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0039.00Program general inpatient routine service cost (line 9 × line 38)039.0040.00Medically necessary private room cost applicable to the Program (line 14 × line 35)040.00			a and observation bed ch	arges)		
31.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 29 ÷ line 3)0.0032.0033.00Average semi-private room per diem charge (line 30 ÷ line 4)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)036.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 90737.0038.00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0038.00Adjusted general inpatient routine service cost (line 9 x line 38)039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)039.00					-	
32.00       Average private room per diem charge (line 29 + line 3)       0.00       32.00         33.00       Average semi-private room per diem charge (line 30 + line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 907       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         Adjusted general inpatient routine service cost per diem (see instructions)       916.85       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       0       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00			÷line 28)			
33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 907       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       38.00         Adjusted general inpatient routine service cost per diem (see instructions)       916.85       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       0       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 907       37.00         27 minus line 36)       PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       916.85       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       916.85       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       0       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00						
36.00       Private room cost differential adjustment (line 3 x line 35)       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 907)       0       37.00         27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY       0       37.00         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       916.85       38.00         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       916.85       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       0       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00	34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34.00
37. 00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 889, 907 27 minus line 36)       37. 00         PART II - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       38. 00         38. 00       Adjusted general inpatient routine service cost per diem (see instructions)       916. 85       38. 00         39. 00       Program general inpatient routine service cost (line 9 x line 38)       0       39. 00         40. 00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40. 00			ne 31)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       916.85       38.00         39.00       Program general inpatient routine service cost (line 9 x line 38)       0       39.00         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	-	36.00 37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0039.00Program general inpatient routine service cost (line 9 x line 38)039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)916.8538.0039.00Program general inpatient routine service cost (line 9 x line 38)039.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00				916.85	38.00
			-			39.00
			. ,			40. 00 41. 00

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OOUDUT			ODEDAT

RELD HOSPITAL	&	HEALTH	CARE	SERVI CES

		HOSPI TAL & HEAL	TH CARE SERVI	CES	In Lie	eu of Form CMS-	2552-
	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0048	Period:	Worksheet D-1	1
			Component	CCN: 15-T048	From 01/01/2017 To 12/31/2017		enared
						5/7/2018 3:57	
			Titl	e XIX	Subprovider -	Cost	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
				col. 2)		4)	
	r	1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0		0.	00 C	C	) 42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.			43.
	CORONARY CARE UNIT	0	(	0.1			44.
	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL I NTENSI VE CARE UNI T						46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description						
2 00		-+ D 2 2	11			1.00	10
	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)			
7.00	PASS THROUGH COST ADJUSTMENTS	41 through 40)(3		лтз <i>)</i>			, 47.
0. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sur	n of Parts I and	C	50.
1. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	C	51.
2.00	and IV)	E(1)					5
	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non ph	cicion anacti	actict and		
3.00	medical education costs (line 49 minus line	5 1	area, non-phy	siciali anesti	ictist, dHU		1 33.
	TARGET AMOUNT AND LIMIT COMPUTATION	02)				1	
4.00	Program di scharges					C	54.
	Target amount per discharge					0.00	55.
	Target amount (line 54 x line 55)					C	
	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	C	
3.00	Bonus payment (see instructions)	perting period o	nding 100/	undeted and a	ampounded by the		
9.00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	nai ng 1996, i	ipuated and co	silipounded by the	0.00	/ 59.
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upd	ated by the r	arket basket		0.00	60.
	If line 53/54 is less than the lower of line				the amount by	C	
	which operating costs (line 53) are less tha		(lines <mark>54</mark> x	60), or 1% or	f the target		
	amount (line 56), otherwise enter zero (see	i nstructi ons)					
	Relief payment (see instructions)						
3.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc				<u> </u>	) 63.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	na period (See	C	64.
	instructions) (title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cos	ts after <mark>De</mark> cembe	r 31 of the c	cost reporting	g period (See	C	65.
	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (l'ine 6	4 plus line 6	5)(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 re	porting period	C	67.
7.00	(line 12 x line 19)	e costs through	December 31 C		sporting period		07.
8.00	Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost repo	orting period	C	68.
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient					C	69.
0.00	PART III - SKILLED NURSING FACILITY, OTHER N				<b>N</b>	1	70
D. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70.
	Program routine service cost (line 9 x line			<i>L</i> )			72.
	Medically necessary private room cost applic	,	(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine serv						74.
5.00	Capital-related cost allocated to inpatient	routine service	costs (from V	lorksheet B, I	Part II, column		75.
	26, line 45)	no ))					_,
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.
	Inpatient routine service cost (line 74 minu						78.
	Aggregate charges to beneficiaries for exces		ovider record	ls)			79.
0. 00	Total Program routine service costs for comp				nus line 79)		80.
	Inpatient routine service cost per diem limi						81.
	Inpatient routine service cost limitation (I	,					82.
3.00	Reasonable inpatient routine service costs (		)				83.
1.00	Program inpatient ancillary services (see in		c)				84.
	Utilization review - physician compensation						85. 86.
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougii oo)			l	- 00.
						C	87.
7.00	TOTAL ODSELVATION DEC CAVS USEE INSTRUCTIONS						
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	88.

Health Financial Systems REID	HOSPI TAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
		Titl	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	588, 978	2, 889, 907	0. 20380	05 0	0	90.00
91.00 Nursing School cost	0	2, 889, 907	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 889, 907	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 889, 907	0.00000	0 0	0	93.00

Heal th Financi		REID HOSPITAL & HEALTH			In Li	eu of Form CMS-	
INPATIENT ANC	ILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0048	Peri od:	Worksheet D-3	3
					From 01/01/201 To 12/31/201		parod
					10 12/31/201	5/7/2018 3: 57	
			Title	× XVIII	Hospi tal	PPS	
С	Cost Center Description			Ratio of Cos		Inpatient	
	•			To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1.00	2.00	3.00	
	ENT ROUTINE SERVICE COST CENTERS						
	DULTS & PEDIATRICS				23, 582, 75		30.00
	NTENSIVE CARE UNIT				4, 327, 35		31.00
	SUBPROVIDER – IPF				336, 28	4	40.00
	SUBPROVIDER – IRF					0	41.00
43.00 04300 N							43.00
	ARY SERVICE COST CENTERS			1			
	PERATING ROOM			0. 2062			
	DELIVERY ROOM & LABOR ROOM			0. 2746			
	ADI OLOGY-DI AGNOSTI C			0. 1754			
	CARDI AC CATHETERI ZATI ON			0. 1295	42 15, 184, 18	8 1, 966, 990	59.00
	ABORATORY			0. 1855			
	RESPI RATORY THERAPY			0. 16893			
	PHYSI CAL THERAPY			0. 6453		1, 375, 272	
	LECTROCARDI OLOGY			0. 1282			
	LECTROENCEPHALOGRAPHY			0. 2688			
	IEDICAL SUPPLIES CHARGED TO PATIEN	TS		0. 1993			
	MPL. DEV. CHARGED TO PATIENT			0. 68354			
	RUGS CHARGED TO PATIENTS			0. 3161			
	RENAL DIALYSIS			1.0830		3 573, 623	
	NCILLARY - OTHER			0.0000	00	0 0	76.00
	CARDIAC REHABILITATION			0. 3694	70 3, 95	6 1, 462	76.97
	ENT SERVICE COST CENTERS						
91.00 09100 E				0. 2024		4 1, 710, 131	
	DBSERVATION BEDS (NON-DISTINCT PAR	T)		0. 7667			
	AMILY PRACTICE			0. 4848	70 7, 29	4 3, 537	93.00
	REIMBURSABLE COST CENTERS					_	
	URABLE MEDICAL EQUIP-RENTED			1. 3335		0 0	
	otal (sum of lines 50 through 94 a				141, 143, 85	9 35, 241, 786	
	ess PBP Clinic Laboratory Service		(line 61)			0	201.00
202.00 N	let charges (line 200 minu <mark>s l</mark> ine 20	01)			141, 143, 85	9	202.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT				Workchast P 2	2552
			Period: From 01/01/2017	Worksheet D-3	•
	Component		To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Title	e XVIII	Subprovider -	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	<u> </u>
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	0		30
00 03100 INTENSIVE CARE UNIT			0		31
00 04000 SUBPROVIDER - I PF			6, 497, 616		40
00 04100 SUBPROVIDER - IRF			0, 477, 010		41
00 04300 NURSERY			0		43
ANCI LLARY SERVI CE COST CENTERS		1		I	1 ''
00 05000 OPERATING ROOM		0. 20625	68 47, 437	9, 784	50
00 05200 DELIVERY ROOM & LABOR ROOM		0. 27466		0	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 17544			
00 05900 CARDI AC CATHETERI ZATI ON		0. 12954			
00 06000 LABORATORY		0. 18559		137, 419	
00 06500 RESPI RATORY THERAPY		0. 16893		72, 219	
00 06600 PHYSI CAL THERAPY		0. 64538			
00 06900 ELECTROCARDI OLOGY		0. 12822			
00 07000 ELECTROENCEPHALOGRAPHY		0. 26887			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19938	37 0	0	71
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 68354	6 0	0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 31615	i9 1, 160, 930	367, 038	73
. 00 07400 RENAL DIALYSIS		1.08309	18, 285		
. 00 03950 ANCI LLARY - OTHER		0.00000	0 0	0	76
. 97 07697 CARDI AC REHABI LI TATI ON	· · · · · · · · · · · · · · · · · · ·	0. 36947	0 0	0	76
OUTPATIENT SERVICE COST CENTERS		1			
. 00 09100 EMERGENCY		0. 20248		120, 608	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 76679			
00 04040 FAMILY PRACTICE		0. 48487	0 0	0	93
OTHER REIMBURSABLE COST CENTERS				-	
00 09600 DURABLE MEDI CAL EQUI P-RENTED		1. 33357		-	
D.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 820, 147	1, 000, 686	
1.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		2 020 147		201
2.00 Net charges (line 200 minus line 201)			3, 820, 147		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0048	Period:	Worksheet D-3	2552
ATTENT ANGLEART SERVICE COST AFFURTIONWENT	FIOVIDEI C	GN. 13-0040	From 01/01/2017	WULKSHEEL D-3	,
	Component	CCN: 15-T048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Titl€	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
00 03000 ADULTS & PEDIATRICS			0		30
00 03100 I NTENSI VE CARE UNI T			0		31
00 04000 SUBPROVI DER - I PF			0		40
00 04100 SUBPROVIDER - IRF			1, 854, 479		41
00 04300 NURSERY			1,001,177		43
ANCI LLARY SERVI CE COST CENTERS					1 ``
00 05000 OPERATING ROOM		0. 2062	58 45, 863	9, 460	50
00 05200 DELIVERY ROOM & LABOR ROOM		0. 2746	66 0	0	52
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1754	48 63, 196	11, 088	54
00 05900 CARDI AC CATHETERI ZATI ON		0. 1295	42 174	23	5
00 06000 LABORATORY		0. 1855	98 206, 946	38, 409	60
00 06500 RESPI RATORY THERAPY		0. 1689	37 177, 220	29, 939	6
00 06600 PHYSI CAL THERAPY		0. 6453		906, 691	
00 06900 ELECTROCARDI OLOGY		0. 1282		582	
00 07000 ELECTROENCEPHALOGRAPHY		0. 2688		180	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1993		0	
00 07200 I MPL. DEV. CHARGED TO PATI ENT		0.6835		2, 139	
00 07300 DRUGS CHARGED TO PATIENTS		0. 3161		106, 911	
00 07400 RENAL DIALYSIS 00 03950 ANCILLARY - OTHER		1.0830		12, 448 0	
97 07697 CARDIAC REHABILITATION		0. 0000		0	
OUTPATIENT SERVICE COST CENTERS		0. 3094	70 0	0	1 / 0
00 09100 EMERGENCY		0. 2024	86 5, 562	1, 126	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7667		0	
00 04040 FAMILY PRACTICE		0. 4848		0	
OTHER REIMBURSABLE COST CENTERS				-	
00 09600 DURABLE MEDI CAL EQUI P-RENTED		1. 3335	77 0	0	96
D.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 261, 826	1, 118, 996	
1.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201
2.00 Net charges (line 200 minus line 201)			2, 261, 826		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0048	Period:	Worksheet D-3	3
			From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			U U	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS			0		30. (
. 00 03100 INTENSIVE CARE UNIT			1, 418, 785		31.0
. 00 04000 SUBPROVIDER - IPF			364, 875		40.0
. 00 04100 SUBPROVIDER - IRF			0		41.0
. 00 04300 NURSERY			401, 317		43.
ANCI LLARY SERVI CE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 2062			
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2746			3 52.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1754			
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1295			
. 00 06000 LABORATORY		0. 1855			
. 00 06500 RESPI RATORY THERAPY		0. 16893			
. 00 06600 PHYSI CAL THERAPY		0. 6453			
. 00 06900 ELECTROCARDI OLOGY		0. 1282		11, 155	69.0
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2688			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1993			
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 6835			
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3161			
. 00 07400 RENAL DIALYSIS		1.0830		31, 122	2 74.
. 00 03950 ANCI LLARY - OTHER		0.0000			
. 97 07697 CARDI AC REHABI LI TATI ON		0. 3694	70 54	20	) 76.
OUTPATIENT SERVICE COST CENTERS					
. 00 09100 EMERGENCY		0. 2024		379	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7667		0	92.
. 00 04040 FAMILY PRACTICE		0. 4848	70 0	0	) 93.
OTHER REIMBURSABLE COST CENTERS					
. 00 09600 DURABLE MEDICAL EQUIP-RENTED		1. 3335		Ŭ	
0.00 Total (sum of lines 50 through 94 and 96 through			5, 243, 506	1, 269, 694	
1.00 Less PBP Clinic Laboratory Services-Program only	y charges (line 61)		0		201.
2.00 Net charges (line 200 minus line 201)			5, 243, 506		202.

leal th Financial Systems         REID HOSPITAL           NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	& HEALTH CARE SERVI	CN: 15-0048	Period:	u of Form CMS-: Worksheet D-3	
WATENT ANOLEANT SERVICE COST AT ONTOWNENT			From 01/01/2017		
	Component	CCN: 15-S048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.00	0100	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1. 00 03100 I NTENSI VE CARE UNI T			0		31.
0.00 04000 SUBPROVIDER - IPF			418, 625		40.
1.00 04100 SUBPROVIDER - IRF			0		41.
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		43.
0. 00 05000 OPERATING ROOM		0. 20625	58 0	0	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 27466	6 0	0	52.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17544	18 0	0	54.
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12954	12 0	0	59.
D. 00 06000 LABORATORY		0. 18559		0	
5. 00 06500 RESPI RATORY THERAPY		0. 16893		0	
6. 00 06600 PHYSI CAL THERAPY		0. 64538		0	
7. 00 06900 ELECTROCARDI OLOGY D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 12822 0. 26887		0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 19938		0	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 68354		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 31615		0	
4. 00 07400 RENAL DIALYSIS		1.08309		0	74.
6. 00 03950 ANCI LLARY - OTHER		0.0000	0 0	0	76.
6. 97 07697 CARDI AC REHABI LI TATI ON		0.36947	70 0	0	76.
OUTPATIENT SERVICE COST CENTERS		0.000.00			1
1.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 20248		70	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3. 00 04040 FAMILY PRACTICE		0. 4848		0	
OTHER REIMBURSABLE COST CENTERS		0.4646	0 0	0	73.
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED		1. 33357	77 0	0	96.
00.00 Total (sum of lines 50 through 94 and 96 through			347		200.
01.00 Less PBP Clinic Laboratory Services-Program only	/ charges (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)			347		202.
	•				

Health Financial Systems	REID HOSPI	TAL & HEALTH CARE SERVI	CES	In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE	COST APPORTI ONMENT	Provider C	CN: 15-0048	Peri od:	Worksheet D-3	
				From 01/01/2017		
		Component	CCN: 15-T048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Ti †1	e XIX	Subprovider -	Cost	piii
				' I RF		
Cost Center Desc	ription		Ratio of Cos		Inpati ent	
			To Charges	5	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
INPATIENT ROUTINE SERV	LCE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATR				0		30.00
31.00 03100 I NTENSI VE CARE U				0		31.00
40. 00 04000 SUBPROVIDER - IP				0		40.00
41.00 04100 SUBPROVIDER - IR				0		41.00
43. 00 04300 NURSERY				0		43.00
ANCI LLARY SERVICE COST	CENTERS					10100
50.00 05000 OPERATI NG ROOM			0. 2062	58 0	0	50.00
52.00 05200 DELIVERY ROOM &	LABOR ROOM		0. 2746	66 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNO			0. 1754		0	54.00
59.00 05900 CARDI AC CATHETER	I ZATI ON		0. 1295	42 0	0	59.00
60. 00 06000 LABORATORY			0. 1855	98 0	0	60.00
65.00 06500 RESPI RATORY THER	APY		0. 1689	37 0	0	65.00
66.00 06600 PHYSI CAL THERAPY			0. 6453	87 0	0	66.00
69.00 06900 ELECTROCARDI OLOG	Y		0. 1282	22 0	0	69.00
70.00 07000 ELECTROENCEPHALO	GRAPHY		0. 2688	71 0	0	70.00
71.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENTS		0. 1993	87 0	0	71.00
72.00 07200 I MPL. DEV. CHARG	ED TO PATIENT		0. 6835	46 0	0	72.00
73.00 07300 DRUGS CHARGED TO	PATI ENTS		0. 3161	59 0	0	73.00
74.00 07400 RENAL DIALYSIS			1.0830		0	74.00
76.00 03950 ANCI LLARY - 0THE			0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI			0. 3694	70 0	0	76.97
OUTPATIENT SERVICE COS	T CENTERS		1			
91.00 09100 EMERGENCY			0. 2024			91.00
92.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART)		0. 7667			92.00
93.00 04040 FAMILY PRACTICE			0. 4848	70 0	0	93.00
OTHER REIMBURSABLE COS				1		
96.00 09600 DURABLE MEDI CAL			1. 3335	-		
	nes 50 through 94 and 96 thr			0	0	200.00
	Laboratory Services-Program	only charges (line 61)		0		201.00
202.00 Net charges (lin	e 200 minus line 201)			0		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/7/2018 3:57	
		Title XVIII	Hospi tal	PPS	- F
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
. 00	DRG Amounts Other than Outlier Payments			0	
. 01	DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	36, 318, 327	1.01
. 02	DRG amounts other than outlier payments for discharges occurs	ring on or after October	1 (see	12, 369, 475	1.02
0.0	instructions)				1.00
. 03	DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for discharges occurring	prior to uctober	0	1.03
. 04	DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	on or after	0	1.0
. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			721, 158	2.00
. 01	Outlier reconciliation amount			0	
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting period (see instr	uctions)	7, 091, 172 151. 56	
. 00	Indirect Medical Education Adjustment	or tring period (see mistr		131.30	4.00
. 00	FTE count for allopathic and osteopathic programs for the most	st recent cost reporting	period ending on	0.00	5.00
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet	the criteria for an add	-on to the can	0.00	6.00
. 00	for new programs in accordance with 42 CFR 413.79(e)			0.00	0.00
. 00	MMA Section 422 reduction amount to the IME cap as specified			0.00	•
. 01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	r 42 CFR §412. 105(T)(1)(	IV)(B)(2) IT the	0.00	7.0
. 00	Adjustment (increase or decrease) to the FTE count for allopa	athi <mark>c an</mark> d osteopathic pr	ograms for	0.00	8.0
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	.79(c)( <mark>2)</mark> (iv), 64 FR 263	40 (May 12,		
. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl	lots under § 5503 of the	ACA. If the cost	0.00	8.0
	report straddles July 1, 2011, see instructions.				
. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	lots from a closed teach	ing hospital	0.00	8.0
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	nes (8, 8,01 and 8,02)	(see	0.00	9.0
0 00	instructions)	ment waar from wown maan	rdo	0.00	10.0
	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	rus	0.00 0.00	
2.00	Current year allowable FTE (see instructions)			0.00	12.0
3.00 4.00	Total allowable FTE count for the prior year.	our unded on or after Se	ntombor 20 1007	0.00 0.00	
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after se	ptember 30, 1997,	0.00	14.0
	Sum of lines 12 through 14 divided by 3.			0.00	
6.00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo			8.85 0.00	
	Adjusted rolling average FTE count	uşui e		8.85	
9.00	Current year resident to bed ratio (line 18 divided by line 4	4).		0. 058393	
	Prior year resident to bed ratio (see instructions)			0.056276	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 056276 1, 473, 682	1
	IME payment adjustment - Managed Care (see instructions)			214, 636	
2 00	Indirect Medical Education Adjustment for the Add-on for § 42		CED 412 105	0.00	1 22 0
3. 00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).	uent cap stots under 42	CFR 412.105	0.00	23.0
4.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
5.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	e 24 (see	0.00	25.0
6. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions	5)		0	
9.00	Total IME payment ( sum of lines 22 and 28)	5)		1, 473, 682	
9. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		214, 636	
D. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	natient days (see instru	ctions)	3. 78	30. 0
	Percentage of Medicaid patient days (see instructions)	patrone days (see fiistiu		21.95	
2.00	Sum of lines 30 and 31			25.73	32.0
3.00	Allowable disproportionate share percentage (see instructions	s)		10.44	33.0

## 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	<u>2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E	
			rom 01/01/2017	Part A	
			o 12/31/2017	Date/Time Pre	pared:
				5/7/2018 3: 57	pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			6, 766, 695, 164	
35.01	Factor 3 (see instructions)		0. 000215261	0. 000381566	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see	1, 286, 719	2, 581, 942	35.02
	instructions)				
35.03	Pro rata share of the hospital uncompensated care payment amour	nt (see instructions)	962, 395	650, 791	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	)	1, 613, 186		36.00
	Additional payment for high percentage of ESRD beneficiary disc	charges (lines 40 through	46)		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding di		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	3			
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
	an 685. (see instructions)		0		
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify	v for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,		0.00		43.00
45.00	instructions)	, 003, 004 an 005. (300	0		+5.00
44.00	Ratio of average length of stay to one week (line 43 divided by	v line 41 divided by 7	0.000000		44.00
44.00	days)	y The 41 divided by 7	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
			0.00		
46.00	Total additional payment (line 45 times line 44 times line 41.0	01)			46.00
47.00	Subtotal (see instructions)		53, 766, 579		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural nospitals	65, 136, 251		48.00
	only. (see instructions)				
				Amount	
10.00				1.00	10.00
49.00	Total payment for inpatient operating costs (see instructions)			65, 350, 887	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			4, 116, 755	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		307, 913	52.00
53.00	Nursing and Allied Health Managed Care payment			26, 689	53.00
54.00	Special add-on payments for new technologies			3, 107	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intrud	ctions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III	I, column 9, lines 30 thr	ough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IN	V, col. 11 line 200)	-	70, 215	58.00
59.00	Total (sum of amounts on lines 49 through 58)			69, 875, 566	59.00
60.00	Primary payer payments			42, 268	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus 4	line 60)		69, 833, 298	61.00
62.00	Deductibles billed to program beneficiaries	·		5, 291, 664	62.00
63.00	Coinsurance billed to program beneficiaries			99, 687	63.00
64.00	Allowable bad debts (see instructions)			652, 754	
65.00	Adjusted reimbursable bad debts (see instructions)			424, 290	
66.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		352, 840	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	policoble to MC DDCs (	instruction-	64, 866, 237	
68.00	Credits received from manufacturers for replaced devices for ap			0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F	FUI SCH SEE INSTRUCTIONS)		0	69.00
70.00	OTHER ADJUSTMENTS			-6, 870	
70.50	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) adjustment (see ir	structions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
	USD bonus novement HDD adjustment amount (see instructions)			0	70. 91
70. 91	HSP bonus payment HRR adjustment amount (see instructions)				
	Bundled Model 1 discount amount (see instructions)			0	70.92
70. 91	Bundled Model 1 discount amount (see instructions)				
70. 91 70. 92				0 340, 178 -213, 609	70. 93
70. 91 70. 92 70. 93 70. 94	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			340, 178 -213, 609	70. 93
70. 91 70. 92 70. 93 70. 94	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			340, 178 -213, 609	70. 93 70. 94

	ncial Systems REID HOSPITAL & HEALTI N OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od:	u of Form CMS-2 Worksheet E	2002
	N OF REIMBURSEMENT SETTLEMENT	Provider C	CN. 13-0046	From 01/01/2017	Part A	
				To 12/31/2017	Date/Time Pre	pare
		Ti tl c	e XVIII	Hospi tal	5/7/2018 3:57 PPS	pm
		iiie			Amount	
				0	1.00	<u> </u>
0.96 Low	volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0		70.
	corresponding federal year for the period prior to 10/1)			-	-	
	volume adjustment for federal fiscal year (yyyy) (Enter i corresponding federal year for the period ending on or af			0	0	70.
	Volume Payment-3				0	70.
	adjustment amount (see instructions)				0	
	nt due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			64, 985, 936	71.
	estration adjustment (see instructions)				1, 299, 719	
	nstration payment adjustment amount after sequestration				0	
	rim payments				63, 681, 786	
	ative settlement (for contractor use only) nce due provider/program (line 71 minus lines 71.01, 71.0	2 72 and			0 4, 431	
73)		2, 72, anu			4,431	/4.
	ested amounts (nonallowable cost report items) in accorda	nce with			0	75.
	Pub. 15-2, chapter 1, §115.2					
	E COMPLETED BY CONTRACTOR (lines 90 through 96)					
	rating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	
	tal outlier from Wkst. L, Pt. I, line 2 rating outlier reconciliation adjustment amount (see instr	uctions)			0	
	tal outlier reconciliation adjustment amount (see instruc				0	
	rate used to calculate the time value of money (see instr				0.00	
. 00   Time	value of money for operating expenses (see instructions)	· ·			0	95
5.00 Time	value of money for capital related expenses (see instruc	tions)			0	96
				Prior to 10/1 1.00		
					2.00	
	Bonus Payment Amount					
	Bonus Payment Amount bonus amount (see instructions)					100
0. 00 HSP	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment					100
0.00 HSP HVBP	bonus amount (see instructions)					
0.00 HSP HVBP 1.00 HVBP 2.00 HVBP	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) Padjustment amount for HSP bonus payment (see instruction	s)		0	0.000000000	101
00. 00 HSP HVBP 01. 00 HVBP 02. 00 HVBP HRR /	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment	s)		0. 0000000000	0.000000000 0	101 102
0.00 HSP HVBP 1.00 HVBP 2.00 HVBP HRR 3.00 HRR	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) Padjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions)			0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR 7 3. 00 HRR 4. 00 HRR	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions	, (	stment	0. 0000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103
0. 00 HSP HVBP 11. 00 HVBP 12. 00 HVBP HRR / 13. 00 HRR 14. 00 HRR Rural	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) Adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst	) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103 104
0.00 HSP HVBP 1.00 HVBP 2.00 HVBP HRR / 3.00 HRR 4.00 HRR Rural 0.00 Is t	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions	) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103 104
0.00 HSP HVBP 11.00 HVBP 2.00 HVBP HRR / 13.00 HRR 14.00 HRR 0.00 Is t Cent Cost	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) I community Hospital Demonstration Project (\$410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement	) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103 104 200
0.00 HSP HVBP 11.00 HVBP 2.00 HVBP 13.00 HRR 14.00 HRR 14.00 HRR 0.00 I s t Cent Cost 11.00 Medi	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin	) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103 104 200 201
0.00 HSP HVBP 1.00 HVBP 2.00 HVBP 3.00 HRR 4.00 HRR 4.00 HRR 0.00 Is t <u>Cost</u> 1.00 Medi 2.00 Medi	bonus amount (see instructions) Adjustment for HSP Bonus Payment P adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (\$410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions)	) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0. 000000000 0 0. 0000	101 102 103 104 200 201 202
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR 0. 00 I s t Cost 1. 00 Medi 2. 00 Medi 3. 00 Case	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) mix adjustment factor (see instructions)	) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0	101 102 103 104 200 201 202
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR 0. 00 Is t Cost 1. 00 Medi 2. 00 Medi 3. 00 Case Comp	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0	101 102 103 104 200 201 202
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 3. 00 HRR 4. 00 HRR Rural 0. 00 Is t Cost 1. 00 Medi 3. 00 Case Compi perio	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) How State of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) How adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od)	) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0	101 102 103 104 200 201 202 203
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 4. 00 HRR 3. 00 HRR Rural 0. 00 Is t Cost 1. 00 Medi 3. 00 Case Compi peri 0 4. 00 Medi	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under t e 49)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0. 0000000000 0 0. 0000 0 0	101 102 103 104 200 201 202 203 203 204 204 205
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0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 2. 00 HVBP 3. 00 HRR 3. 00 HRR 0. 00 I s t Cont 2. 00 Medi 3. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 7. 00 Prog 8. 00 Medi 9. 00 Adj u	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement rram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions)	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 203 204 205 206 207 208 209
0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR 4. 00 HRR 0. 00 Is t Cent Cost 1. 00 Medi 2. 00 Medi 3. 00 Case Comp peri d 4. 00 Medi 5. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 5. 00 Prog 8. 00 Medi 9. 00 Adj u 9. 00 Adj u 9. 00 Adj u	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount e-mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement iram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101 102 103 200 201 202 203 203 204 205 206 207 208 209 210
0.00 HSP HVBP 1.00 HVBP 2.00 HVBP 3.00 HRR 4.00 HRR 4.00 HRR 1.00 Is t Cost 1.00 Medi 2.00 Medi 3.00 Case 6.00 Medi 5.00 Case 6.00 Medi 5.00 Case 6.00 Medi 5.00 Case 6.00 Medi 9.00 Adj u 0.00 Rese 1.00 Tota	bonus amount (see instructions) Adjustment for HSP Bonus Payment Padjustment factor (see instructions) Padjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount e-mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement rram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, istment to Medicare IPPS payments (see instructions) erved for future use	) ration) Adju riod under t e 49) first year ructions)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0	101 102 103 200 201 202 203 203 204 205 206 207 208 209 210
00.00 HSP HVBP 11.00 HVBP 22.00 HVBP 23.00 HVR HRR 44.00 HRR Rural 00.00 I s t Cost Cost 01.00 Medi 02.00 Medi 02.00 Medi 03.00 Case 6.00 Medi 04.00 Prog 08.00 Medi 07.00 Prog 08.00 Medi 09.00 Adj u 0.00 Rese 1.00 Tota Comp 2.00 Tota	bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe- ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement gram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, istment to Medicare IPPS payments (see instructions) arision of PPS versus Cost Reimbursement I adjustment to Medicare Part A IPPS payments (from line	) ration) Adjú riod under t e 49) first year ructions) line 59)	he 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0 0	101 102 103 200 201 202 203 204 205 206 207 208 209 210 211
00.00 HSP HVBP 1.00 HVBP 22.00 HVBP 22.00 HVBP 23.00 HRR Alt 00 HRR Rural 00.00 I s t Cost Comp peri 1 02.00 Medi 12.00 Medi 12.00 Medi 105.00 Case Comp peri 1 05.00 Case 06.00 Medi 105.00 Case 100 Medi 100 Necs 11.00 Prog 12.00 Tota Comp 12.00 Tota 13.00 Low	bonus amount (see instructions) Adjustment for HSP Bonus Payment P adjustment factor (see instructions) P adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe- ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iin care discharges (see instructions) e-mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement irram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, istment to Medicare IPPS payments (see instructions) arision of PPS versus Cost Reimbursement	) ration) Adju riod under t e 49) first year ructions) line 59) 211)	of the curre	0. 0000000000 0 0. 0000000000 0 0. 00000 0	0.0000000000 0 0.0000 0 0	101 102 103 200 201 202 203 203 204 205 206 207

In Lieu of Form CMS-2552-10

	ATION OF DSH PAYMENT PERCENTAGE		Provider CC	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet DSH Date/Time Pre 5/7/2018 3:57	pared:
				XVIII	Hospi tal	PPS	
		Values	Values	·	Override Value		
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line	3. 78	0.00	0.00	0.00	0.00	1.00
2.00	30 - Revised from CMS) Percentage of Medicaid patient days to total days (From line 27)	21. 95	0.00			21.95	2.00
3. 00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	25. 73	0.00			21.95	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	151. 56	0.00			151.56	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	10. 44	0.00			7.32	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
9.00	S-2, Line 22 Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes No				Yes No	8.00 9.00
	S-2, Line 45	No				No	10.00
	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0. 00	0.00	0.00	0.00	0.00	12.00
	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2.40	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICALD DAY		0			042	15 00
	In-State Medicaid paid days (Worksheet S-2, line 24, column 1) In-State Medicaid eligible unpaid paid days	942 567				942 567	15.00 16.00
	(Worksheet S-2, line 24, column 2) Out-of-State Medicaid paid days (Worksheet	387	0			387	17.00
18. 00	S-2, line 24, column 3) Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	241	0			241	18.00
	M/A Medicaid HMO days (Worksheet S-2, line 24,	0 6, 144	0 0			0 6, 144	
20. 00	column 5) Other Medicaid days (Worksheet S-2, line 24,	114	0			114	20.00
21. 00	column 6) Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	8, 395	0			8, 395	21.00
22. 00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	36, 850	0			36, 850	22.00
	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	161	0			161	
	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	1, 231	0			1, 231	
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	38, 242	0			38, 242	26.00
	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	21. 95	0.00			21.95	27.00

	ATION OF DSH PAYMENT PERCENTAGE		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet DSH Date/Time Pre 5/7/2018 3:57	pared:
				XVIII	Hospi tal	PPS	
		Original .n	ncrx Values	Adj usted	.mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		-	1			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	10. 44		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0.00		0.00	Fal se	29.00
30.00	Line 28 or 29 as applicable		10.44		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		10. 44		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	o Override Value	Revi sed Val ue	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	ls this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00
			N				
		1					

Heal th	Financial Systems REID	HOSPI TAL & HEALT	H CARE SERVICES	In Lieu	u of Form CMS-	2552-10
CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet DSH	1
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28.00	If line 3 is greater than 20.2% - 5.88% plus	7.32				28.00
	82.5% of the difference between 20.2% and					
	line 3					
29.00	If line 3 is less than 20.2% - 2.5% plus 65%	0.00				29.00
	of the difference between 15% and line 3					
	Line 28 or 29 as applicable	7.32				30.00
31.00	If Urban and fewer than 100 beds, Rural and	7.32				31.00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

CALCUL	Financial Systems REID HOSPITAL & HEALT ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Period: From 01/01/2017	u of Form CMS-: Worksheet E Part B	2002 10
			To 12/31/2017		
		Title XVIII	Hospi tal	PPS	pili
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	stions)		38, 121 40, 399, 702	
2.00 3.00	OPPS payments	.110115)		40, 399, 702	
4.00	Outlier payment (see instructions)			53, 530	
4.01	Outlier reconciliation amount (see instructions)	unti ana)		0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COL. 13, TINE 200		163, 609	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			38, 121	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			121, 766	12 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			121, 766	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for		0	0	
	had such payment been made in accordance with 42 CFR §413.13(	(e)	0		
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	nlvifline 18 exceeds li	ne 11) (see	83, 645	
	instructions)	<b>3</b> V	, ,		
20.00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			38, 121	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			48, 580, 654	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			268	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	or CAH, see instructions)	)	8, 875, 522	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2.	z and z3j (see	39, 742, 985	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I			187, 169	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			39, 930, 154 10, 354	
32.00	Subtotal (line 30 minus line 31)			39, 919, 800	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 1, 197, 246	33.00 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			778, 210	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		647, 160	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			40, 698, 010	
39.00	OTHER ADJUSTMENTS			-2, 727	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)			39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	ctions)	0	
40.00	Subtotal (see instructions)			40, 694, 509	
40.01	Sequestration adjustment (see instructions)			813, 890	
40. 02 41. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 39, 843, 753	
41.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			36, 866	
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			1	1
90.00	Original outlier amount (see instructions)				90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				92.00 93.00
	Total (sum of lines 91 and 93)				94.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E	
			Date/Time Pre	
			5/7/2018 3:57	pm
	Title XVIII	Hospi tal	PPS	
			Overri des	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges (	(line 12)		0	112.00

ALCUL	Financial Systems REID HOSPITAL & HEAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E	
		Component CCN: 15-SO48	From 01/01/2017 To 12/31/2017	Part B Date/Time Pre 5/7/2018 3:57	
		Title XVIII	Subprovider -	PPS	piii
		·		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)	unti ana)		1, 566	
. 00 . 00	Medical and other services reimbursed under OPPS (see instru OPPS payments	ictions)		1, 603 1, 813	
. 00	Outlier payment (see instructions)			0	
. 01	Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	ructions)		0.000	
. 00 . 00	Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
. 00	Transitional corridor payment (see instructions)			0.00	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		13	9.
0.00	Organ acqui si ti ons			0	
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 566	11.
	Reasonable charges				
2.00	Ancillary service charges			4, 953	12.
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)			13.
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			4, 953	14.
5.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.
6.00	Amounts that would have been realized from patients liable f			0	
	had such payment been made in accordance with 42 CFR §413.13	3(e)	-		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
8.00 9.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ne 11) (see	4, 953 3, 387	
7.00	instructions)			0,007	17.
0. 00	Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds li	ne 18) (see	0	20.
1 00	instructions)			1, 566	21
1.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			1, 566	
	Cost of physicians' services in a teaching hospital (see ins	structions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4,01, 8 and 9)			1, 826	24.
F 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 25
	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (f	for CAH see instructions)		0 61	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			3, 331	
	instructions)				
8.00	Direct graduate medical education payments (from Wkst, E-4,			0	
9.00 0.00	ESRD direct medical education costs (from Wkst. E-4, line 36 Subtotal (sum of lines 27 through 29)	5)		0 3. 331	
1.00	Primary payer payments			0,001	31.
2.00	Subtotal (line 30 minus line 31)			3, 331	32.
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	I CES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	
	Subtotal (see instructions)			3, 331	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructio			0	39
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repl		tions)	0	
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			3, 331	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			67 0	
	Interim payments			3, 212	
2.00	Tentative settlement (for contractors use only)			0	42.
	Balance due provider/program (see instructions)			52	
4.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	cnapter 1,	0	44.
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)	1		0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93.

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E	
	Component CCN: 15-S048	To 12/31/2017		
	Title XVIII	Subprovider -	PPS	
			Overri des	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges	(line 12)		0	112.00

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E Part B	
	Component CCN: 15-TO48	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
	Title XVIII	Subprovider -	PPS	
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
00 Medical and other services (see instructions) 00 Medical and other services reimbursed under OPPS	(see instructions)		61 32	
0 OPPS payments	s (see This if uctions)		62	
00 Outlier payment (see instructions)			0	
01 Outlier reconciliation amount (see instructions)			0	
00 Enter the hospital specific payment to cost rati	o (see instructions)		0.000	
00 Line 2 times line 5 00 Sum of lines 3, 4, and 4.01, divided by line 6			0 0.00	
00 Transitional corridor payment (see instructions)	)		0.00	
00 Ancillary service other pass through costs from			0	
00 Organ acqui si ti ons			0	
00 Total cost (sum of lines 1 and 10) (see instruct	tions)		61	11
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				+
00 Ancillary service charges			192	12.
00 Organ acquisition charges (from Wkst. D-4, Pt. I	II, col. 4, line 69)		0	
00 Total reasonable charges (sum of lines 12 and 13	3)		192	14
Customary charges				1 45
00 Aggregate amount actually collected from patient 00 Amounts that would have been realized from patie			0	
had such payment been made in accordance with 42			0	'0
00 Ratio of line 15 to line 16 (not to exceed 1.000	0000)		0.000000	17
00 Total customary charges (see instructions)			192	
00 Excess of customary charges over reasonable cost	t (complete only if line 18 exceeds li	ne 11) (see	131	19
instructions) 00 Excess of reasonable cost over customary charges	s (complete only if line 11 exceeds li	ne 18) (see	0	20
instructions)			0	20
00 Lesser of cost or charges (see instructions)			61	21
00 Interns and residents (see instructions)			0	
00 Cost of physicians' services in a teaching hospi 00 Total prospective payment (sum of lines 3, 4, 4.			0 62	
COMPUTATION OF REIMBURSEMENT SETTLEMENT			02	24
00 Deductibles and coinsurance (for CAH, see instru			0	25
00 Deductibles and Coinsurance relating to amount of			0	26
00 Subtotal [(lines 21 and 24 minus the sum of line	es 25 and 26) plus the sum of lines 22	and 23] (see	123	27
instructions) 00 Direct graduate medical education payments (from	n Wkst F-4 line 50)		0	28
00 ESRD direct medical education costs (from Wkst.			0	
00 Subtotal (sum of lines 27 through 29)			123	30
00 Primary payer payments			0	
00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFE			123	32
00 Composite rate ESRD (from Wkst. I-5, line 11)	ESSTONAL SERVICES)		0	33
00 Allowable bad debts (see instructions)			0	
00 Adjusted reimbursable bad debts (see instruction			0	
00 Allowable bad debts for dual eligible beneficiar	ri <mark>e</mark> s (see instructions)		0	
00 Subtotal (see instructions) 00 MSP-LCC reconciliation amount from PS&R			123 0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (se	ee instructions)		-	39
97 Demonstration payment adjustment amount before s	•		0	
98 Partial or full credits received from manufactur	rers for replaced devices (see instruc	tions)	0	
<ul><li>99 RECOVERY OF ACCELERATED DEPRECIATION</li><li>00 Subtotal (see instructions)</li></ul>			0 123	
01 Sequestration adjustment (see instructions)			123	
02 Demonstration payment adjustment amount after se	equestrati on		0	
00 Interim payments			98	41
00 Tentative settlement (for contractors use only)			0	
00 Balance due provider/program (see instructions) 00 Protested amounts (nonallowable cost report item	ns) in accordance with CMS Dub 15 2	chanter 1	23 0	
§115. 2	$m_{3}$ in accordance with two Pub. 15-2,		0	44
TO BE COMPLETED BY CONTRACTOR				1
00 Original outlier amount (see instructions)			0	
00 Outlier reconciliation adjustment amount (see i	-		0	
00 The rate used to calculate the Time Value of Mor 00 Time Value of Money (see instructions)	ley		0.00 0	
00 Total (sum of lines 91 and 93)				94

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E	
	Component CCN: 15-TO48	To 12/31/2017		
	Title XVIII	Subprovider -	PPS	
		IRF		
			Overri des	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges	(line 12)		0	112.00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0048	Period: From 01/01/2017 To 12/31/2017		pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	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		63, 556, 5	86 0	39, 801, 653 0	1.00 2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	07/31/2017	125, 2	00 03/09/2017	42, 100	3.01
3. 02				0	0	3. 02
3.03 3.04				0	0	3.03 3.04
3.04 3.05				0	0	3.04
. 00	Provider to Program			0	0	5. 0.
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52 3.53				0	0	3.5 3.5
3.53 3.54				0	0	3.5
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 🥒		125, 2	-	42, 100	3.9
	3. 50-3. 98)		(0 (01 7		00.040.750	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	•	63, 681, 7	86	39, 843, 753	4.0
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	C				5.0
	Program to Provider					
5.01 5.02	TENTATI VE TO PROVIDER			0	0	5.0 5.0
5.02 5.03				0	0	5.0 5.0
	Provider to Program			-		0.0
. 50	TENTATI VE TO PROGRAM			0	0	5.5
5.51				0	0	5.5
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5 5.9
. 99	5. 50-5. 98)			0	0	5.5
. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 0
. 01	SETTLEMENT TO PROVIDER		4,4		36, 866	6.C
o. 02 '. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		63, 686, 2	0 17	0 39, 880, 619	6.0 7.0
. 00	Total modecare program traditity (account during)		00,000,2	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0048 CCN: 15-S048	Period: From 01/01/2017 To 12/31/2017		pare
		Ti tl e	e XVIII	Subprovider -	PPS	-1-
		I npati er	nt Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		5, 347, 2	0	3, 212	1. 2. 3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
)1 )2	ADJUSTMENTS TO PROVIDER			0	0	3
)3				0	0	3
)4				0	0	3
)5				0	0	3
~	Provider to Program		1	0		
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 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)		5, 347, 2	24	3, 212	4
0	TO BE COMPLETED BY CONTRACTOR			-		5
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0
)1	Program to Provider			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program		1			
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	•		0	0	5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		2, 0	93	52	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		5, 349, 3		3, 264	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
)0	Name of Contractor					8

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0048 CCN: 15-T048	Period: From 01/01/2017 To 12/31/2017		pare
		Title	e XVIII	Subprovider - IRF	PPS	
		I npati er	nt Part A		rt B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		2, 845, 6	0	98 0	1. 2. 3.
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				•	
D1 D2	ADJUSTMENTS TO PROVIDER			0	0	
)3				0	0	3
)4				0	0	3
)5				0	0	3
0	Provider to Program		1	0	0	
50 51	ADJUSTMENTS TO PROGRAM			0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 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)		2, 845, 6	92	98	4
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1 )2	TENTATI VE TO PROVI DER			0	0	5
)3				0	0	
	Provider to Program		1			
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	5
o∠ 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines	•		0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on				Ĵ	6
11	the cost report. (1)	•	17 /	70		,
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		17,6	0	23	6
)2 )0	Total Medicare program liability (see instructions)		2, 863, 3	70	121	7
			_, ,	Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
00	Name of Contractor		0	1.00	2.00	8

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0048	Peri od:	Worksheet E-1	
			From 01/01/2017	Part II	
			To 12/31/2017		
		<b>T</b> I II NO (1   1		5/7/2018 3:57	pm
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00
			,	Overri des	
				1.00	
	CONTRACTOR OVERRIDES				

108.00 Override of HIT payment

108.00



ALCUL	Financial Systems REID HOSPITAL & HEA ATION OF REIMBURSEMENT SETTLEMENT	LTH CARE SERVICES Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-SO48	From 01/01/2017 To 12/31/2017	Part II	pare
		Title XVIII	Subprovider -	PPS	piii
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	edical education payments)		6, 023, 999	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 recent	cost report filed on or b	efore November	0.00	4
01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE co	unt for residents that wer	o displaced by	0.00	4
01	program or hospital closure, that would not be counted with			0.00	4
	CFR §412. 424(d) (1) (iii) (F) (1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs i	n the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents withi	n the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions)		0.00	
00	Average Daily Census (see instructions)	a the newer of [150 1]		27.616438	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised t	o the power of .5150 -1}.		0.000000	1 1 1 1
00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11	۱ <b>/</b>		6, 023, 999	
	Nursing and Allied Health Managed Care payment (see instruc			0, 023, 444	1
	Organ acquisition (DO NOT USE THIS LINE)			0	14
	Cost of physicians' services in a teaching hospital (see in	structions)		0	
	Subtotal (see instructions)			6, 023, 999	
	Primary payer payments			0	
	Subtotal (line 16 less line 17).			6, 023, 999	1
	Deducti bl es			360, 472	10
. 00	Subtotal (line 18 minus line 19)			5, 663, 527	20
	Coinsurance			207, 158	
	Subtotal (line 20 minus line 21)			5, 456, 369	
	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		0	2
	Adjusted reimbursable bad debts (see instructions)			0	2
	Allowable bad debts for dual eligible beneficiaries (see in	istructions)		0	2
	Subtotal (sum of lines 22 and 24)			5, 456, 369	
. 00 . 00	Direct graduate medical education payments (from Wkst. E-4, Other pass through costs (see instructions)	111le 49)		0 2, 118	2
	Outlier payments reconciliation			2, 110	2
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Pioneer ACO demonstration payment adjustment (see instructi	ons)		0	30
	Demonstration payment adjustment amount before sequestratio			0	
	Total amount payable to the provider (see instructions)	-		5, 458, 487	3.
01	Sequestration adjustment (see instructions)			109, 170	3
	Demonstration payment adjustment amount after sequestration	I		0	
	Interim payments			5, 347, 224	
	Tentative settlement (for contractor use only)			0	33
	Balance due provider/program (line 31 minus lines 31.01, 31			2, 093	
. 00	Protested amounts (nonallowable cost report items) in accor	dance with CMS Pub. 15-2,	cnapter 1,	0	35
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Worksheet E-3, Part 11, line 2	1		0	50
	Outlier reconciliation adjustment amount (see instructions)			0	5
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				5:

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	Worksheet E-3	
		Component CCN: 15-TO48	From 01/01/2017 To 12/31/2017	Part III Date/Time Prep 5/7/2018 3:57	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
00	Net Federal PPS Payment (see instructions)			2, 816, 816	
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0240	
00 00	Inpatient Rehabilitation LIP Payments (see instructions) Outlier Payments			101, 124 20, 028	
00	Unweighted intern and resident FTE count in the most recei	at cost reporting period en	ding on or prior	0.00	
D1	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE (		0 1		
1	program or hospital closure, that would not be counted wi (CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
00	New Teaching program adjustment. (see instructions)			0.00	6
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents with teaching program" (see instructions)	nin the new program growth p	eriod of a "new	0.00	8
00	Intern and resident count for IRF PPS medical education ad	djustment (see instructions)		0.00	
00	Average Daily Census (see instructions)			8.635616	
00	Teaching Adjustment Factor (see instructions)			0.00000	
00	Teaching Adjustment (see instructions)				1
00 00	Total PPS Payment (see instructions) Nursing and Allied Health Managed Care payments (see inst	suction)		2, 937, 968 0	
00	Organ acquisition (DO NOT USE THIS LINE)			0	1
00	Cost of physicians' services in a teaching hospital (see i	instructions)		0	1
00	Subtotal (see instructions)			2, 937, 968	
00	Primary payer payments			0	1
00	Subtotal (line 17 less line 18).			2, 937, 968	1
00	Deducti bl es			11, 816	
00	Subtotal (line 19 minus line 20)			2, 926, 152	
00	Coinsurance			4,606	
00	Subtotal (line 21 minus line 22)			2, 921, 546	
00 00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		0	2
00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i	instructions)		0	2
00	Subtotal (sum of lines 23 and 25)	(instructions)		2, 921, 546	
00	Direct graduate medical education payments (from Wkst. E-4	4 line 49)		2, 721, 340	2
00	Other pass through costs (see instructions)	.,		260	
00	Outlier payments reconciliation			0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	× •		0	3
50	Pioneer ACO demonstration payment adjustment (see instruct			0	3
. 99	Demonstration payment adjustment amount before sequestrati	i on 🔻		0	3
00	Total amount payable to the provider (see instructions)			2, 921, 806	
01	Sequestration adjustment (see instructions)			58, 436	
02	Demonstration payment adjustment amount after sequestration	טח			3.
00 00	Interim payments Tentative settlement (for contractor use only)	*		2, 845, 692 0	
00	Balance due provider/program (line 32 minus lines 32.01, 3	32 02 33  and  34		0 17, 678	
00	Protested amounts (nonallowable cost report items) in acco §115.2		chapter 1,	0	
	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	、 、		20, 028	
. 00	Outlier reconciliation adjustment amount (see instructions	5)		0	
. 00	The rate used to calculate the Time Value of Money			0.00	52

		CARE_SERVICES Provider CCN: 15-0048	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pare
				5/7/2018 3:57	pm
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	
D	ART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR Y		2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES		TA SERVICES		1
	npatient hospital/SNF/NF services		2, 372, 099		1 1.
	ledical and other services		2,072,077	2, 374, 025	2.
	rgan acquisition (certified transplant centers only)		0	2,071,020	3.
	ubtotal (sum of lines 1, 2 and 3)		2, 372, 099	2, 374, 025	4.
	npatient primary payer payments		0		5.
	utpatient primary payer payments			0	6.
	ubtotal (line 4 less sum of lines 5 and 6)		2, 372, 099	2, 374, 025	7.
	OMPUTATION OF LESSER OF COST OR CHARGES				
	easonabl e Charges				1
	outine service charges		0		8.
	ncillary service charges		5, 243, 506	9, 261, 654	9.
. 00 0	rgan acquisition charges, net of revenue		0		10.
. 00	ncentive from target amount computation		0		11.
. 00 T	otal reasonable charges (sum of lines 8 through 11)		5, 243, 506	9, 261, 654	12.
CI	USTOMARY CHARGES				
. 00 A	mount actually collected from patients liable for payment for s	services on a charge	0	0	13.
-	asi s				
	mounts that would have been realized from patients liable for		n 0	0	14.
	charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
	atio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.00000	
	otal customary charges (see instructions)		5, 243, 506	9, 261, 654	
	xcess of customary charges over reasonable cost (complete only	IT Line 16 exceeds	2, 871, 407	6, 887, 629	17.
	ine 4) (see instructions)		-	0	10
	<ul> <li>ixcess of reasonable cost over customary charges (complete only</li> <li>6) (see instructions)</li> </ul>	IT TThe 4 exceeds ITh	e u	0	18.
	nterns and Residents (see instructions)		0	0	19.
	ost of physicians' services in a teaching hospital (see instructions)	stions)	0	0	20.
	ost of covered services (enter the lesser of line 4 or line 16)		2, 372, 099	2, 374, 025	
	ROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			2, 374, 023	21.
	ther than outlier payments		0	0	22.
	utlier payments		0	0	23.
	Program capital payments		0	Ũ	24.
	apital exception payments (see instructions)		0		25.
	outine and Ancillary service other pass through costs		0	0	26.
	ubtotal (sum of lines 22 through 26)		0	0	27.
3. 00 C	ustomary charges (title V or XIX PPS covered services only)		0	0	28.
9. OO T	itles V or XIX (sum of Lines 21 and 27)	• • • • • • • • • • • • • • • • • • •	2, 372, 099	2, 374, 025	29.
C	OMPUTATION OF REIMBURSEMENT SETTLEMENT				
	xcess of reasonable cost (from line 18)		0	0	30.
	ubtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2, 372, 099	2, 374, 025	
. 00 D	educti bl es		0	0	32.
	ioi nsurance		0	0	33.
	llowable bad debts (see instructions)		0	0	
	tilization review		0		35.
	ubtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	2, 372, 099	2, 374, 025	
	ERO OUT TITLE XIX		-2, 372, 099	-2, 374, 025	
	ubtotal (line 36 ± line 37)		0	0	38.
	irect graduate medical education payments (from Wkst. E-4)		0		39.
	otal amount payable to the provider (sum of lines 38 and 39)		0	0	40.
	nterim payments		0	0	41.
	alance due provider/program (line 40 minus line 41)		0	0	42.
	rotested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.
	hapter 1, §115.2				
0	VERRIDES verride Ancillary service charges (line 9)		0		109.

			To 10/01/0017	Data /Tima Dira	000-
		Component CCN: 15-SO48	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pare
		Title XIX	Subprovider -	Cost	
			I PF I npati ent	Outpati ent	
			1.00	2.00	<u> </u>
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR X	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		70		
	Inpatient hospital/SNF/NF services Medical and other services		70	0	1
	Organ acquisition (certified transplant centers only)		0	0	
	Subtotal (sum of lines 1, 2 and 3)		70	0	
	Inpatient primary payer payments		0		5
	Outpatient primary payer payments		70	0	
	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		70	0	7
-	Reasonable Charges				1
	Routi ne servi ce charges		0		8
	Ancillary service charges		347	0	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0 347	0	11
-	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		347	0	_ 12
	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basis				
	Amounts that would have been realized from patients liable for		n 0	0	14
	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR §413. 13(e)	0. 000000	0. 000000	15
	Total customary charges (see instructions)		347	0.000000	
	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	277	0	
	line 4) (see instructions)	•			
	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y if line 4 exceeds lin	e 0	0	18
	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 1		70	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provi		0	
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0	0	24
	Capital exception payments (see instructions)		0		25
	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) Titles V or XIX (sum of lines 21 and 27)		70	0	
-	COMPUTATION OF REIMBURSEMENT SETTLEMENT		70	0	2'
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	70	0	
	Deducti bl es		0	0	
	Coinsurance 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	1 33)	70	0	
	ZERO OUT TITLE XIX		-70	0	
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0	0	39
	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	43
	chapter 1, §115.2 DVERRI DES				-

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E-3 Part VII	
		Component CCN: 15-T048	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pare
		Title XIX	Subprovider -	Cost	
			IRF	Outratiant	
			Inpatient 1.00	Outpatient 2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00 00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		0	0	1
	Reasonable Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		0	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES		0	0	12
. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable for	1 3	n 0	0	14
. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0.000000	15
. 00	Total customary charges (see instructions)		0.000000	0.000000	1
. 00	Excess of customary charges over reasonable cost (complete onl	vifline 16 exceeds	0	0	
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl		e 0	0	
	16) (see instructions)	y II IIIe 4 exceeds III	6 0	0	
. 00 . 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
. 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	2
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00 . 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		0	0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		V	0	2
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
. 00			0	0	
. 00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
. 00 . 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	0	30
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00	Interim payments		0	0	4
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	ce with CMS Pub 15-2,	0	0	
	OVERRI DES		I		1

RECT	Financial Systems REID HOSPITAL & HEALTH GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO	CN: 15-0048	In Lie Period:	Worksheet E-4	
DI CA	L EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
		Title	XVIII	Hospi tal	PPS	pin
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	0.00	1
	ending on or before December 31, 1996.					
00	Unweighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	uctions)	0.00	2
00 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		8413 79 (m)	(see	0.00 0.00	
	instructions for cost reporting periods straddling 7/1/2011)			(333	01.00	
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	
51	straddling 7/1/2011)		cost reporti	ng per rous	0.00	
02	ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4
00	periods stradding 7/1/2011)			inco 1 01 and	0.00	5
50	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	TTHE 4 prus T	THES 4.01 and	0.00	
00	Unweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	8.85	6
~~	records (see instructions)				0.00	
00	Enter the lesser of line 5 or line 6		Primary Care	Other	0.00 Total	
			1.00	2.00	3.00	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0.0	0 0.00	0.00	8
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	iso	0.0	0 0.00	0.00	
0	multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0.00	
	6.					
00	Weighted dental and podiatric resident FTE count for the curr			0.00		10
01 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	rrent year	0.0	0.00		10
00	Total weighted resident FTE count for the prior cost reportin	q year (see	0.0			1
	instructions)					
00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0.0	0 0.00		1:
00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0	0.00		14
00	Adjustment for residents in initial years of new programs		0.0			1!
01	Unweighted adjustment for residents in initial years of new p		8.8			1!
00 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		8.8 0.0			10
01	closure		0.0	0.00		
00	Adjusted rolling average FTE count		8.8			1
00 00	Per resident amount Approved amount for resident costs		85, 000. 0 752, 25		752, 250	18
00	Approved amount for resident costs		752,25	0 0	752, 250	
					1.00	
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	0.00	20
00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			8.85	2
00	Allowable additional direct GME FTE Resident Count (see instr				0.00	
00	Enter the locally adjustment national average per resident am	ount (see in	structions)		0.00	
00 00	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 752, 250	24
00			Inpatient Par	t Managed care	752, 250	2.
			A	3		
			1.00	2.00	3.00	
00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		28, 10	5 4, 279		20
00	Total Inpatient Days (see instructions)		48, 28			20
00	Ratio of inpatient days to total inpatient days		0. 58204			28
00	Program direct GME amount		437, 84			29
. 00	Reduction for direct GME payments for Medicare Advantage			9, 419	40F 000	30
00	Net Program direct GME amount		I	1	495, 082	13

	SPITAL & HEALTH			u of Form CMS-2	
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATI	IENT DIRECT	Provider CCN: 15-0048	Period: From 01/01/2017	Worksheet E-4	
MEDICAL EDUCATION COSTS			To 12/31/2017	Date/Time Pre	nared
				5/7/2018 3:57	
		Title XVIII	Hospi tal	PPS	
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSI	TE RATE - TITLE	XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
EDUCATION COSTS)					
32.00 Renal dialysis direct medical education costs ( and 94)	from Wkst. B, P	t. I, sum of col. 20 ar	nd 23, lines 74	0	32.0
33.00 Renal dialysis and home dialysis total charges	(What C Dt I	col 9 sum of lines	74 and $94$	852, 259	22 0
4.00 Ratio of direct medical education costs to tota				0. 000000	
5.00 Medicare outpatient ESRD charges (see instructi		<u>32</u> THE 33)		0.000000	
6.00 Medicare outpatient ESRD direct medical educati		34 x line 35)		0	
APPORTIONMENT BASED ON MEDICARE REASONABLE COST					
Part A Reasonable Cost					1
37.00 Reasonable cost (see instructions)				66, 824, 078	37.0
8.00 Organ acquisition costs (Wkst. D-4, Pt. III, co	ol. 1, line 69)			0	38. (
9.00 Cost of physicians' services in a teaching hosp	oital (see instr	uctions)		0	39.
0.00 Primary payer payments (see instructions)				42, 268	40.
1.00 Total Part A reasonable cost (sum of lines 37 t	hrough 39 minus	line 40)		66, 781, 810	41.
Part B Reasonable Cost					
2.00 Reasonable cost (see instructions)				40, 604, 707	
3.00 Primary payer payments (see instructions)				10, 354	
4.00 Total Part B reasonable cost (line 42 minus lin	ne 43)			40, 594, 353	
5.00 Total reasonable cost (sum of lines 41 and 44)				107, 376, 163	
6.00 Ratio of Part A reasonable cost to total reason				0. 621943	
7.00 Ratio of Part B reasonable cost to total reason ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN				0. 378057	47.0
8.00 Total program GME payment (line 31)	PART A AND PAR	I B		495, 082	1 10
9.00 Part A Medicare GME payment (line 46 x 48) (tit		(coo instructions)		495, 082 307, 913	
50.00 Part & Medicare GME payment (line 46 x 48) (tit				187, 169	
0.00 prart & Medicare GML payment (The 47 X 40) (th	ne will only)		I	107, 109	1.50.

	Financial Systems REID HOSPITAL & HEA E SHEET (If you are nonproprietary and do not maintain	Provider C		Peri od:	eu of Form CMS-2 Worksheet G	
ind-1 il y)	ype accounting records, complete the General Fund column			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	epare
-		General Fund	Specific Purpose Func	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	27, 681, 461		0 0	0	1
00	Temporary investments	319, 305, 335	1	0 0	0	
00	Notes receivable	017,000,000		0 0	0	
00	Accounts receivable	135, 911, 705		0 0	0	
00	Other receivable	-3, 041, 363		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-84, 009, 860		0 0	0	
00	Inventory	6, 778, 933		0 0	0	
00	Prepai d expenses	5, 838, 222		0 0	0	
00	Other current assets	0,000,000		0 0	0	
. 00	Due from other funds	-1		0 0	0	
. 00	Total current assets (sum of lines 1-10)	408, 464, 432		0 0	0	
. 00	FIXED ASSETS	400, 404, 432	1			1''
. 00	Land	14, 477, 094		0 0	0	12
. 00	Land improvements	38, 224, 615		0 0	-	
. 00	Accumulated depreciation	-22, 102, 619		0 0	0	
. 00	Buildings	292, 529, 105		0 0	0	
. 00	Accumulated depreciation	-127, 175, 566			0	
. 00	Leasehold improvements			0 0	0	
		12, 484, 100		0 0	-	
. 00	Accumulated depreciation	-6, 298, 437			0	
	Fixed equipment	2, 103, 825		0	0	
	Accumulated depreciation	-1, 380, 672		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Major movable equipment	173, 697, 797	1	0 0	0	
	Accumulated depreciation	-142,047,754		0 0	0	
. 00	Mi nor equipment depreciable	C		0 0	0	
	Accumul ated depreciation	C		0 0	0	
	HIT designated Assets	C		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0		
. 00	Total fixed assets (sum of lines 12-29)	234, 511, 488		0 0	0	30
	OTHER ASSETS					
. 00	Investments	C		0 0	0	
. 00	Deposits on Leases	C		0 0	0	
. 00	Due from owners/officers	0		0 0	0	33
. 00	Other assets	47, 44 <mark>2, 89</mark> 2		0 0	0	34
. 00	Total other assets (sum of lines 31-34)	47, 442, 892		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	690, 418, 812		0 0	0	36
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	17, 744, 255		0 0	0	37
	Salaries, wages, and fees payable	22, 328, 207		0 0	0	38
. 00	Payrol I taxes payable	C		0 0	0	39
. 00	Notes and Loans payable (short term)	6, 913, 765		0 0	0	40
	Deferred income	C		0 0	0	
	Accel erated payments	-2, 046, 153			1	42
	Due to other funds	C		0 0	0	
	Other current liabilities	0		0 0		
	Total current liabilities (sum of lines 37 thru 44)	44, 940, 074		0 0	-	
20	LONG TERM LIABILITIES	, , , , , , , , , , , , ,				1 ``
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	211, 585, 397		0 0	0	
	Unsecured Loans	, 000, 077		0 0	0	
. 00	Other long term liabilities	19, 854, 498		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	231, 439, 895		0 0	0	
	Total liabilities (sum of lines 45 and 50)	276, 379, 969		0 0	-	
. 50	CAPITAL ACCOUNTS	2,0,017,707	1	<u> </u>	. 0	
. 00	General fund balance	414, 038, 843				52
. 00	Specific purpose fund	414, 030, 043		0		53
				~		
	Donor created - endowment fund balance - restricted					54
	Donor created - endowment fund balance - unrestricted			0	1	55
. 00	Governing body created - endowment fund balance			0	-	56
. 00 . 00	0 5		1		0	
. 00 . 00 . 00	Plant fund balance - invested in plant					
<ol> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> <li>00</li> </ol>	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	58
. 00 . 00 . 00 . 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, replacement, and expansion					
. 00 . 00 . 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,	414, 038, 843 690, 418, 812	1	0 0	0	59

FATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0048		iod: m 01/01/2017 12/31/2017	Worksheet G-1 Date/Time Pre 5/7/2018 3:57	repare
	General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
	1 00	2 00	3 00		4 00	5.00	
00       Fund balances at beginning of period         00       Net income (loss) (from Wkst. G-3, line 29)         00       Total (sum of line 1 and line 2)         00       ROUNDING         00       ROUNDING         00       O         00       D         00       O         00       O         00       D         00<	1.00 85 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 370, 778, 024 43, 260, 734 414, 038, 758 85 414, 038, 843 0 414, 038, 843	3.00		4.00 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
	6.00	7.00	8.00				
00       Fund balances at beginning of period         00       Net income (loss) (from Wkst. G-3, line 29)         00       Total (sum of line 1 and line 2)         00       ROUNDING         00       00         00       00	000			0			1. 2. 3. 4. 5. 6. 7. 8.
00 00 00 00 00 00 00 00 00 00	00		U	0			9. 10. 11. 12. 13. 14. 15. 16. 17.
<ul> <li>.00 Total deductions (sum of lines 12-17)</li> <li>.00 Fund balance at end of period per balance sheet (line 11 minus line 18)</li> </ul>	000			0 0			18. 19.

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN			iod: m 01/01/2017 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/7/2018 3:57	pared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services			-			
1.00	Hospital		49, 768, 72			49, 768, 720	1.00
2.00	SUBPROVIDER - IPF		10, 793, 41			10, 793, 410	
3.00	SUBPROVI DER – I RF		3, 509, 16	52		3, 509, 162	
4.00	SUBPROVI DER			~		0	4.00
5.00 5.00	Swing bed - SNF Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			U		0	7.00
3.00	NURSING FACILITY						8.00
9.00 9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		64, 071, 29	22		64, 071, 292	
10.00	Intensive Care Type Inpatient Hospital Services		04,071,27	~ _		04,071,272	10.00
11.00	INTENSIVE CARE UNIT		8, 898, 82	20		8, 898, 820	11.00
12.00	CORONARY CARE UNIT		0,0,0,02			0,0,0,020	12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	8, 898, 82	20		8, 898, 820	16.00
	11-15)					-,,	
17.00	Total inpatient routine care services (sum of lines 10 and 16)		72, 970, 11	12		72, 970, 112	17.00
18.00	Anci I lary servi ces		207, 328, 20	)9	462, 270, 310	669, 598, 519	18.00
19.00	Outpati ent servi ces		82, 21	8	66, 934, 824	67, 017, 042	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						25.00
26.00	HOSPICE		1, 022, 38		3, 803, 767	4, 826, 151	
27.00	OTHER		43, 330, 48		130, 065, 143	173, 395, 631	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to WKST.	324, 733, 41		663, 074, 044	987, 807, 455	28.00
	G-3, Line 1) PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			1	429, 973, 158		29.00
30.00	ADD (SPECIFY)			0	427, 773, 130		30.00
31.00				0			31.00
32.00				õ			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
12.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer			429, 973, 158		43.00

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Heal th	Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0048	Peri od:	Worksheet G-3	
				From 01/01/2017	Data /Tima Dray	aarad.
				To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
					37772010 3. 37	pin
					1.00	
1.00	Total patient revenues (from Wkst. G	-2, Part I, column 3, lin	e 28)		987, 807, 455	1.00
2.00	Less contractual allowances and disc	ounts on patients' accoun	ts		573, 102, 752	2.00
3.00	Net patient revenues (line 1 minus l	ine 2)			414, 704, 703	3.00
4.00	Less total operating expenses (from	Wkst. G-2, Part II, line	43)		429, 973, 158	4.00
5.00	Net income from service to patients	(line 3 minus line 4)			-15, 268, 455	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests,	etc			4, 223, 124	6.00
7.00	Income from investments				39, 840, 090	7.00
8.00	Revenues from telephone and other mi	scellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio se	ervi ce			0	9.00
10.00	Purchase di scounts				137, 116	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen servi				299, 045	
14.00	Revenue from meals sold to employees	and guests			3, 596, 663	
15.00	Revenue from rental of living quarte				0	15.00
16.00	Revenue from sale of medical and sur		han patients		0	16.00
17.00	Revenue from sale of drugs to other				18, 000	
18.00	Revenue from sale of medical records				32, 171	
19.00	Tuition (fees, sale of textbooks, ur	iforms, etc.)			44, 750	19.00
20.00	Revenue from gifts, flowers, coffee	shops, and canteen			0	20.00
21.00	Rental of vending machines				31, 221	21.00
22.00	Rental of hospital space				6, 519, 733	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER				3, 787, 276	24.00
25.00	Total other income (sum of lines 6-2	24)			58, 529, 189	25.00
26.00	Total (line 5 plus line 25)				43, 260, 734	26.00
	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27	and subscripts)			0	28.00
29.00	Net income (or loss) for the period	(line 26 minus line 28)			43, 260, 734	29.00

Heaplice CDL:         15-152.10         From 07/27/271         Dist // The Program eti:           100         CAP REL COST- BLOG & FIX*         SUBTOTAL		Financial Systems RELE SIS OF HOSPITAL-BASED HOSPICE COSTS	D HOSPI TAL & HEALT	H CARE SERVI Provider C		Peri od:	worksheet 0	2552-10
SALARIES         OTHER         SUBTOTAL         CALLORS: FL         SUBTOTAL           1.00         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS: HUGE COST_CENTERS         0				Hospi ce CC	N: 15-1524		Date/Time Pre 5/7/2018 3:57	pared: pm
ENTRAL SERVICE COST CENTERS         0         2.00         3.00         4.00         5.00           1.00         CAP REL COSTS BLOK & FLXT*         0			SALARI ES	OTHER		. RECLASSI FI -	SUBTOTAL	
CRNPRAL SERVICE COST CONTERS         0			1.00	2.00			5.00	
2.00         CAP REL COSTS-AWARE FOULP*         9, 643         9, 643         0         9, 443         2.00         9, 1290         3.00         9, 1290         3.00         1, 249, 537         -1, 049, 678         174, 899         4.00           4.00         ADMINISTRATIVE & CENERAL *         1, 191, 305         33, 232         1, 224, 537         -1, 049, 678         174, 899         4.00         0							1	
3.00         DMPLOYEE EBLIFT DEPARTIENT*         0         91, 290         91, 290         0         91, 290         1, 1, 04, 378           5.00         PLANT OPERATION & MAINTENNACE*         0         28         22, 253         -1, 049, 678         28         5.00           6.00         LUNDRY & LINES SERVICE*         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
4.00       ADMIN ISTRATIVE & GENERAL*       1, 191, 305       33, 232       1, 224, 537       -1, 049, 678       174, 869       4.00         6.00       LAUNDRY & LINEN SERVICE*       0								
5.00         PLANT OPERATION & MINIMETANCE*         0         28         28         0         28         5.00         0			1 101 205					
6.00         LAINDRY & LINEN SERVICE*         0<			1, 191, 305					
7.00         POUSERCEPTING*         0			0					
B. 00         DIETARY*         0         2. 605         0         2. 605         0         0. 0 <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></th<>			0	0		0 0		
10. 00         ROUTINE MEDICAL SUPPLIES*         0 <th< td=""><td></td><td></td><td>0</td><td>2, 605</td><td>2,60</td><td>05 0</td><td>2, 605</td><td></td></th<>			0	2, 605	2,60	05 0	2, 605	
11.00       UEDICAL RECORDS*       0       0       0       0       0       0       0       0       11.00         12.00       STAFT TAMASPORTATION*       0       0       0       0       0       11.00         13.00       UNUNTEER SERVICE COORDINATION*       0       0       0       0       0       13.00         14.00       PHARMACY*       0       145.028       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       0       144.487       16.00       0       0       0       16.00       0       17.00       17.00       17.00       17.00       0       0       0       0       0       25.00       0       0       0       0       0       0       0       25.00       0       0       0       0       0       0       0       0       25.00       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td>9.00</td><td>NURSING ADMINISTRATION*</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>9.00</td></t<>	9.00	NURSING ADMINISTRATION*	0	0		0 0	0	9.00
12.00       STAFF TRANSPORTATION*       0       0       0       0       12.00       0       0       0       0       13.00         13.00       VOLUNTERS SERVICE COORDINATION*       0       145.028       145.028       0       145.028       0       145.028       0       145.028       0       145.028       0       146.028       145.028       0       146.028       145.028       0       146.028       145.028       0       16.00       17.00         15.00       PINECT PATLENT CARE SERVICE COST CENTERS       0       0       0       0       25.00       0       0       0       25.00       0       0       0       0       26.00       0       0       0       0       26.00       0       0       0       27.00       0       0       0       27.00       0       0       0       0       0       27.00       0	10.00	ROUTINE MEDICAL SUPPLIES*	0	0		0 0	0	10.00
13.00         VOLUNTEER SERVICE COORDINATION*         0         0         0         0         0         13.00           14.00         PHARMACY*         0         145.028	11.00	MEDI CAL RECORDS*	0	0		0 0	0	11.00
14.00       PHARMACY*       0       145.028			0	0		0 0	-	
15.00       PHYSICIAN ADMINISTRATIVE SERVICES*       0       44.487       0       44.487       0       44.487       15.00         16.00       THE GENERAL SERVICES       0       0       0       0       0       16.00         17.00       PATIENT CARE-CONTRACTED**       0       0       0       0       0       25.00       0       0       0       0       0       25.00       0       0       0       0       0       25.00       0       0       0       0       0       0       25.00       0       0       0       0       0       25.00       0       0       0       0       0       0       0       0       25.00       0       0       0       0       0       0       0       25.00       0       0       0       0       0       0       0       0       0       25.00       0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>)</td><td>0 0</td><td>-</td><td>1</td></t<>			0	0	)	0 0	-	1
16.00       OTHER GENERAL SERVICE*       0       0       0       0       16.00         17.00       PATLENT/RESIDENTAL CARE SERVICES       0       0       0       0       0       25.00         16.00       PHYSICIAN SERVICES**       0       0       0       0       26.00       0       0       26.00       0       0       26.00       0       0       0       26.00       0       0       0       26.00       0       0       0       26.00       0       0       0       26.00       0       0       0       26.00       0       0       0       0       26.00       0       0       0       26.00       0       0       0       0       0       0       26.00       0			0					
17. 00       PATLENT/RESIDENTIAL CARE SERVICES       17. 00         25. 00       INPATLENT CARE-CONTRACED**       0       0       0       25. 00         60. 00       PICIC ES**       0       0       0       0       25. 00         70. 00       NURSE PRACTITIONER**       0       0       0       0       27. 00         80. 00       PRCISTERED NURSE**       0       0       0       0       27. 00         80. 00       PRCISTERED NURSE**       0       0       0       27. 00       27. 00         80. 00       PRCISTERED NURSE**       0       0       0       0       27. 00         80. 00       PRVSICAL THERAPY**       0       0       0       0       33. 00         80. 00       SPEECH/LANGUAGE PATHOLOGY**       0       0       0       0       33. 00         80. 00       SPRECH/LANGUAGE PATHENT**       0       0       0       0       33. 00         80. 00       COUNSELINC**       0       0       0       0       0       33. 00         80. 00       COUNSELINC**       0       0       0       0       33. 00       0       0       0       0       0       0			0	44, 487	44,48			
DIRECT PATIENT CARE SERVICE COST CENTERS         Image: Contracted and the contrecontracted and the contracted and the contracted and			0	0	,	0 0	0	
25.00       INPATIENT CARE-CONTRACTED**       0	17.00							17.00
26.00       PHYSICIAN SERVICES**       0 </td <td>25.00</td> <td></td> <td></td> <td>0</td> <td>)</td> <td>0 0</td> <td>0</td> <td>25.00</td>	25.00			0	)	0 0	0	25.00
28.00       REGISTERED NURSE**       0       0       001.971       901.971       28.00         29.00       LPNUVA**       0       0       42.796       42.796       29.00         30.00       PHYSICAL THERAPY**       0       0       0       30.00       30.00       30.00       31.00       32.00         31.00       OCCUPATIONAL THERAPY**       0       0       0       0       0       31.00         32.00       MEDICAL SOCIAL SERVICES**       0       0       0       0       0       33.00         33.00       MEDICAL SOCIAL SERVICES**       0       0       0       0       0       33.00         35.00       DIETARY COUNSELING**       0 <td< td=""><td></td><td></td><td>0</td><td>Ō</td><td></td><td>-</td><td></td><td></td></td<>			0	Ō		-		
29       00       LPA/LVM**       0       0       42,796       42,796       29,00       0<			0	0		0 0		1
30.00         PHYSICAL THERAPY**         0	28.00	REGI STERED NURSE**	0	0		0 901, 971	901, 971	28.00
31.00         OCUPATIONAL THERAPY**         O <td>29.00</td> <td>LPN/LVN**</td> <td>0</td> <td>0</td> <td></td> <td>0 42, 796</td> <td>42, 796</td> <td>29.00</td>	29.00	LPN/LVN**	0	0		0 42, 796	42, 796	29.00
32:00         SPEECH/LANGUAGE PATHOLOGY**         0         0         0         0         0         0         0         0         0         32:00           33:00         MEDI CAL SOCI AL SERVICES**         0         0         0         0         0         0         33:00           35:00         DI ETARY COUNSELI NG**         0         0         0         0         0         0         34:00           36:00         COUNSELI NG**         0         0         0         0         0         0         0         0         0         0         35:00           37:00         HOSPICE AI DE & HOMEMAKER SERVICES**         0         0         0         0         0         0         0         0         0         0         38:00           00         DURABLE MEDI CAL EQUI PMENT/OXYGEN*         0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td>1</td>			0	0		0 0	-	1
33.00       MEDI CAL SOCIAL SERVI CES**       0       0       0       0       33.00         34.00       SPIR ITUAL COUNSELI NG**       0       0       0       0       0       34.00         35.00       DI ETARY COUNSELI NG**       0       0       0       0       0       35.00         36.00       COUNSELI NG - OTHER**       0       0       0       0       0       35.00         37.00       HOSPI CE A IDE & HOMEMAKER SERVI CES**       0       0       0       0       0       36.00         38.00       DARABLE MEDI CAL EQUI PMENT/OXYGEN*       0       0       0       0       0       0       38.00         39.00       PATI ENT TRANSPORTATI ON**       0       118, 641       118, 641       118, 641       39.00       0			0	0		0 0	-	1
34.00       SPIRITUAL COUNSELING**       0       0       0       34.00         35.00       DIETARY COUNSELING**       0			0	0		0 0	, o	1
35.00       DI ETARY COUNSELING OTHER**       0       0       0       35.00         36.00       COUNSELING OTHER**       0       <			0	0	)	0 0	-	1
36.00       COUNSELING - OTHER**       0       0       0       0       0       0       36.00         37.00       HOSPICE AIDE & HOMEMAKER SERVICES**       0       0       0       0       104,911       104,911       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN**       0				0		0 0	-	1
37. 00       HOSPI CE AI DE & HOMEMAKER SERVI CES**       0       0       0       104, 911       37. 00         38. 00       DURABLE MEDI CAL EQUI PMENT / OXYGEN*       0       0       0       0       0       38. 00         39. 00       PATI ENT TRANSPORTATI ON**       0       118, 641       0       118, 641       0       189. 00         40. 00       IMAGI NG SERVI CES**       0       0       0       0       0       0       0         42. 00       MEDI CAL SUPPLIES-NON-ROUTINE**       0       194, 297       0       194, 297       0       141, 207         42. 00       MEDI CAL SUPPLIES-NON-ROUTINE**       0       738, 348       738, 348       0       738, 348       2. 50         43. 00       OUTPATI ENT SERVI CES **       0       0       0       0       0       0       43. 00         44. 00       PALLI ATIVE RADI ATI ON THERAPY**       0       0       0       0       0       0       44. 00         45. 00       PALLI ATIVE CHEMOTHERAPY**       0       0       0       0       0       0       0       0         60. 00       DITHER PATIENT CRARE SERVI CES (SPECI FY)**       0       0       0       0       0			0			0 0	0	1
38.00       DURABLE MEDI CAL EQUI PMENT/OXYGEN**       0       0       0       0       38.00         39.00       PATI ENT TRANSPORTATI ON**       0       118,641       118,641       0       118,641       39.00         40.00       IMAGI NG SERVICES**       0			0	0		0 104 011	10/ 011	1
39.00       PATI ENT TRANSPORTATI ON**       0       118, 641       118, 641       0       0       0         40.00       IMAGI NG SERVI CES**       0			0	0		0 0	0	
40.00       IMAGI NG SERVI CES**       0 </td <td></td> <td></td> <td>Ő</td> <td>118, 641</td> <td>118.6</td> <td>41 0</td> <td>118,641</td> <td>1</td>			Ő	118, 641	118.6	41 0	118,641	1
41.00       LABS & DI AGNOSTI CS**       0       0       0       0       0       41.00         42.00       MEDI CAL_SUPPLI ES-NON-ROUTI NE**       0       194, 297       194, 297       0       194, 297       42.50         42.50       DRUSS CHARGED TO PATI ENTS**       0       738, 348       0       738, 348       0       738, 348       0       738, 348       0       63.00         44.00       PALLI ATI VE RADI ATI ON THERAPY**       0			0					1
42. 50       DRUGS CHARGED TO PATIENTS**       0       738, 348       738, 348       0       738, 348       42. 50         43. 00       OUTPATIENT SERVICES**       0       0       0       0       0       43. 00         44. 00       PALLIATIVE RADIATION THERAPY**       0       0       0       0       0       44. 00         45. 00       PALLIATIVE CHEMDHERAPY**       0       0       0       0       44. 00         46. 00       OTHER PATIENT CARE SERVICES (SPECIFY)**       0       0       0       0       45. 00         MONREI MBURSABLE COST CENTERS       0       0       0       0       0       0       60. 00         60. 00       BEREAVEMENT PROGRAM *       0       0       0       0       0       60. 00         61. 00       VOLUNTEER PROGRAM *       0       0       0       0       61. 00         62. 00       FUNDRAI SI NG*       0       0       0       0       62. 00         63. 00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       64. 00         64. 00       OTHER PHYSI CI AN SERVICES*       0       0       0       64. 00         65. 00       OTHER PHYSI CI AN	41.00		0	0		0 0	0	41.00
43.00       OUTPATIENT SERVICES**       0       0       0       0       43.00         44.00       PALLIATIVE RADIATION THERAPY**       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY**       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY**       0       0       0       0       44.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)**       0       0       0       0       45.00         60.00       BEREAVEMENT PROGRAM *       0       0       0       0       0       0       60.00         61.00       VOLUNTEER PROGRAM *       0       0       0       0       61.00       0       62.00         63.00       HOSPI CE/PALLIATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLIATIVE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSICIAN SERVICES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       AUVERTI SI NG*       0	42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	194, 297	194, 29	97 0	194, 297	42.00
44.00       PALLI ATI VE RADI ATI ON THERAPY**       0       0       0       0       44.00         45.00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       45.00         46.00       OTHER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       0       0       46.00         NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0	42.50		0	738, 348	738, 3	48 0	738, 348	42.50
45.00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       45.00         46.00       OTHER PATI ENT CARE SERVICES (SPECIFY)**       0       0       0       0       0       46.00         NONREI MBURSABLE COST CENTERS         60.00       BEREAVEMENT PROGRAM *       0       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       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       64.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00       66.00         67.00       ADVERTI SI NG*       0       150       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0			0	0		0 0		
46. 00       OTHER PATI ENT CARE SERVICES (SPECIFY)**       0 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>, o</td><td></td></td<>			0	0		0 0	, o	
NONREI MBURSABLE COST CENTERS           60.00         BERAVEMENT PROGRAM *         0			0	0	0	0 0	-	
60.00       BEREAVEMENT PROGRAM *       0<	46.00			0	)	0 0	0	46.00
61.00       VOLUNTEER PROGRAM *       0       0       0       61.00         62.00       FUNDRAI SI NG*       0       0       0       0       62.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68.00         69.00       THRI FT STORE*       0       0       0       0       0       0       0         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0       0       71.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       2,	60 00			0	1	0 0	0	60.00
62.00       FUNDRAI SI NG*       0       0       0       62.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       64.00         66.00       RESI DENTI AL CARE*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68.00         69.00       THRI FT STORE*       0       0       0       0       0       69.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       71.00         100.00       TOTAL       1, 191, 305       1, 377, 749       2, 569, 054       0       2, 569, 054       100.00			0	0				
63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       68.00       69.00       160       0       68.00         69.00       THRI FT STORE*       0       0       0       0       69.00       69.00       69.00       69.00       0       0       69.00       0 </td <td></td> <td></td> <td>Ö</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			Ö	0		0 0		
64.00       PALLI ATI VE CARE PROGRAM*       0       0       0       0       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       68.00       69.00       0       0       68.00         69.00       THRI FT STORE*       0       0       0       0       69.00       64.00         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0       69.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       0       71.00         100.00       TOTAL       1, 191, 305       1, 377, 749       2, 569, 054       0       2, 569, 054       100.00			Ő	0		0 0		
65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       150       0       150       67.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68.00         69.00       THRI FT STORE*       0       0       0       69.00       0       69.00         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0       69.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       0       71.00         100.00       TOTAL       1, 191, 305       1, 377, 749       2, 569, 054       0       2, 569, 054       100.00			Ő	0		0 0		
67. 00       ADVERTI SI NG*       0       150       150       67. 00         68. 00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68. 00         69. 00       THRI FT STORE*       0       0       0       0       69. 00       69. 00       0       0       0       69. 00       0       0       0       69. 00       0       0       0       69. 00       0       0       0       0       69. 00       0       0       0       0       69. 00       70. 00       70. 00       70. 00       70. 00       70. 00       70. 00       70. 00       70. 00       70. 00       70. 00       71. 00       0       0       0       0       0       70. 00       71. 00       71. 00       71. 90       2, 569, 054       100. 00       71. 00       71. 00       71. 91, 305       1, 377, 749       2, 569, 054       0       2, 569, 054       100. 00       71. 00       71. 00       71. 91, 305       71. 749       71. 91, 749       71. 91, 71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91       71. 91	65.00		0	0		0 0	0	65.00
68.00         TELEHEALTH/TELEMONI TORI NG*         0         0         0         68.00           69.00         THRI FT STORE*         0         0         0         0         69.00           70.00         NURSI NG FACILI TY ROOM & BOARD*         0         0         0         0         0         70.00           71.00         OTHER NONREI MBURSABLE (SPECI FY)*         0         0         0         0         71.00           100.00         TOTAL         1, 191, 305         1, 377, 749         2, 569, 054         0         2, 569, 054         100.00			0	0		0 0		1
69.00         THRI FT STORE*         0         0         0         0         69.00           70.00         NURSI NG FACILITY ROOM & BOARD*         0         0         0         0         70.00           71.00         OTHER NONREIMBURSABLE (SPECIFY)*         0         0         0         0         71.00           100.00         TOTAL         1, 191, 305         1, 377, 749         2, 569, 054         0         2, 569, 054         100.00			0	150	1!			
70. 00         NURSI NG FACI LI TY ROOM & BOARD*         0         0         0         0         70. 00           71. 00         OTHER NONREI MBURSABLE (SPECI FY)*         0         0         0         0         0         71. 00           100. 00         TOTAL         1, 191, 305         1, 377, 749         2, 569, 054         0         2, 569, 054         100. 00			0	0		0 0		
71. 00         OTHER NONREI MBURSABLE (SPECI FY)*         0         0         0         0         0         71. 00           100. 00         TOTAL         1, 191, 305         1, 377, 749         2, 569, 054         0         2, 569, 054         100. 00			0	0		0 0		
100.00         TOTAL         1, 191, 305         1, 377, 749         2, 569, 054         0         2, 569, 054         100.00			0	0		0		
				ں ۱ 277 حرم 1		-		
					Z, 209, U	0	2, 309, 054	100.00

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

LYS	IS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	l: 15-0048	Peri od:	Worksheet O
			Hospice CCN:	15-1524	From 01/01/2017 To 12/31/2017	Date/Time Prepar 5/7/2018 3:57 pr
					Hospi ce I	57772018 3. 57 pi
		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			
00	CAP REL COSTS-MVBLE EQUIP*	0	9, 643			
00	EMPLOYEE BENEFITS DEPARTMENT*	-50	91, 240			
00	ADMI NI STRATI VE & GENERAL*	0	174, 859			
00	PLANT OPERATION & MAINTENANCE*	0	28			
)0 )0	LAUNDRY & LINEN SERVICE* HOUSEKEEPING*	0	0			
0	DI ETARY*	0	2, 605			
0	NURSI NG ADMI NI STRATI ON*	0	2,000			
00	ROUTI NE MEDI CAL SUPPLI ES*	0	0			1
00	MEDI CAL RECORDS*	0	0			1
00	STAFF TRANSPORTATION*	0	0			1
00	VOLUNTEER SERVICE COORDINATION*	0	0			1
00	PHARMACY*	0	145, 028			1
00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	44, 487			1
00	OTHER GENERAL SERVICE*	0	0			1
00	PATI ENT/RESI DENTI AL CARE SERVI CES					1
~~	DI RECT PATI ENT CARE SERVI CE COST CENTERS	-				
	INPATIENT CARE-CONTRACTED**	0	-			2
00 00	PHYSICIAN SERVICES** NURSE PRACTITIONER**	0	0			2
00	REGISTERED NURSE**		901, 971			2
00	LPN/LVN**	0	42, 796			2
00	PHYSICAL THERAPY**	0	0			3
00	OCCUPATIONAL THERAPY**	0	0			3
00	SPEECH/LANGUAGE PATHOLOGY**	0	0			3
00	MEDICAL SOCIAL SERVICES**	0	0			3
	SPI RI TUAL COUNSELI NG**	0	0			3
00	DI ETARY COUNSELI NG**	0	0			3
00	COUNSELING - OTHER**	0	0			3
00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	104, 911			3
00 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	110 (11			3
00	PATI ENT TRANSPORTATI ON** I MAGI NG SERVI CES**	0	118, 641 0			3
00	LABS & DI AGNOSTI CS**	0				4
00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	194, 297			4
50	DRUGS CHARGED TO PATIENTS**	0	738, 348			4
00	OUTPATI ENT SERVICES**	0	0			4
00	PALLIATIVE RADIATION THERAPY**	0	0			4
00	PALLIATIVE CHEMOTHERAPY**	0	0			4
00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0			4
	NONREI MBURSABLE COST CENTERS					
00	BEREAVEMENT PROGRAM *	0	0			6
00	VOLUNTEER PROGRAM *	0	0			6
00						6
00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*		0			6
00 00	PALLI ATI VE CARE PROGRAM* OTHER PHYSI CI AN SERVI CES*	0				6
00	RESIDENTIAL CARE*					6
00	ADVERTI SI NG*	-150				6
00	TELEHEALTH/TELEMONI TORI NG*	0	0			6
	THRI FT STORE*	0	o			6
	NURSING FACILITY ROOM & BOARD*	0	o o			7
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0			7
00	TOTAL	-200	2, 568, 854			10

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

Heal th Financial Systems         REI           ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI         REI	D HOSPITAL & HEAL CE ROUTINE HOME	Provider C	CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet 0-2	
CARE		Hospice CC		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	pared: pm
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGISTERED NURSE	0	0		0 849, 115	849, 115	28.00
29.00 LPN/LVN	0	0		0 40, 288	40, 288	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	0	0		0 0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 98, 763	98, 763	
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00 PATIENT TRANSPORTATION	0	111, 689	111, 68	<sup>19</sup> 0	111, 689	
40. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	182, 911	182, 91		182, 911	
42.50 DRUGS CHARGED TO PATIENTS	0	695, 081	695, 08	0	695, 081	
43. 00 OUTPATIENT SERVICES	0	0		0 0	0	
44. 00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45. 00 PALLI ATI VE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *		989, 681	989, 68	988, 166	1, 977, 847	100.00

100.00	TOTAL		909,00	707,001	900, 100	1, 777, 047
* Tran	sfer the amount in column 7 to Wkst. 0-5,	column 1, line 5	1.			
		ADJUSTMENTS		5		
			± col. 6)			
		6.00	7.00			
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED					
26.00	PHYSI CI AN SERVI CES		0	0		
27.00	NURSE PRACTITIONER		0	0		
28.00	REGI STERED NURSE		0 849, 11			
29.00	LPN/LVN		0 40, 28	8		
30.00	PHYSI CAL THERAPY		0	0		
31.00	OCCUPATIONAL THERAPY		0	0		
32.00	SPEECH/LANGUAGE PATHOLOGY		0	0		
33.00	MEDICAL SOCIAL SERVICES		0	0		
34.00	SPI RI TUAL COUNSELI NG		0	0		
35.00	DI ETARY COUNSELING		0	0		
36.00	COUNSELING - OTHER		0	0		
37.00	HOSPICE AIDE & HOMEMAKER SERVICES		0 98, 76	3		
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN		0	0		
39.00	PATI ENT TRANSPORTATI ON		0 111, 68	19		
40.00	I MAGI NG SERVI CES		0	0		
41.00	LABS & DIAGNOSTICS		0	0		
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE		0 182, 91	1		
42.50	DRUGS CHARGED TO PATIENTS		0 695, 08	1		
43.00	OUTPATI ENT SERVICES		0	0		
44.00	PALLIATIVE RADIATION THERAPY		0	0		
45.00	PALLI ATI VE CHEMOTHERAPY		0	0		
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)		0	0		
100.00	TOTAL *		0 1, 977, 84	7		1

25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00

40.00

41. 00 42. 00

42.50

43.00 44.00 45.00

46.00

100.00

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

Health Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATIENT	Provider CO		Period:	Worksheet 0-3	
RESPI TE CARE		Hospi ce CC	N: 15-1524	From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
		nospi ce cci	1. 15-1524	10 12/31/2017	5/7/2018 3: 57	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col	. RECLASSI FI -	SUBTOTAL	
			1 + col. 2)	CATIONS		
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	0	0		0 7, 126		
29.00 LPN/LVN	0	0		0 338	338	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	0	0		0 0	0	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 829	829	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	
39. 00 PATI ENT TRANSPORTATI ON	0	937	93	7 0	937	39.00
40. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 535			1, 535	
42.50 DRUGS CHARGED TO PATIENTS	0	5, 833	5, 83	3 0	5, 833	42.50
43. 00 OUTPATI ENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	0	8, 305	8, 30	8, 293	16, 598	100.00

 100.00
 TOTAL \*
 0

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	o	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	7, 126	28.00
29.00	LPN/LVN	0	338	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL 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	829	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	937	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 535	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	5, 833	42.50
43.00	OUTPATI ENT SERVI CES	0	0	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	16, 598	100.00
* Trar	nsfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 52.		

Health Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E GENERAL	Provider CO		Period:	Worksheet 0-4	
INPATIENT CARE		Hospi ce CCI		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col 1 + col. 2)	. RECLASSI FI - CATI ONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00 INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
26. 00 PHYSI CLAN SERVI CES	0	0		0 0	0	
27.00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00 REGI STERED NURSE	0	0		0 45, 730	45, 730	
29.00 LPN/LVN	0	0		0 2, 170	2, 170	
30. 00 PHYSI CAL THERAPY	0	0		0 0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00 MEDI CAL SOCI AL SERVI CES	0	0		0 0	0	33.00
34. 00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 5, 319	5, 319	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39. 00 PATI ENT TRANSPORTATI ON	0	6, 015	6, 01	5 0	6, 015	39.00
40. 00 I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	9, 851	9, 85	0	9, 851	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	37, 434	37, 43	4 0	37, 434	42.50
43. 00 OUTPATI ENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	0	53, 300	53, 30	0 53, 219	106, 519	100.00

 100.00
 TOTAL \*
 0

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	45, 730	28.00
29.00	LPN/LVN	0	2, 170	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	5, 319	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	6, 015	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	9, 851	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	37, 434	42.50
43.00	OUTPATI ENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
	PALLIATIVE CHEMOTHERAPY	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	106, 519	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53.		

	LOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C		Peri od:	Worksheet 0-5	
(PENSES	S FOR ALLOCATION	Hospi ce CC		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
				Hospi ce I		
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)	EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see instructions)		
			1.00	2.00	3.00	
G	ENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
	CAP REL COSTS-BLDG & FIXT			0 7,763	7, 763	1 1.
00 C	CAP REL COSTS-MVBLE EQUIP		9, 64			
00 E	EMPLOYEE BENEFITS DEPARTMENT		91, 24	0 221, 697	312, 937	3.
00 A	ADMI NI STRATI VE & GENERAL		174, 85	9 392, 008	566, 867	4.
DO P	PLANT OPERATION & MAINTENANCE		2	8 0	28	5
00 L	AUNDRY & LINEN SERVICE			0 0	0	
	IOUSEKEEPI NG			0 27,622	27, 622	7
	DI ETARY		2,60		_/	
	URSING ADMINISTRATION			0 0		
	ROUTINE MEDICAL SUPPLIES			0 172		
	IEDI CAL RECORDS			0 49, 753		
	STAFF TRANSPORTATION			0	0	
	/OLUNTEER SERVICE COORDINATION			0	0	
	PHARMACY		145, 02			
	PHYSI CI AN ADMI NI STRATI VE SERVI CES		44, 48		44, 487	
	OTHER GENERAL SERVICE			0 0		
	PATIENT/RESIDENTIAL CARE SERVICES			28, 051	28, 051	1 ''
	IOSPICE CONTINUOUS HOME CARE			0	0	50
	IOSPI CE ROUTI NE HOME CARE		1, 977, 84		1, 977, 847	
	IOSPI CE I NPATI ENT RESPI TE CARE		16, 59		16, 598	
	IOSPI CE GENERAL I NPATI ENT CARE		106, 51		106, 519	
	ONREIMBURSABLE COST CENTERS			1		
00 B	BEREAVEMENT PROGRAM			0	0	60 [
	/OLUNTEER PROGRAM			0	0	
	FUNDRAI SI NG			0	0	
	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			0	0	
	PALLIATIVE CARE PROGRAM			0	0	
	OTHER PHYSI CI AN SERVI CES			0	0	
	RESI DENTI AL CARE			0	0	
	ADVERTI SI NG			0	0	
	FELEHEALTH/TELEMONI TORI NG			0	0	
	THRIFT STORE			0	0	
	NURSING FACILITY ROOM & BOARD DTHER NONREIMBURSABLE (SPECIFY)	-		0		
	IEGATIVE COST CENTER			0	0	
D. 00 T			2, 568, 85	-		
			1 2, 500, 05	1 070,471	1 5,405,545	1.00

ST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C	CN: 15-0048	Period:	Worksheet 0-6	
			Hospi ce CCI	N: 15-1524	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/7/2018 3:57	pare pm
					Hospi ce I		
	Descriptions	TOTAL EXPENSESC	AP REL BLDG & FIX	CAP REL MVBL EQUI P	E EMPLOYEE BENEFI TS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	ЗA	
	GENERAL SERVICE COST CENTERS						
00	CAP REL COSTS-BLDG & FIXT	7, 763	7, 763				1.
00	CAP REL COSTS-MVBLE EQUIP	9, 643		9, 64	13		2.
00	EMPLOYEE BENEFITS DEPARTMENT	312, 937	0		0 312, 937		3.
0C	ADMINISTRATIVE & GENERAL	566, 867	7, 763		0 37, 203	611, 833	4
00	PLANT OPERATION & MAINTENANCE	28	0		0 0	28	5
0C	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6
00	HOUSEKEEPING	27, 622	0		0 0	27, 622	7
00	DI ETARY	2,605	0		0 0	2, 605	8
00	NURSI NG ADMI NI STRATI ON	0	0		0 0	2,000	
00	ROUTINE MEDICAL SUPPLIES	172	0		0 0	172	
00	MEDI CAL RECORDS	49, 753	0		0 0	49, 753	
00	STAFF TRANSPORTATION	0	0		0 0	0	
00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	
00	PHARMACY	314, 453	0		0 0	314, 453	
00	PHYSICIAN ADMINISTRATIVE SERVICES	44, 487	0		0 0	44, 487	
00	OTHER GENERAL SERVICE	44, 487	0		0 0	44,487	
00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	28, 051	
00	LEVEL OF CARE		0		U	26, 031	1 ''
00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50
					-	-	
00	HOSPICE ROUTINE HOME CARE	1, 977, 847		1 0	259, 576		
00	HOSPICE INPATIENT RESPITE CARE	16, 598	0	1, 30			
00	HOSPICE GENERAL INPATIENT CARE	106, 519	0	8, 34	13, 980	128, 842	53
~~	NONREI MBURSABLE COST CENTERS		0			0	1
00	BEREAVEMENT PROGRAM	0	0		0 0	0	
00	VOLUNTEER PROGRAM	0	0		0 0	0	
00	FUNDRAI SI NG	0	0		0 0	0	1
00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	
00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	
00	OTHER PHYSI CI AN SERVI CES	0	0		0 0	0	
00	RESI DENTI AL CARE	0	0		0 0	0	
00	ADVERTI SI NG	0	0		0 0	0	
00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	
00	THRI FT STORE	0	0		0 0	0	
00	NURSING FACILITY ROOM & BOARD	0				0	
00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	
00	NEGATI VE COST CENTER	0	0		0 0		99
). 00	TOTAL	3, 465, 345	7, 763	9, 64	43 312, 937	3, 465, 345	100
			•				
		Ň					

LOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL	ID HOSPITAL & HEA SERVICE COSTS		CN: 15-0048	P€ Fr To	eriod: rom 01/01/2017 o 12/31/2017	u of Form CMS-: Worksheet O-6 Part I Date/Time Pre	par
					Hospi ce I	37772010 3. 37	pin
Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVIO		HOUSEKEEPING	DI ETARY	
	4.00	5.00	6.00		7.00	8.00	
ENERAL SERVICE COST CENTERS							
CAP REL COSTS-BLDG & FIXT							] 1
CAP REL COSTS-MVBLE EQUIP							2
MPLOYEE BENEFITS DEPARTMENT							3
ADMINISTRATIVE & GENERAL	611, 833						4
PLANT OPERATION & MAINTENANCE	6	34	L				5
	0			0			6
	5, 923	(			33, 545		7
		(			0	3 164	
		(			0	0,101	9
		-			0		10
		-			0		11
		(			0		12
	-	(			0		13
	Ŭ,	(			0		14
		(			0		
		-			0		15
	-				0		16
	6,015	(	)		0		17
			1				1
							50
							51
	27,626	29		0	29, 022	2, 737	53
			1				
	0	(			-		60
	0	(			0		61
FUNDRAI SI NG	0	(	)		0		62
HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	(			0		63
PALLIATIVE CARE PROGRAM	0	C			0		64
THER PHYSICIAN SERVICES	0	0			0		65
RESI DENTI AL CARE	0	(		0	0	0	66
ADVERTI SI NG	0				0		67
TELEHEALTH/TELEMONI TORI NG	o				0		68
THRI FT STORE	0				0		69
	Ŭ				Ű		70
	0	ſ		0	0	0	
NEGATI VE COST CENTER	0			0	0	0	
TOTAL	611, 833	34		0	33, 545	3, 164	
	011,000	- 34	1	U	55, 545	5, 104	
	ENERAL SERVICE COST CENTERS AP REL COSTS-BLDG & FIXT AP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL LANT OPERATION & MAINTENANCE AUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY JURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES HEDICAL RECORDS STAFF TRANSPORTATION YOLUNTEER SERVICE COORDINATION HARMACY PHYSICIAN ADMINISTRATIVE SERVICES DTHER GENERAL SERVICE ATIENT/RESIDENTIAL CARE SERVICES EVEL OF CARE HOSPICE CONTINUOUS HOME CARE HOSPICE CONTINUE HOME CARE HOSPICE CONTINUE HOME CARE HOSPICE CONTINUE HOME CARE HOSPICE CONTINE HOME CARE HOSPICE GENERAL INPATIENT CARE ONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM YOLUNTEER PROFINE YOLONG A SOUTION A BOARD YOLUNTEER PROFINE YOLONG A SOUTION A BOARD YOLUNTEER PROFINE YOLONG A SOUTION A BOARD YOLONG A SOUTION A BOARD YOLONG A SOUTION A BOARD YOLONG A SOUTION A BOARD YOL A SOUTIONE A SOUTION A BOARD YOL A	& GENERAL         4.00         ENERAL SERVICE COST CENTERS         CAP REL COSTS-BLDG & FIXT         CAP REL COSTS-MVBLE EQUIP         IMPLOYEE BENEFITS DEPARTMENT         DDMINISTRATIVE & GENERAL         VLANT OPERATION & MAINTENANCE         CAUNDRY & LINEN SERVICE         IOUSEKEEPING         DIETARY         MURSING ADMINISTRATION         OUJUNE MEDICAL SUPPLIES         STAFF TRANSPORTATION         OCULINTEER SERVICE COORDINATION         ONDUTINE MEDICAL SUPPLIES         THER GENERAL SERVICE         ONALTER SERVICE COORDINATION         ONDULINTEER SERVICE COORDINATION         ONALTIENT/RESIDENTIAL CARE SERVICES         OYATIENT/RESIDENTIAL CARE SERVICES         OYATIENT/RESIDENTIAL CARE SERVICES         OSSPICE CONTINUOUS HOME CARE         OSSPICE CONTINUOUS HOME CARE         ONSPICE CONTINUOUS HOME CARE         ONSPICE ROUTINE HOME CARE         ONSPICE ROUTINE HOME CARE         ONSPICE CONTINUOUS HOME CARE         ONSPICE ROUTINE HOME CARE         ONSPICE ROUTINE HOME CARE         ONSPICE ROUTINE HOME CARE         ONREI MBURSABLE COST CENTERS         VEREAVEMENT PROGRAM         OULUNTEER PROGRAM         OUNDRAI	Descriptions       ADMINISTRATIVE & GENERAL       PLANT OPERATION & MAINTENANCE         AP REL COSTS - BLOG & FIXT AP REL COSTS - BLOG & FIXT AP REL COSTS - MUBLE EQUIP	Descriptions         ADMINISTRATIVE & GENERAL         PLANT OPERATION & MAINTENANCE         LAUNDRY & LINEN SERVI WAINTENANCE           4.00         5.00         6.00           ENERAL SERVICE COST CENTERS AP REL COSTS-BLOG & FIXT AP REL COSTS-MUBLE EQUIP IMPLOYEE BENEFITS DEPARTMENT UDMINISTRATIVE & GENERAL         611, 833           LANT OPERATION & MAINTENANCE         6         34           AUNDRY & LINEN SERVICE         0         0           INTSING ADMINISTRATIVE         559         0           JURSING ADMINISTRATION         0         0           REDICAL RECORDS         10, 668         0           JURSING ADMINISTRATION         0         0           REDICAL RECORDS         10, 668         0           TAFF TRANSPORTATION         0         0           VOLUNTEER SERVICE COORDINATION         0         0           VOLUNTEER SERVICE COORDINATION         0         0           VHSICIAN ADMINISTRATIVE SERVICES         9, 539         0           VTHER GENERAL SERVICE         0, 015         0           OPENAL DENTIAL CARE SERVICES         0, 015         0           OPENAL DENTIAL CARE SERVICES         29, 539         0           OTHER MURSABLE COST CENTERS         0         0           OBPICE CONTINEHOME CARE	Descriptions         ADMINISTRATIVE & GENERAL         PLANT         LAUNDRY & LINEN SERVICE           ENERAL         SERVICE         0         5.00         6.00           ENERAL         SERVICE         0.00         5.00         6.00           ENERAL         SERVICE         0.00         6.00         6.00           CAP REL COSTS-BLDG & FLXT         4.00         5.00         6.00           CAP REL COSTS-MBLE EQUIP         MMULOYEE BERNETT         611,833         34           DAUNDRY & LINEN SERVICE         0         0         0         0           INTENDENT TO BERNICE         0         0         0         0         0           INTENS AGAININISTRATION         0         0         0         0         0         0           INTEN RE DICAL SUPPLIES         37         0         0         0         0         0           OULINTER SERVICE         0         0         0         0         0         0         0           IPHER GENERAL SERVICE         0         0         0         0         0         0         0           IPTAF         TRAF TRANSPORTATION         0         0         0         0         0         0         0	Descriptions         ADM INISTRATIVE & GENERAL         PLANT operation (ADM INISTRATIVE (ADM INISTRATIVE)         PLANT operation (ADM INISTRATIVE)         Housekeeping (ADM INISTRATION (ADM INISTRATION)           ENERAL SERVICE COST CENTERS         4.00         5.00         6.00         7.00           ENERAL SERVICE COST CENTERS         4.00         5.00         6.00         7.00           ENERAL SERVICE COST CENTERS         611,833         34         0         0         0           MPLOYEE BENEFITS DEPARTMENT IDMIN ISTRATIVE & CENERAL         611,833         34         0         0         0           CANNOPY & LINEN SERVICE         0         0         0         0         0         0           UNISIN GRADMIN ISTRATION         559         0         0         0         0         0           UNISIN GRADMIN ISTRATION         0         0         0         0         0         0           UNISING ADMIN INSTRATION         0         0         0         0         0         0           UNISING ADMIN INSTRATION         0         0         0         0         0         0           UNISING ADMIN INSTRATION         0         0         0         0         0         0           VIEEL OF CADE         0 </td <td>Descriptions         ADMINISTRATIVE &amp; GENERAL         PLANT &amp; GENERAL         Descriptions         LINENSERVICE         HOUSEKEEPING         DIETARY           AP REL COSTS - BLOG &amp; FIXT AP REL COSTS - MUBLE EQUIP MPLOYEE BENEFITS DEPARTMENT OWIN ISTRATIVE &amp; GENERAL         0         5.00         6.00         7.00         8.00           ANDRY &amp; LINEN SERVICE         OSTS - MUBLE EQUIP MPLOYEE BENEFITS DEPARTMENT OWIN ISTRATIVE &amp; GENERAL         611,833         0</td>	Descriptions         ADMINISTRATIVE & GENERAL         PLANT & GENERAL         Descriptions         LINENSERVICE         HOUSEKEEPING         DIETARY           AP REL COSTS - BLOG & FIXT AP REL COSTS - MUBLE EQUIP MPLOYEE BENEFITS DEPARTMENT OWIN ISTRATIVE & GENERAL         0         5.00         6.00         7.00         8.00           ANDRY & LINEN SERVICE         OSTS - MUBLE EQUIP MPLOYEE BENEFITS DEPARTMENT OWIN ISTRATIVE & GENERAL         611,833         0

T ALLOCATION - HOSPITAL-BASED HOSPICE GENE	RAL SERVICE COSTS	Provider CO	CN: 15-0048	Period: From 01/01/2017	Worksheet 0-6 Part I	ò
		Hospi ce CCI	N: 15-1524	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
				Hospi ce I		
Descriptions	NURSI NG ADMI NI STRATI ON	ROUTI NE MEDI CAL SUPPLI ES	MEDI CAL RECORDS	STAFF TRANSPORTATI ON	VOLUNTEER SERVI CE COORDI NATI ON	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
CAP REL COSTS-BLDG & FIXT						1
CAP REL COSTS-MVBLE EQUIP						2
D EMPLOYEE BENEFITS DEPARTMENT						3
D ADMINISTRATIVE & GENERAL						4
D PLANT OPERATION & MAINTENANCE						5
D LAUNDRY & LINEN SERVICE						6
D HOUSEKEEPI NG						7
D DI ETARY						8
NURSING ADMINISTRATION	0					9
DO ROUTINE MEDICAL SUPPLIES	0	209				10
DO MEDICAL RECORDS	0		60, 4	21		11
DO STAFF TRANSPORTATION	0		1	0		12
DO VOLUNTEER SERVICE COORDINATION	0			0	C	13
DO PHARMACY	0			0	C	14
DO PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	C	15
OO OTHER GENERAL SERVICE	0			0	C	16
DO PATIENT/RESIDENTIAL CARE SERVICES						17
LEVEL OF CARE						
DO HOSPICE CONTINUOUS HOME CARE	0	0		0 0	C	50
DO HOSPICE ROUTINE HOME CARE	0	196	56, 8	80 0	C	51
DO HOSPICE INPATIENT RESPITE CARE	0	2	4	78 0	C	52
DO HOSPICE GENERAL INPATIENT CARE	0	11	3, 0	63 0	C	53
NONREI MBURSABLE COST CENTERS						
DO BEREAVEMENT PROGRAM	0			0	C	60
DO VOLUNTEER PROGRAM	0			0	C	61
DO FUNDRAI SI NG	0			0	C	62
DO HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	C	63
DO PALLIATIVE CARE PROGRAM	0			0	C	64
00 OTHER PHYSICIAN SERVICES	O			0	C	65
DO RESIDENTIAL CARE	0			0	C	66
DO ADVERTI SI NG	0			0	C	67
DO TELEHEALTH/TELEMONI TORI NG	0			0	C	68
DO THRI FT STORE	0			0	C	69
DO NURSING FACILITY ROOM & BOARD						70
OO OTHER NONREIMBURSABLE (SPECIFY)	0			0	C	71
DO NEGATIVE COST CENTER	0	0		0 0	C	99
OO TOTAL	0	209	60, 4	21 0	C	100
				<u> </u>		
•						

	LOCATI ON - HOSPI TAL-BASED HOSPI CE GENERAL		LTH CARE SERVI Provider CO Hospice CCI	CN: 15-0048	In Lie Period: From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part I Date/Time Pre 5/7/2018 3:57	epare
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE	Hospi ce I AL PATI ENT/ RESI DENTI AL CARE SERVI CES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	ENERAL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT						1
	CAP REL COSTS-MVBLE EQUIP						2
	MPLOYEE BENEFITS DEPARTMENT						3
	DMINISTRATIVE & GENERAL						4
	PLANT OPERATION & MAINTENANCE						5
	AUNDRY & LINEN SERVICE						6
	IOUSEKEEPI NG						7
	DI ETARY						8
	IURSI NG ADMI NI STRATI ON						9
	OUTINE MEDICAL SUPPLIES						10
	IEDI CAL RECORDS						11
	STAFF TRANSPORTATION						12
	OLUNTEER SERVICE COORDINATION	001.07/					13
	PHARMACY	381, 876	= 1				14
	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	54, 026		-		15
	ITHER GENERAL SERVICE	0			0		16
	ATTENT/RESIDENTIAL CARE SERVICES				34, 066		17
	EVEL OF CARE	0	0	1	0	0	50
	IOSPICE CONTINUOUS HOME CARE IOSPICE ROUTINE HOME CARE	359, 496	-		0	3, 184, 587	
	IOSPICE ROUTINE HOME CARE	3,019	50, 860 427		0 4, 596		
	IOSPICE INPATIENT RESPICE CARE	19, 361	2, 739		0 4, 598		
	ONREIMBURSABLE COST CENTERS	19, 301	2, 139		29,470	242, 900	53
	BEREAVEMENT PROGRAM				0	0	60
	OLUNTEER PROGRAM	0			0	0	
	UNDRALSING	0			0	0	
	IOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS	0	•		0	0	
	ALLIATIVE CARE PROGRAM	0			0	0	
	THER PHYSI CI AN SERVI CES	0			0	0	
	RESI DENTI AL CARE	o o	0		0 0	0	
	DVERTI SI NG	0			0	0	
	ELEHEALTH/TELEMONI TORI NG	0			0	0	
	THRIFT STORE	0			0	0	
	IURSING FACILITY ROOM & BOARD	, i i i i i i i i i i i i i i i i i i i			0	0	
	THER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	
$00 \pm 0$	IEGATI VE COST CENTER	0	0		0 0	0	
		381, 876	54, 026		0 34,066		

	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSIS	Provider CC	CN: 15-0048	Peri od:	Worksheet 0-6	
ATIS	TICAL BASIS		Hospice CCN	N: 15-1524	From 01/01/2017 To 12/31/2017		pare
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C		EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (I	DOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
~	GENERAL SERVICE COST CENTERS	445				1	1 1
0	CAP REL COSTS-BLDG & FIXT	445					1
0	CAP REL COSTS-MVBLE EQUIP		445	1 101 0	0.5		2
0	EMPLOYEE BENEFITS DEPARTMENT	0	0			0.050.540	3
0	ADMI NI STRATI VE & GENERAL	445	0	141, 6			
0	PLANT OPERATION & MAINTENANCE	0	0		0 0		
0	LAUNDRY & LINEN SERVICE	0	0		0 0		
0	HOUSEKEEPING	0	0		0 0	,	
0	DI ETARY	0	0		0 0	_,	
0	NURSING ADMINISTRATION	0	0		0 0	-	
00	ROUTINE MEDICAL SUPPLIES	0	0		0 0		
00	MEDI CAL RECORDS	0	0		0 0		
00	STAFF TRANSPORTATION	0	0		0 0		
00	VOLUNTEER SERVICE COORDINATION	0	0		0 0		
00	PHARMACY	0	0		0 0		
00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0		
00	OTHER GENERAL SERVICE	0	0		0 0	-	
00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	28, 051	17
	LEVEL OF CARE					-	1
00	HOSPICE CONTINUOUS HOME CARE				0 0		
00	HOSPICE ROUTINE HOME CARE			988, 1			
00	HOSPICE INPATIENT RESPITE CARE	0	60	8, 2			
00	HOSPICE GENERAL INPATIENT CARE	0	385	53, 2	18 0	128, 842	53
~~	NONREI MBURSABLE COST CENTERS		0		0	0	1.0
00	BEREAVEMENT PROGRAM	0	0		0 0		
00	VOLUNTEER PROGRAM	0	0		0 0		
00			0		0 0		
00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0		
00	PALLIATIVE CARE PROGRAM	0	0		0 0	-	
00	OTHER PHYSI CI AN SERVI CES	0	0		0 0		
00	RESIDENTIAL CARE	0	0		0 0	-	
	ADVERTI SI NG	-	0		0 0	-	
00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	-	
00	THRIFT STORE	0	0			-	
00	NURSING FACILITY ROOM & BOARD				0		70
00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	
			0 ( 1 2	212.0		(11 000	99
. 00		17. 444944	21.669663	0.2626	84	0.214414	101
	NEGATIVE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	) 7, 763 17. 444944	9, 643 21. 669663			611, 8: 0. 2144	

T ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TISTICAL BASIS	RVICE COSTS	Provider CC		Period: From 01/01/2017 To 12/31/2017		
					5/7/2018 3:57	
				Hospi ce I		
Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPI NG (SQUARE FEET)		NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS	r			F		
00       CAP REL COSTS-BLDG & FIXT         100       CAP REL COSTS-MVBLE EQUIP         101       EMPLOYEE BENEFITS DEPARTMENT         102       ADMINISTRATIVE & GENERAL         103       ADMINISTRATIVE & GENERAL         104       PLANT OPERATION & MAINTENANCE         105       LAUNDRY & LINEN SERVICE         106       HOUSEKEEPING         107       DI ETARY         108       ROUTINE MEDICAL SUPPLIES         109       MEDICAL RECORDS         100       STAFF TRANSPORTATION         100       VOLUNTEER SERVICE COORDINATION         100       PHARMACY         100       PHYSICIAN ADMINISTRATIVE SERVICES         101       OTHER GENERAL SERVICE         102       PATIENT/RESIDENTIAL CARE SERVICES         103       PATIENT/RESIDENTIAL CARE SERVICES	445 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			5 0 1,060 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
0 HOSPI CE CONTINUOUS HOME CARE 00 HOSPI CE ROUTI NE HOME CARE 00 HOSPI CE INPATIENT RESPI TE CARE 00 HOSPI CE GENERAL INPATIENT CARE NONREI MBURSABLE COST CENTERS	60 385	0				50 51 52 53
NORKETMBORSABLE COST CENTERS         OB BEREAVEMENT PROGRAM         OV VOLUNTEER PROGRAM         OO FUNDRAISING         OO HOSPICE/PALLIATIVE MEDICINE FELLOWS         OO PALLIATIVE CARE PROGRAM         OO THER PHYSICIAN SERVICES         OO RESIDENTIAL CARE         OO ADVERTISING         OO TELEHEALTH/TELEMONITORING         OO THER NONREIMBURSABLE (SPECIFY)         OO NEGATIVE COST CENTER         .OO COST TO BE ALLOCATED (per Wkst. 0-6, Part 1)         .OO UNIT COST MULTIPLIER	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	33, 54		0 0 0 0	60 61 62 63 64 65 66 67 68 69 70 71 99 100 101

Cost Center Descriptions       ROUTINE MEDICAL SUPPLIES (PATIENT DAY         10.00       10.00         CAP REL COSTS-BLDG & FIXT       10.00         2.00       CAP REL COSTS-BLDG & FIXT         2.00       CAP REL COSTS-MVBLE EQUIP         3.00       EMPLOYEE BENEFITS DEPARTMENT         4.00       ADMINISTRATIVE & GENERAL         5.00       PLANT OPERATION & MAINTENANCE         5.00       LAUNDRY & LINEN SERVICE         7.00       HOUSEKEEPING         8.00       DI ETARY         9.00       NURSING ADMINISTRATION         0.00       ROUTINE MEDICAL SUPPLIES         11.00       MEDICAL RECORDS         2.00       STAFF TRANSPORTATION         3.00       VOLUNTEER SERVICE COORDINATION         4.00       PHARMACY         5.00       PHYSICIAN ADMINISTRATIVE SERVICES         6.00       OTHER GENERAL SERVICE	11.00	(MI LEAGE)	Hospice I       VOLUNTER       ON       SERVICE       COORDINATIO       (HOURS OF       SERVICE)       13.00	(CHARGES)	1. ( 2. ( 3. ( 4. ( 5. ( 6. ( 0. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. (
GENERAL SERVICE COST CENTERS         00       CAP REL COSTS-BLDG & FIXT         00       CAP REL COSTS-MVBLE EQUIP         00       EMPLOYEE BENEFITS DEPARTMENT         00       ADMINISTRATIVE & GENERAL         00       PLANT OPERATION & MAINTENANCE         00       HOUSEKEEPING         00       DI ETARY         00       ROUTINE MEDICAL SUPPLIES         1.00       MEDICAL RECORDS         2.00       STAFF TRANSPORTATION         3.00       VOLUNTEER SERVICE COORDINATION         4.00       PHARMACY         5.00       PHYSICIAN ADMINISTRATIVE SERVICES	37			14.00	2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. (
00       CAP REL COSTS-BLDG & FIXT         00       CAP REL COSTS-MVBLE EQUI P         00       EMPLOYEE BENEFITS DEPARTMENT         00       ADMI NI STRATI VE & GENERAL         00       PLANT OPERATI ON & MAI NTENANCE         00       LAUNDRY & LI NEN SERVI CE         00       HOUSEKEEPI NG         00       DI ETARY         00       ROUTI NE MEDI CAL SUPPLI ES         1.00       ROUTI AL RECORDS         2.00       STAFF TRANSPORTATI ON         3.00       VOLUNTEER SERVI CE COORDI NATI ON         4.00       PHARMACY         5.00       PHYSI CI AN ADMI NI STRATI VE SERVI CES		87	0		2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. (
7. 00 PATI ENT/RESI DENTI AL CARE SERVI CES			0 0 0	-	13.0
0.00     HOSPICE CONTINUOUS HOME CARE       .00     HOSPICE ROUTINE HOME CARE       .00     HOSPICE INPATIENT RESPITE CARE	13 1	0 27 43 17	0 0 0 0	0 0 0 17, 02 0 14 0 91	3 52.
NONREI MBURSABLE COST CENTERS         00       BEREAVEMENT PROGRAM         00       VOLUNTEER PROGRAM         00       FUNDRAI SI NG         00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS         00       PALLI ATI VE CARE PROGRAM         00       OTHER PHYSI CI AN SERVI CES         00       RESI DENTI AL CARE         00       ADVERTI SI NG         00       TELEHEALTH/TELEMONI TORI NG         00       THRI FT STORE         00       NURSI NG FACI LI TY ROOM & BOARD         00       OTHER NONREI MBURSABLE (SPECI FY)         00       NEGATI VE COST CENTER         0.00       COST TO BE ALLOCATED (per Wkst. 0-6, Part 1)         1.00       UNI T COST MULTI PLI ER	09 60, 4 55 3. 3405			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

Financial Systems REI LOCATION - HOSPITAL-BASED HOSPICE GENERAL S	D HOSPITAL & HEAL				u of Form CMS-	
LUCATION - HUSPITAL-BASED HUSPICE GENERAL S ICAL BASIS	SERVICE CUSIS	Provider CC Hospice CCN		Period: From 01/01/2017 To 12/31/2017		
					5/7/2018 3:57	'pm
Cost Contor Descriptions			DATIENT/	Hospi ce I		
cost center bescriptions				_		
	SERVI CES					
	(PATIENT DAYS)	BASI S)				
			DAYS)			
	15.00	16.00	17.00			
						1.
						2.
						4.
						5.
						6.
						7.
						8
						9
ROUTI NE MEDI CAL SUPPLI ES						10.
IEDI CAL RECORDS						11
STAFF TRANSPORTATION						12
/OLUNTEER SERVICE COORDINATION						13
PHARMACY						14
PHYSICIAN ADMINISTRATIVE SERVICES	18, 087					15
OTHER GENERAL SERVICE		0				16.
			1, 0	60		17.
						1 - 0
						50.
			1	4.2		51.
						52.
	91/	0	9	17		1 03.
		0				60.
						61.
						62.
		0				63
PALLIATIVE CARE PROGRAM		0				64
OTHER PHYSICIAN SERVICES		0				65
RESI DENTI AL CARE	0	0		0		66
ADVERTI SI NG		0				67
FELEHEALTH/TELEMONI TORI NG		0				68
		0				69
						70
	0	0		0		71
NEGATIVE COST CENTER			24.0			99
COST TO BE ALLOCATED (per Wkst. 0-6, Part I JNIT COST MULTIPLIER	) 54,026 2.987007	0 0. 000000	34,0			100.
	2.98/00/	0.000000	32. 1377	30		101.
	MEDI CAL RECORDS STAFF TRANSPORTATION /OLUNTEER SERVI CE COORDINATION PHARMACY PHYSI CI AN ADMINISTRATIVE SERVI CES DTHER GENERAL SERVI CE PATIENT/RESIDENTIAL CARE SERVI CES EVEL OF CARE HOSPI CE CONTINUOUS HOME CARE HOSPI CE CONTINUOUS HOME CARE HOSPI CE INPATIENT RESPITE CARE HOSPI CE GENERAL INPATIENT CARE IONREI MBURSABLE COST CENTERS BREAVEMENT PROGRAM /OLUNTEER PROGRAM /OLUNTER PROGRAM /OLUNTER PROGRAM /OLUNTER PROGRAM /OLUNTER PROGRAM /OLUNTER PROGRAM DTHER PHYSI CI AN SERVI CES RESI DENTIAL CARE ADVERTI SI NG FELEHEALTH/TELEMONI TORI NG HRI FT STORE UNRSI NG FACILI TY ROOM & BOARD DTHER NONREI MBURSABLE (SPECI FY)	ADMI NI STRATI VE SERVI CES (PATI ENT DAYS) 15.00 ENERAL SERVI CE COST CENTERS CAP REL COSTS-BLDG & FI XT CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFI TS DEPARTMENT DOWNLOYEE BENEFI TS DEPARTMENT DAWN IN STRATI VE & GENERAL PLANT OPERATI ON & MAI NTENANCE AUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY WURSI NG ADMI NI STRATI ON QUUTI NE MEDI CAL SUPPLI ES MEDI CAL RECORDS STAFF TRANSPORTATI ON YOLUNTEER SERVI CE COORDI NATI ON HARMACY PHYSI CI AN ADMI NI STRATI VE SERVI CES THER GENERAL SERVI CE HOSPI CE CONTI NUOUS HOME CARE HOSPI CE GENERAL INPATI ENT CARE HOSPI CE CONTI NUOUS HOME CARE HOSPI CE CONTI NUOUS HOME CARE HOSPI CE GENERAL INPATI ENT CARE HOSPI CE GENERAL INPATI ENT CARE HOSPI CE GENERAL INPATI ENT CARE HOSPI CE CONTI NUOUS HOME CARE HOSPI CE CONTI NUCH HOME CARE HOSPI CE CONTI	Cost Center Descriptions PHYSICIAN ADMINISTRATIVE SERVICE (SERVICE) (PATIENT DAYS) OTHER GENERAL SERVICE COST CENTERS AP REL COSTS-MUBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT DAMINISTRATIVE & GENERAL VLANT OPERATION & MAINTENANCE AUNDRY & LINEN SERVICE OUSEKEEPING DIETARY UURSING ADMINISTRATION COLUNTER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES EVEL OF CARE OSPICE CONTINUOUS HOME CARE OSPICE CONTINUE MEDICINE FELLOWS OSPICE INPATIENT RESPITE CARE OSPICE OF CARE OSPICE CARE OSPICE OF CARE OSPICE CARE O OSPICE CARE OSPICE OF CARE OSPICE OF CARE OSPICE CONTINUE MEDICINE FELLOWS OSPICE INPATIENT RESPITE CARE OSPICE ONTINE HOME	Cost Center Descriptions     PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)     OTHER GENERAL SERVICE (PATIENT DAYS)     PATIENT/ RESIDENTIAL CARE SERVICE (IN-FACILIT DAYS)       ENERAL SERVICE COST CENTERS     15.00     16.00     17.00       ADM RIS COSTS-BLDG & FIXT DAYS     15.00     16.00     17.00       AP REL COSTS-MULE EQUIP IMPLOYEE BENEFITS DEPARTMENT DAWINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE AUNDRY & LINEN SERVICE OUSEKEEPING DI ETARY UNRSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES EDEICAL RECORDS STAFF TRANSPORTATION OLUNTER SERVICE COORDINATION PHYSICIAN ADMINISTRATIVE SERVICES     18,087     0       OTHER GENERAL SERVICE OSPICE CONTINUOUS HOME CARE OSPICE CONTINUES HOME CARE OSPICE PROGRAM OUNDRATIENT CONTENTS OSPICE CONTINUES HOME CARE OSPICE	Cost Center Descriptions PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS) ENERAL SERVICE COST CENTERS IS. 00 I6.00 I7.00 ENERAL SERVICE COST CENTERS IS.00 I6.00 I7.00 I	Cost Center Descriptions           PHYSICIAN         OTHER GENERAL         PATIENT/ RESIDENTIAL SERVICES         OTHER GENERAL         PATIENT/ RESIDENTIAL CARE SERVICES           ADM IN STRATUS         SERVICES         OTHER GENERAL         PATIENT/ RESIDENTIAL CARE SERVICES           ADP REL COSTS-BLOG & FIXT         DIA         DIA         DIA           ADP REL COSTS-MUBLE COUP         IS.00         16.00         17.00           ADP REL COSTS-MUBLE COUP         MURSING         DIA         DIA           ADMIN STRATIVE & GENERAL         PATIENT         DIA         DIA           ADM OPERATION & MAINTENANCE         DIA         DIA         DIA           AUNDRY & LINEN SERVICE         DIA         DIA         DIA         DIA           AUNT OPERATION & MAINTENANCE         DIA         DIA         DIA         DIA           AUNT OPERATION & MAINTENANCE         DIA         DIA         DIA         DIA           AUNTINE MEDICAL SUPPLIES         EDICAL RECORDS         DIA         DIA         DIA           MURSING ADMINI STRATIVE SERVICES         18.087         DIA         DIA         DIA           OSPICE CONTINUOUS HOWE CARE         DIA         DIA         DIA         DIA           OSPICE CONTINUOUS HOWE CARE         DIA         DIA         DIA </td

		VICE COSTS BY	Provider CO		Peri od:	eu of Form CMS- Worksheet 0-7	
	DF CARE				From 01/01/201	7	
			Hospi ce CCN	N: 15-1524	To 12/31/201	7 Date/Time Pre 5/7/2018 3:57	parec pm
		1			Hospi ce I		
				Charges by	/ LOC (from Prov	ider Records)	
	Cost Center Descriptions	From Wkst. C, Cc	ost to Charge	НСНС	HRHC	HI RC	
		Part I, Col. 9	Ratio	nono			
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
00	PHYSI CAL THERAPY	66.00	0. 645387		0	0 0	
0	OCCUPATIONAL THERAPY	67.00					2.
0	SPEECH PATHOLOGY	68.00					3.
00	DRUGS CHARGED TO PATIENTS	73.00	0. 316159		0	0 0	4.
0	DURABLE MEDICAL EQUIP-RENTED	96.00	1. 333577		0	o o	5.
0	LABORATORY	60.00	0. 185598		0	0 0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0. 199387		-	0 0	
o	FAMILY PRACTICE	93.00	0. 484870		-	0 0	
0	RADI OLOGY-THERAPEUTI C	55.00	0.404070		0	0	9.
	ANCI LLARY - OTHER		0. 000000		0	o o	
		76.00					
	CARDI AC REHABI LI TATI ON	76. 97	0. 369470		0	0 0	
00	Totals (sum of lines 1–11)	01 1 00					11.
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
	Cast Captor Decarintiana	Records) HGI P HC			VIII DC (apl 1		-
	Cost Center Descriptions	HGIPHO	col. 2	col. 3)	col. 4)	xHGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS					1	
00	PHYSI CAL THERAPY	0	0		0	0 0	
00	OCCUPATIONAL THERAPY						2.
0	SPEECH PATHOLOGY						3.
00	DRUGS CHARGED TO PATIENTS	0	0		0	0 0	4.
00	DURABLE MEDICAL EQUIP-RENTED	0	0		0	ol o	5.
0	LABORATORY	0	0		0	0 0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0			0 0	
			0		-		
		J			0	0	9.
-					0		
		0	0				
		0	0				
00 1	lotals (sum of lines 1-11)		0		0	0  0	11.
)0 )0 00 97	MEDICAL SUPPLIES CHARGED TO PATIENTS FAMILY PRACTICE RADIOLOGY-THERAPEUTIC ANCILLARY - OTHER CARDIAC REHABILITATION Totals (sum of lines 1-11)				0		0 0 0 0 0

ALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		CARE SERVICES Provider CCN: 15-0048		Worksheet 0-8	2552-
			From 01/01/2017		
	Hospi ce CCN	1: 15-1524	To 12/31/2017	Date/Time Pre 5/7/2018 3:57	
			Hospi ce I		
		TITLE XVIII		TOTAL	
		MEDICARE	MEDICAID	0.00	
HOSPICE CONTINUOUS HOME CARE		1.00	2.00	3.00	
.00 Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst.	0-7. col. 6.			0	1.0
line 11)	0 11 0011 01			, i i i i i i i i i i i i i i i i i i i	
2.00 Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. (
0.00 Total average cost per diem (line 1 divided by line 2)				0.00	3. (
.00 Unduplicated program days (Wkst. S-9 col. as appropriate, I	ine 10)		0 0		4.0
6.00 Program cost (line 3 times line 4)			0 0		5.0
HOSPICE ROUTINE HOME CARE				L	
5.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst.	0-7, col. 7,			3, 184, 587	6.0
line 11) 2.00  Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 027	7.0
8.00 Total average cost per diem (line 6 divided by line 7)				187.03	
0.00 Unduplicated program days (Wkst. S-9, col. as appropriate,	ling 11)	14, 1	10 777		9.0
0.00 Program cost (line 8 times line 9)	rine rij	2, 638, 9			10.
HOSPICE INPATIENT RESPITE CARE		2,000,7	70 110,022		1 10.1
1.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst.	0-7, col. 8,			37, 858	111.0
line 11)					
2.00 Total unduplicated days (Wkst. S-9, col. 4, line 12)				143	
3.00 Total average cost per diem (line 11 divided by line 12)				264.74	
4.00 Unduplicated program days (Wkst. S-9, col. as appropriate,	line 12)		25 5		14. (
5.00 Program cost (line 13 times line 14)		33, 0	93 1, 324		15. (
HOSPICE GENERAL INPATIENT CARE 6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst.	0.7 00 0			242.000	11/
6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. line 11)	0-7, COL. 9,			242, 900	16.
7.00 Total unduplicated days (Wkst. S-9, col. 4, line 13)				917	17.
8.00 Total average cost per diem (line 16 divided by line 17)				264.89	
9.00 Unduplicated program days (Wkst. S-9, col. as appropriate,	line 13)	7	28 61	201107	19.
0.00 Program cost (line 18 times line 19)		192, 8			20.
TOTAL HOSPICE CARE					
1.00 Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 465, 345	
2.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)				18, 087	
3.00 Average cost per diem (line 21 divided by line 22)				191.59	23. (

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 01/01/2017 Parts I-II Date/Time Prepared: 5/7/2018 3:57 pm То 12/31/2017 Title XVIII Hospi tal PPS 1.00 PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 1.00 Capital DRG other than outlier 3, 927, 261 1.00 Model 4 BPCI Capital DRG other than outlier 1.01 Ο 1.01 2.00 Capital DRG outlier payments 89,742 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) 99.41 3.00 4.00 Number of interns & residents (see instructions) 8.85 4.00 5.00 Indirect medical education percentage (see instructions) 2.54 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 6.00 99, 752 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, 116, 755 12.00 1 00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 0 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 3 00 Total inpatient program capital cost (line 1 plus line 2) 3 00 0 4.00 Capital cost payment factor (see instructions) 0 4.00 Total inpatient program capital cost (line 3 x line 4) 0 5.00 5.00 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 1.00 0 1.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 2 00 2 00 0 3.00 Net program inpatient capital costs (line 1 minus line 2) 0 3.00 Applicable exception percentage (see instructions) 0.00 4.00 4.00 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 5.00 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 0.00 6.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 7.00 0 7.00 Capital minimum payment level (line 5 plus line 7) 8.00 0 8.00 9.00 Current year capital payments (from Part 1, 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) Current year allowable operating and capital payment (see instructions) 0 15.00 15.00 Current year operating and capital costs (see instructions) 16.00 16.00 0 17.00 Current year exception offset amount (see instructions) 0 17.00