	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa since the beginning of the cost reporting period bein			FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION - SUMMARY	Provi der CCN: 15-004	From 01/01/2018	Worksheet S Parts I-III Date/Time Prepared: 5/22/2019 7:59 am
PART I - COST	REPORT STATUS			
Provi der	1. [ X ] Electronically filed cost report		Date: 5/22/20	19 Time: 7:59 am
use only	<ol> <li>[ ] Manually submitted cost report</li> <li>[ 0 ] If this is an amended report enter the number</li> <li>[ F ] Medicare Utilization. Enter "F" for full or "</li> </ol>	of times the provide L" for low.	er resubmitted this o	cost report
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	or this Provider CCN		or Code: 4 Jumn 1 is 4: Enter nes reopened = 0-9.
DART II OFRI	I EL CATLON			

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by REID HOSPITAL & HEALTH CARE SERVICES (15-0048) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	
Date	

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	<u> </u>	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	154, 367	763, 882	0	0	1.00
2.00	Subprovi der - IPF	0	43, 421	15		0	2.00
3.00	Subprovi der - I RF	0	42, 873	12		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	240, 661	763, 909	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.

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1401 CHESTER BOULEVARD 1.00 PO Box: 1.00 State: IN 2.00 City: RICHMOND Zip Code: 47374 County: WAYNE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REID HOSPITAL & HEALTH 150048 99915 07/01/1966 Ν 0 3.00 1 CARE SERVICES SUBPROVI DER Subprovi der - IPF 99915 01/01/2001 4.00 15S048 Ν 0 4.00 5.00 Subprovi der - IRF REHAB UNIT 15T048 99915 5 01/01/2003 Р 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSPI CE 14.00 151524 99915 11/03/1993 14.00 Hospital-Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d el i gi bl e paid days days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 118 24.00 878 6.749 219 229 427 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Heal th	Financial Systems REID HOSPITAL	& HFALTH	CARE SERVI	CES		- 1	n Lieu	of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Perion From To	od: 01/01	/2018	Worksh Part I Date/T	eet S-2 ime Pre	pared:
		In-State	In-State	Out-of	Out-	of	Medi ca		019 7:5 Ither	9 am
		Medi cai d	Medi cai d	State	Sta		HMO da		di cai d	
		paid days	eligible	Medi cai d	Medi c			- I	days	
			unpai d	paid days	eligi					
			days		unpa					
		1.00	2. 00	3. 00	4.0		5. 00	_	5. 00	
25. 00	If this provider is an IRF, enter the in-state	C	103	0		0		378		25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,									
	out-of-state Medicaid days in column 3, out-of-state									
	Medicaid eligible unpaid days in column 4, Medicaid									
	HMO paid and eligible but unpaid days in column 5.									
					Ur	ban/Ru 1. 00		Date of 2.		
26. 00	Enter your standard geographic classification (not w		s at the be	ginning of	the	1.00	2	۷.	00	26. 00
27 00	cost reporting period. Enter "1" for urban or "2" fo		o o+ +b ·	d of +b- · ·	ct					27. 00
27.00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o				St		2			27.00
	enter the effective date of the geographic reclassif			ррі і сарі е,						
35.00	If this is a sole community hospital (SCH), enter th			CH status i	n		1			35. 00
	effect in the cost reporting period.									
					E	Begi nni		Endi		
36.00	Enter applicable beginning and ending dates of SCH s	tatus Sub	scrint line	36 for num	her (	1.00 01/01/2		2. 12/31		36.00
00.00	of periods in excess of one and enter subsequent dat		3011 Pt 11110	oo roi maii		7170172	2010	12/01	, 2010	00.00
37.00	If this is a Medicare dependent hospital (MDH), ente	r the numb	er of perio	ds MDH stat	us		О			37.00
	is in effect in the cost reporting period.									
37. 01	Is this hospital a former MDH that is eligible for t									37. 01
	accordance with FY 2016 OPPS final rule? Enter "Y" fi instructions)	or yes or	"N" for no.	(see						
38 00	If line 37 is 1, enter the beginning and ending date	s of MDH s	tatus If I	ine 37 is						38. 00
00.00	greater than 1, subscript this line for the number o									00.00
	enter subsequent dates.	<u>'</u>								
						Y/N		Υ,		
20.00	Door this facility qualify for the inneticat beauty	l normont	adi uatmant	for low val	· · · · ·	1. 00 N	)		00 00	39.00
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i					IN		ŗ	V	39.00
	1 "Y" for yes or "N" for no. Does the facility meet									
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				es					
	or "N" for no. (see instructions)			,						
40.00	Is this hospital subject to the HAC program reductio					N		1	I	40.00
	"N" for no in column 1, for discharges prior to Octo			yes or "N"	for					
	no in column 2, for discharges on or after October 1	. (see rns	tructions)				V	XVIII	XIX	
								2.00		
	Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payme	nt for dis	proporti ona	te share in	accor	dance	N	N	N	45. 00
47.00	with 42 CFR Section §412.320? (see instructions)									47.00
46.00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks						N	N	N	46. 00
	Pt. III.	t. L, Ft.	III aliu wks	t. L-1, Ft.	1 (111	ougn				
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS	capital?	Enter "Y fo	r yes or "N	l" for	no.	N	N	N	47. 00
48.00	Is the facility electing full federal capital paymen						N	N	N	48. 00
	Teaching Hospitals									
56.00	Is this a hospital involved in training residents in	approved (	GME program	s? Enter"	Y" for	yes	Y			56. 00
57 00	or "N" for no. If line 56 is yes, is this the first cost reporting	neriad duri	ing which s	acidante in	annro	ved	N			57.00
37.00	GME programs trained at this facility? Enter "Y" fo									37.00
	is "Y" did residents start training in the first mon									
	for yes or "N" for no in column 2. If column 2 is "									
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I									
58. 00	If line 56 is yes, did this facility elect cost reim			ans' servic	es as		N			58. 00
50 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye			D+ I			N			59.00
37.00	y to costs of at mod off title 100 of worksheet A! IT ye	o, compreti	WKSt. D-Z	NAHE 413.	85 W	orkshe		Pass-T	hrough	37.00
				Y/N		Li ne		Qual i fi	_	
								Cri te		

	Y/N	Li ne #	Qualification Criterion	
			Code	
	1, 00	2, 00	3. 00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for	Y	2.00	3.00	60.00
any programs that meet the criteria under §413.85? (see instructions)				
60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see		23. 00	1	60. 01
i nstructi ons)				

			LIH CARE SERVI	CES	In Liet	u of Form CMS-2		
HOSPI 7	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der Co		eriod: rom 01/01/2018 o 12/31/2018			
		Y/N	IME	Direct GME	I ME	Direct GME	, din	
		1. 00	2. 00	3. 00	4. 00	5. 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			0.00		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 instructions)						61.01	
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 ACA). (see instructions)						61. 02	
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)						61.03	
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61.04	
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)						61.05	
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	
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1. 00	2. 00	3. 00	4. 00		
	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.  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		61. 10	
						1. 00		
	ACA Provisions Affecting the Health Resources and Se	rvi ces	Admi ni strati or	n (HRSA)		1.00		
62.00	Enter the number of FTE residents that your hospital	trai ne	ed in this cost		iod for which	0. 00	62.00	
62. 01	your hospital received HRSA PCRE funding (see instructional form a during in this cost reporting period of HRSA THC processing the second functional forms and the second functional forms are second functional forms.)	a Teach gram. (	ning Health Cer (see instructio		your hospital	0.00	62. 01	
63. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00	
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
				Si te				
	lo ==== = ==== =			1.00	2. 00	3. 00		
	Section 5504 of the ACA Base Year FTE Residents in Neperiod that begins on or after July 1, 2009 and befo		5	-inis base year	is your cost	reporting		
64.00	Enter in column 1, if line 63 is yes, or your faciliin the base year period, the number of unweighted not resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	ty trai n-prima all no d non-p n colum	ned residents ary care onprovider orimary care an 3 the ratio	0.00	0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Υ Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N"

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am 1. 00 2.00 3.00 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for 76.00 Ν 0 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 81.00 N "Y" for yes and "N" for no. TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86 00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section N 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90.00 yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in Υ 91.00 91.00 Ν full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. N 93 00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν N applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 96.00 Ν Ν applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0.00 0 00 97 00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98 01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 98.03 N N for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 | Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? N 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106. 00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. 108.00 Ν

128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

Health Financial Systems	REID HOSPITAL 8	& HEALTH (	CARE SERVIO	CES			In Lieu	ı of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A F	rovider CC	N: 15-0048		i od: m 01.	/01/2018	Worksheet S- Part I	2
					То		/31/2018		epared:
									J
140.00 Are there any related organization	or home office cost	s as defi	ned in CMS	Pub 15-	1	1	. 00 Y	2. 00	140. 00
chapter 10? Enter "Y" for yes or '	'N" for no in column	1. If yes	, and home	office c					
are claimed, enter in column 2 the	<u>e home office chain n</u>	<u>umber. (s</u> 2.00	<u>ee instruc</u>	tions)			3. 00		
If this facility is part of a cha		er on line		ugh 143 t	he name	and		of the home	
office and enter the home office of 141.00 Name:	contractor name and c Contractor's Nar		number.	Contr	actor' s	s Num	ıber:		141. 00
142.00 Street:	PO Box:			7. 0					142.00
143. 00 Ci ty:	State:			Zi p C	ode:				143. 00
								1. 00	111 00
144.00 Are provider based physicians' cos	sts included in Works	neet A?						Y	144. 00
						1	. 00	2. 00	
145.00 If costs for renal services are cl inpatient services only? Enter "Y'					is		Υ		145. 00
no, does the dialysis facility in	clude Medicare utiliz								
period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolog		revi oust v	filed cos	t report?			N		146. 00
Enter "Y" for yes or "N" for no in	column 1. (See CMS								
yes, enter the approval date (mm/d	dd/yyyy) in column 2.								
117 ooks			"11" 6					1. 00	1.17.00
147.00 Was there a change in the statisti 148.00 Was there a change in the order of								N N	147. 00 148. 00
149.00 Was there a change to the simplifi		od? Enter	"Y" for y	es or "N"				N	149. 00
			Part A 1.00	Part 2.00			tle V 3.00	Title XIX 4.00	
Does this facility contain a prov			mption fro	m the app	licatio	on of	the low	er of costs	
or charges? Enter "Y" for yes or '	"N" for no for each c	component	N N	and Part	B. (Se	ee 42	N 541	3. 13) N	155. 00
156.00 Subprovi der - IPF			N	N			N	N	156.00
157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER			N	N			N	N	157. 00 158. 00
159. 00 SNF			N	N			N	N	159. 00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N N			N N	N N	160. 00 161. 00
Terr. dojemne									101.00
Mul ti campus								1. 00	
165.00 Is this hospital part of a Multica	ampus hospital that h	as one or	more camp	uses in d	i fferen	t CB	SAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	Co	unty	State	Zip Co	ode	CBSA	FTE/Campus	
	0		. 00	2.00	3. 00		4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column								0. 0	0 166. 00
0, county in column 1, state in									
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1. 00	-
Health Information Technology (HI						∖ct	'		
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10						nter	the	Υ	167. 00 0168. 00
reasonable cost incurred for the H	HIT assets (see instr	uctions)	•						
168.01 If this provider is a CAH and is reception under §413.70(a)(6)(ii)						nard	shi p		168. 01
169.00 If this provider is a meaningful u	user (line 167 is "Y"					), e	nter the	9. 9	9169.00
transition factor. (see instruction	ons)					Begi	i nni ng	Endi ng	
170 00 Enter in columns 1 and 2 the FUD L	poginning data and an	dina data	for the	oportina			. 00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and en	urng date	ioi the r	epor ri ng		0//0	71/2UI8	09/30/2018	170.00
					'		'		•

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES		In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provi der CCN: 1		eriod: rom 01/01/2018		
			Т	o 12/31/2018	Date/Time Pre 5/22/2019 7:5	
			<u>'</u>			
				1.00	2. 00	
171.00 If line 167 is "Y", does this provider section 1876 Medicare cost plans report "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in	ed on Wkst. S-3, Pt. I, If column 1 is yes, er	line 2, col. 6	6? Enter	N	(	171.00

	Financial Systems REID HOSPITAL & HEALT				u of Form CMS-	
10SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0048	Peri od: From 01/01/2018 To 12/31/2018		epared:
				Y/N	Date	J alli
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO r	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	h 1 1		N.	ı	1 00
00	reporting period? If yes, enter the date of the change in co		instructions		\/ /I	1.00
			1. 00	<u>Date</u> 2.00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare Pr	rogram2 lf	1.00 N	2.00	3.00	2.00
00	yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.					2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		Y			3.00
	or medical supply companies) that are related to the provide	rorits				
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other relationships? (see instructions)	similar				
	Totationships. (See Thistiactions)		Y/N	Type	Date	
			1.00	2.00	3. 00	
00	Financial Data and Reports  Column 1: Were the financial statements prepared by a Certi	fied Public	Y	A	04/24/2019	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai	r Compiled, lable in				
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit reco		N			5. 00
	those on the fired financial statements? If yes, submit reco	ilci i i a ti oii.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	•	he provider i	s N		6.00
. 00	Are costs claimed for Allied Health Programs? If "Y" see ins			Υ		7.00
00	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	nd/or renewe	d during the	Y		8.00
. 00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions		cal education	n Y		9. 00
0. 00	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	Υ		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11.00
				<u> </u>	Y/N	
					1. 00	
	Bad Debts		41		l v	12.00
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection po			cost reporting	Y N	12. 00 13. 00
3. 00	period? If yes, submit copy.	ircy change	during this t	Lost reporting	IN IN	13.00
1. 00	If line 12 is yes, were patient deductibles and/or co-paymen	ts waived? I	f yes, see ir	nstructi ons.	N	14.00
	Bed Complement		•			
5. 00	Did total beds available change from the prior cost reporting	<u> </u>			N	15. 00
			T A		t B	
		Y/N	Date	Y/N	Date	

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	04/04/2019	Υ	04/04/2019	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems REID HOSPITAL & HEA	ALTH CARE SERV	CES	In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (		Peri od:	Worksheet S	
				rom 01/01/2018 o 12/31/2018		repared:
				1	5/22/2019 7	
			iption O	Y/N 1. 00	Y/N 3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N	Date	Y/N	Date	
21.00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21.00
21.00	records? If yes, see instructions.	IN		IN		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, so Have changes occurred in the Medicare depreciation expense			ng the cost	N N	22. 00 23. 00
23. 00	reporting period? If yes, see instructions.	e due to apprai	Sai S illaue uui i	ing the cost	IN	23.00
24. 00	Were new leases and/or amendments to existing leases enter	red into during	this cost rep	orting period?	N	24. 00
25 00	If yes, see instructions	. 464		16	, ,	25.00
25. 00	Have there been new capitalized leases entered into during instructions.	g the cost repo	orting perioa?	ir yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period? If	yes, see	N	26. 00
	i nstructi ons.					
27. 00	Has the provider's capitalization policy changed during the	ne cost reporti	ng period? If	yes, submit	N	27. 00
	Copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit $\epsilon$	entered into du	ıring the cost	reporti ng	N	28.00
20.00	period? If yes, see instructions.	- hl - (F	)-l-+ C! D-	FIX	.,	20.00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Funa)	Y	29. 00
30. 00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	Υ	30.00
	i nstructi ons.	_				
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					
32.00		ervices furnish	ned through con	tractual	Υ	32.00
	arrangements with suppliers of services? If yes, see instr					
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 apno, see instructions.	opilea pertaini	ng to competit	ive bidding? it	Y	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	arrangement wit	h provi der-bas	ed physicians?	N	34.00
25 00	If yes, see instructions.				, N	25 00
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		ents with the p	rovi der -based	N	35.00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	orepared by the	e home office?			37.00
20.00	If yes, see instructions.	se:!: ee				20.00
38. UU	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er					38.00
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 instructions.	e nome office?	If yes, see			40.00
	THIS CLASS COLORS					
		1.	. 00	2.	00	
41 00	Cost Report Preparer Contact Information	KEDDA		DE LADANO		41 00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KERRY		BEJARANO		41.00
	respectively.					
42. 00	Enter the employer/company name of the cost report	BKD				42.00
12 00	preparer.  Enter the telephone number and email address of the cost	3173834000		NDE INDVIOSEND	COM	42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	31/3034000		KBEJARANO@BKD.	COM	43.00
	The state of the s	1		T		11

Heal th	Financial Systems	REID HOSPITAL & HI	EALTH	CARE SER	/I CES		In Lieu	u of Form CMS	-2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE		Provi der	CCN: 15-0048	Perio		Worksheet S-	2
							01/01/2018		anarad.
						10	12/31/2018	Date/Time Pr 5/22/2019 7:	epareu: 59 am
								0,22,20., ,.	
				3	3. 00				
	Cost Report Preparer Contact Information	on							
41.00	Enter the first name, last name and the	e title/position	SEN	II OR MANAGI	NG CONSULTANT				41.00
	held by the cost report preparer in co	umns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the	cost report							42. 00
	preparer.								
43. 00	Enter the telephone number and email a								43.00
	report preparer in columns 1 and 2, res	specti vel y.							

Heal th Fi nancial SystemsREID HOSPITALHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0048

				'	0 12/31/2018	5/22/2019 7:5	
						I/P Days /	
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	133	48, 545	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO I PF Subprovi der						3.00
4. 00	HMO I RF Subprovi der					_	4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	
6. 00	Hospital Adults & Peds. Swing Bed NF					0	
7. 00	Total Adults and Peds. (exclude observation		133	48, 545	0.00	0	7. 00
0.00	beds) (see instructions)	04.00		10.050	0.00		0.00
8. 00	INTENSIVE CARE UNIT	31.00	30	10, 950	0. 00	0	
9.00	CORONARY CARE UNIT						9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12. 00 13. 00
14. 00	Total (see instructions)	43.00	163	59, 495	0.00	1	
15. 00	CAH visits		103	39, 493	0.00		
16. 00	SUBPROVIDER - IPF	40. 00	38	13, 870		0	16.00
17. 00	SUBPROVI DER - I RF	41.00				0	17.00
18. 00	SUBPROVI DER	41.00	20	7,300		o o	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	116.00			)		24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		221				27.00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		(	) c			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

5/22/2019 7:59 am

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0048

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 32, 282 Hospital Adults & Peds. (columns 5, 6, 7 and 1. 00 18,584 716 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2, 922 7,624 2.00 3.00 HMO IPF Subprovider 698 1,825 3.00 4.00 HMO IRF Subprovider 481 4.00 146 5.00 Hospital Adults & Peds. Swing Bed SNF C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 18, 584 716 32, 282 7.00 beds) (see instructions) INTENSIVE CARE UNIT 2,657 8 00 117 5.246 8 00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12 00 13.00 NURSERY 2,015 13.00 878 14.00 Total (see instructions) 21, 241 39, 543 13. 48 2, 386. 39 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 9, 557 16.00 5.396 254 0.00 67.34 16.00 17.00 SUBPROVIDER - IRF 2, 289 3,725 0.00 21.53 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 953 21.80 21 1, 131 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0 C 0 0.00 0.00 26.25 Total (sum of lines 14-26) 2, 497. 06 27 00 13 48 27 00 Observation Bed Days 28.00 160 3, 714 28.00 29.00 Ambul ance Trips 0 29.00 Employee discount days (see instruction) 30.00 713 30.00 31 00 Employee discount days - IRF 31.00 15 Labor & delivery days (see instructions) 32.00 0 118 190 32.00 Total ancillary labor & delivery room 0 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

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

Provider CCN: 15-0048

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/22/2019 7:50 am

						5/22/2019 7:5	9 am
	·	Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	5, 641	231	10, 402	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			611	2, 006		2.00
3. 00	HMO IPF Subprovi der				144		3. 00
4. 00	HMO I RF Subprovi der				33		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00		0.00		F (44	004	40.400	13.00
14.00	Total (see instructions)	0. 00	C	5, 641	231	10, 402	
15. 00 16. 00	CAH visits	0.00	_	420	0	750	15. 00 16. 00
17. 00	SUBPROVIDER - I PF	0.00	C		0	752 258	
	SUBPROVI DER - I RF SUBPROVI DER	0.00	C	108	U	258	18.00
19. 00							19.00
	NURSING FACILITY						20.00
21. 00							21.00
21.00							22.00
23. 00							23. 00
24. 00	` ′	0.00					24.00
24. 10		0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00		0.00					27.00
28. 00		0.00					28.00
29. 00	3						29.00
30.00							30.00
31. 00							31.00
	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
JZ. U1	outpatient days (see instructions)						32.01
33. 00				0			33.00
	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048 | Period: | Worksheet S-3 | From 01/01/2018 | Part II

12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6)1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 176, 294, 574 200 00 1.00 Total salaries (see 176, 294, 574 5, 579, 596. 03 31.60 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 0 00 3.00 Non-physician anesthetist Part C 0 00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 5.00 Physician and Non C 0 0.00 0.00 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 7.00 21.00 0 1, 408, 751 1, 408, 751 30, 162. 09 46.71 7.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0.00 0.00 8.00 0 organization personnel 9 00 44.00 SNF 0.00 0 00 9 00 10.00 Excluded area salaries (see 81, 171, 544 663, 064 81, 834, 608 1, 841, 645. 12 44.44 10.00 instructions) OTHER WAGES & RELATED COSTS 6, 045, 841 6, 045, 841 11.00 Contract labor: Direct Patient 125, 839. 39 48.04 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 376, 493 0 376, 493 2, 653. 85 141.87 13.00 A - Administrative 14.00 Home office and/or related 0 0 0.00 0.00 14.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0.00 15.00 Home office: Physician Part A 0 0.00 0.00 15.00 - Administrative C 0 0.00 16.00 Home office and Contract 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 24, 754, 313 0 24, 754, 313 17.00 instructions) 18.00 Wage-related costs (other) 0 C 0 18.00 (see instructions) 19.00 19.00 Excluded areas 14, 429, 044 14, 429, 044 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 0 0 21.00 22.00 Physician Part A -C 22.00 Administrative 22 01 Physician Part A - Teaching 22 01 0  $\cap$ 23.00 Physician Part B 0 0 23.00 Wage-related costs (RHC/FQHC) 24.00 0 24.00 Interns & residents (in an 25.00 245, 282 245, 282 25.00 approved program) 25.50 Home office wage-related 0 C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) 25.52 Home office: Physician Part A 0 C 0 25.52 - Administrative wage-related (core) Home office & Contract 25.53 Physicians Part A - Teaching wage-related (core)

| Period: | Worksheet S-3 | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION REID HOSPITAL & HEALTH CARE SERVICES

Provider CCN: 15-0048

					10	o 12/31/2018		
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Pai d Hours	5/22/2019 7:5 Average	9 alli
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
		Nullibei	Reported	Sal ari es	(col. 2 ± col.	Salaries in	(col. 4 ÷	
					`		•	
				(from Wkst. A-6)	3)	col. 4	col . 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI		2.00	3.00	4.00	5.00	0.00	
26. 00	Employee Benefits Department	4.00	2, 061, 325	-420, 080	1, 641, 245	61, 776. 93	26.57	26.00
27. 00	Administrative & General	5. 00						27. 00
28. 00	Administrative & General under		8, 422, 169		8, 422, 169			28. 00
20.00	contract (see inst.)		0, 122, 107	Ĭ	0, 122, 107	101,000.00	00. 70	20.00
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00		6, 649	2, 764, 407			30.00
31. 00	Laundry & Linen Service	8.00						31.00
32. 00	Housekeepi ng	9.00	•					32.00
33. 00	Housekeeping under contract	7.00	1,077,002	1,070	1,701,700	0.00		33.00
00.00	(see instructions)		Ü	Ĭ	Ĭ	0.00	0.00	00.00
34.00		10.00	2, 701, 438	-2, 202, 740	498, 698	34, 944. 39	14. 27	34.00
35. 00	Dietary under contract (see		0	0	0	0.00		35.00
	instructions)		_	_				
36.00	Cafeteri a	11. 00	0	2, 209, 253	2, 209, 253	138, 101. 62	16. 00	36.00
37.00	Maintenance of Personnel	12. 00		0	0	0.00		37.00
38. 00	Nursing Administration	13. 00	0	216, 509	216, 509	2, 080. 00	104. 09	38.00
39. 00	Central Services and Supply	14.00			·	· ·		39.00
40.00	Pharmacy	15. 00	·		·			40.00
41. 00	Medical Records & Medical	16. 00						41.00
	Records Library		., ,	.,		.,		
42.00	1	17. 00	3, 270, 960	7, 886	3, 278, 846	105, 137. 40	31. 19	42.00
	Other General Service	18. 00		0		0.00		43.00
	1			•	•	'		'

Total overhead cost (see

instructions)

7.00

26. 03

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2018 To 12/31/2018 Part III Date/Time Prepared: 5/22/2019 7:59 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Salaries in Sal ari es 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 184, 716, 743 -1, 408, 751 183, 307, 992 5, 653, 469. 44 32. 42 1.00 instructions) 2.00 Excluded area salaries (see 81, 171, 544 663, 064 81, 834, 608 1, 841, 645. 12 44.44 2.00 instructions) 3.00 Subtotal salaries (line 1 103, 545, 199 -2, 071, 815 101, 473, 384 3, 811, 824. 32 3.00 26.62 minus line 2) 4.00 6, 422, 334 6, 422, 334 128, 493. 24 49. 98 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs 24, 754, 313 24, 754, 313 0.00 24. 39 5.00 (see inst.) 134, 721, 846 -2, 071, 815 6.00 Total (sum of lines 3 thru 5) 132, 650, 031 3, 940, 317. 56 6.00 33. 66

50, 793, 004

-271, 053

50, 521, 951

1, 940, 676. 89

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Provider CCN: 15-0048

Period:
From 01/01/2018
To 12/31/2018

Part IV
Date/Time Prepared:
5/22/2019 7:59 am

Amount
Reported

1.00

PART IV - WAGE RELATED COSTS

Part A - Core List
RETIREMENT COST

3.00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   3.00			Reported	
Part A - Core List   RETIREMENT COST			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
1.00		RETI REMENT COST		
2.00	1.00		0	1.00
3.00   Nonqualified Defined Benefit Plan Cost (see instructions)   0   3.00			5. 059. 814	
4.00				
PLAM ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA Pl an Administration fees   0   5.00   6.00   Legal /Accounting/Management Fees-Pension Pl an   0   6.00   Employee Managed Care Program Administration Fees   0   7.00   Employee Managed Care Program Administration   0   8.00   Heal th Insurance (Purchased or Self Funded without a Third Party Administrator)   20, 288, 492   8.02   8.03   Heal th Insurance (Self Funded with a Third Party Administrator)   20, 288, 492   8.02   8.03   Heal th Insurance (Purchased)   0   8.01   8.01   8.01   8.02   8.03   8.02   8.03   8.03   8.04   8.04   8.05			-	
5.00	1. 00		Ŭ	1.00
	5 00		0	5.00
Employee Managed Care Program Administration Fees   0   7.00				
HEALTH AND INSURANCE COST			ŭ,	
8.00   Heal th Insurance (Purchased or Self Funded)   8.00   8.01   Heal th Insurance (Self Funded without a Third Party Administrator)   0   8.00   8.01   Heal th Insurance (Self Funded without a Third Party Administrator)   20, 288, 492   8.02   8.03   Heal th Insurance (Purchased)   0   8.03   9.00   Prescription Drug Plan   276, 332   9.00   9.00   Prescription Drug Plan   276, 332   9.00   11.00   Dental , Hearing and Vision Plan   770, 122   10.00   12.00   Accident Insurance (If employee is owner or beneficiary)   188, 511   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   620, 925   13.00   13.00   Disability Insurance (If employee is owner or beneficiary)   0   14.00   15.00   Workers' Compensation Insurance (If employee is owner or beneficiary)   0   14.00   15.00   Workers' Compensation Insurance (If employee is owner or beneficiary)   16.00   16.00   Non cumulative portion)   755, 230   15.00   16.00   Non cumulative portion)   170, 200   16.00   170, 200	7.00		0	7.00
Real th Insurance (Self Funded without a Third Party Administrator)   0   8.01	9 00		0	0 00
Real th Insurance (Self Funded with a Third Party Administrator)   20, 288, 492   8.02   8.03   Heal th Insurance (Purchased)   0 8.03   9.00   Prescription Drug Plan   276, 332   9.00   0.				
8. 03   Heal th Insurance (Purchased)   0   8. 03   9. 00   Prescription Drug Plan   276, 332   9. 00   10. 00   Dental, Hearing and Vision Plan   770, 122   10. 00   Life Insurance (If employee is owner or beneficiary)   188, 511   11. 00   12. 00   Accident Insurance (If employee is owner or beneficiary)   0   12. 00   13. 00   Disability Insurance (If employee is owner or beneficiary)   620, 925   13. 00   14. 00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14. 00   15. 00   Workers' Compensation Insurance   755, 230   15. 00   16. 00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   0   16. 00   Non cumulative portion)   17AXES   17. 00   FICA-Employers Portion Only   0   11. 116, 258   17. 00   18. 00   Medicare Taxes - Employers Portion Only   0   18. 00   19. 00   Unemployment Insurance   23, 250   19. 00   20. 00   OTHER   20. 00   OTHER   20. 00   OTHER   20. 00   OTHER   20. 00   20. 00   OTHER   20. 00   20. 00   OTHER   20. 00			ŭ,	
9.00   Prescription Drug Plan   276, 332   9.00   10.00   Dental   Hearing and Vision Plan   770, 122   10.00   11.00   Life Insurance (If employee is owner or beneficiary)   188, 511   11.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00   Accident Insurance (If employee is owner or beneficiary)   620, 925   13.00   13.00   Disability Insurance (If employee is owner or beneficiary)   620, 925   13.00   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   14.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   13.00   Cong-Term Care Insurance (If employee is owner or beneficiary)   14.00   Co				
10.00   Dental, Hearing and Vision Plan   770, 122   10.00   11.00   Life Insurance (If employee is owner or beneficiary)   188, 511   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   12.00   13.00   Disability Insurance (If employee is owner or beneficiary)   620, 925   13.00   14.00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14.00   15.00   Workers' Compensation Insurance   755, 230   15.00   Non cumulative portion)   16.00   Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   16.00   Non cumulative portion)   17.00   FICA-Employers Portion Only   11, 116, 258   17.00   18.00   Medicare Taxes - Employers Portion Only   0   18.00   Unemployment Insurance   23, 250   19.00   20.00   21.00   CTHER   21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))   22.00   Day Care Cost and Allowances   0   22.00   23.00   Tuition Reimbursement   329, 705   23.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   20.00   24.00   24.00   Part B - Other than Core Related Cost   24.00   24.00   Part B - Other than Core Related Cost   24.00   24.00   Part B - Other than Core Related Cost   24.00   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Part B - Other than Core Related Cost   24.00   Par			-	
11. 00 Life Insurance (If employee is owner or beneficiary) 12. 00 Accident Insurance (If employee is owner or beneficiary) 13. 00 Disability Insurance (If employee is owner or beneficiary) 14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 'Workers' Compensation Insurance 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
12.00				
13. 00 Disability Insurance (If employee is owner or beneficiary)  14. 00 Long-Term Care Insurance (If employee is owner or beneficiary)  15. 00 'Workers' Compensation Insurance  16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  17. 00 FICA-Employers Portion Only  18. 00 Medicare Taxes - Employers Portion Only  19. 00 Unemployment Insurance  20. 00 State or Federal Unemployment Taxes  17. 00 OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22. 00 Day Care Cost and Allowances  23. 00 Tuition Reimbursement  24. 00 Part B - Other than Core Related Cost				
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances Tuition Reimbursement  23.00 Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FICA-Employers Portion Only 18.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 20.00 OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances 23.00 Tuit ion Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.  Non cumulative portion)  TAXES  17.00 FI CA-Employers Portion Only  18.00 Medicare Taxes - Employers Portion Only  19.00 Unemployment Insurance  20.00 State or Federal Unemployment Taxes  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  23.00 Tuit ion Reimbursement  24.00 Part B - Other than Core Related Cost			· · ·	
Non cumulative portion) TAXES  17. 00 FI CA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 0 DTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			755, 230	
TAXES   17.00   FI CA-Employers Portion Only   11, 116, 258   17.00   18.00   Medicare Taxes - Employers Portion Only   0   18.00   19.00   Unemployment Insurance   23, 250   19.00   20.00   OTHER   21.00   Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
17. 00   FI CA-Employers Portion Only   11, 116, 258   17. 00   18. 00   19. 00				
18.00       Medicare Taxes - Employers Portion Only       0       18.00         19.00       Unemployment Insurance       23,250       19.00         20.00       State or Federal Unemployment Taxes       0       20.00         OTHER         21.00       Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))       0       21.00         22.00       Day Care Cost and Allowances       0       22.00         23.00       Tuit ion Reimbursement       329,705       23.00         24.00       Total Wage Related cost (Sum of Lines 1 -23)       39,428,639       24.00         Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 23,250 19.00 20.00 State or Federal Unemployment Taxes 0 20.00  OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuit ion Reimbursement 329,705 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 39,428,639 Part B - Other than Core Related Cost			11, 116, 258	17. 00
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 329,705 23.00 Total Wage Related cost (Sum of Lines 1 -23) 39,428,639 Part B - Other than Core Related Cost	18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
OTHER  21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost  21.00  22.00  329,705  339,428,639  24.00	19.00	Unempl oyment Insurance	23, 250	19.00
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  22.00 Day Care Cost and Allowances  Tuition Reimbursement  24.00 Total Wage Related cost (Sum of Lines 1 -23)  Part B - Other than Core Related Cost	20.00	State or Federal Unemployment Taxes	0	20.00
instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost		OTHER		
instructions))  22.00 Day Care Cost and Allowances  23.00 Tuition Reimbursement  24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost	21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 23.00 39,428,639 24.00				
23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 23.00 39,428,639 24.00	22.00	Day Care Cost and Allowances	0	22.00
24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  39,428,639  24.00			329, 705	23.00
Part B - Other than Core Related Cost				
	25. 00		0	25. 00
		1	۳	

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
HOODITAL CONTRACT LABOR AND DENEELT COST		D 1 L . OON 45 0040	D	West states at C. O.

HOSPI 7	TAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0048		i od: om 01/01/2018	Worksheet S-3 Part V	
			То		Date/Time Pre 5/22/2019 7:5	
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				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			6, 045, 841	39, 428, 639	1. 00
2.00	Hospi tal			6, 045, 841	24, 999, 595	2.00
3.00	Subprovi der - IPF			0	663, 736	3.00
4.00	Subprovi der - I RF			0	235, 193	4. 00
5.00	Subprovi der - (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	Hospi tal -Based SNF					8.00
9.00	Hospi tal -Based NF					9.00
10.00	Hospi tal -Based OLTC					10.00
11. 00	Hospi tal -Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce			0	226, 536	13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospi tal -Based-CMHC					16.00
17.00	Renal Dialysis			O	0	17.00
18. 00	Other			О	13, 303, 579	18. 00

Heal th	n Financial Systems	REI D	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
HOSPI	TAL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	Provider CCN: 15-0048   Period:   From 01/01/2018		Worksheet S-9 B PARTS I THROUGH IV	
				Hospi ce CC	N: 15-1524		Date/Time Pre 5/22/2019 7:5	pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1 00		Facility		5.00		
	DART I FURNILLUEUT DAVO FOR O	1.00	2. 00	3.00	4.00	5. 00	6. 00	
4 00	PART I - ENROLLMENT DAYS FOR C	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	JBER 1, 2015			1 00
1.00	Hospice Continuous Home Care							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 Part II - CENSUS DATA FOR COST	DEDODTING DED	LODE DECLINIUM	DEFODE OCTOBE	D 1 2015			5.00
6. 00	Number of patients receiving	KEPUKITING PEK	TODS BEGINNING	DEFUKE UCTUBE	K 1, 2015			6.00
0.00	hospi ce care							0.00
7. 00	Total number of unduplicated							7.00
7.00	Continuous Care hours billable							7.00
	to Medicare							
8. 00	Average Length of Stay (line 5							8.00
	/ line 6)							

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

		Title XVIII	Title XIX	0ther	Total (sum of	
					col s. 1	
					through 3)	
		1. 00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGIN	NNING ON OR AFT	TER OCTOBER 1,	2015		
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	14, 363	973	2, 340	17, 676	11.00
12.00	Hospice Inpatient Respite Care	97	9	0	106	12.00
13.00	Hospice General Inpatient Care	835	12	0	847	13.00
14.00	Total Hospice Days	15, 295	994	2, 340	18, 629	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

	Financial Systems REID HOSPITAL & HEALTH TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co		Peri od:	u of Form CMS-2 Worksheet S-1			
позы	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider Co	JN. 13-0046	From 01/01/2018		U		
				To 12/31/2018				
					5/22/2019 7:5	9 am		
					1. 00			
	Uncompensated and indigent care cost computation							
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 col ur	mn 8)	0. 302453	1.00		
	Medicaid (see instructions for each line)				00 057 747			
2.00	Net revenue from Medicaid				33, 057, 716			
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	tal navmon	ts from Modi	cal d2	N	3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f			Lai u :	0	1		
6. 00	Medi cai d charges	Tom wearea	u		146, 338, 982			
7. 00	Medicaid cost (line 1 times line 6)				44, 260, 664			
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	nus sum of li	nes 2 and 5; if	11, 202, 948			
	< zero then enter zero)					]		
	Children's Health Insurance Program (CHIP) (see instructions f	or each lir	ne)					
9. 00	Net revenue from stand-alone CHIP				0			
10.00								
11. 00 12. 00		(Line 11 mi	nuc line O	if a zoro thon	0			
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.0 enter zero)							
	Other state or local government indigent care program (see ins	tructions 1	for each line	e)		1		
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00		
14.00	Charges for patients covered under state or local indigent car	e program	(Not included	din lines 6 or	0	14.00		
	10)							
15. 00	State or local indigent care program cost (line 1 times line 1				0	1		
16. 00	Difference between net revenue and costs for state or local in	ndigent care	e program (li	ne 15 minus line	0	16. 00		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, Ch	IID and stat	to/Local indi	gont care progra	ume (eoo	1		
	instructions for each line)	iir anu sta	te/Tocal Thui	gent care progra	iiis (see			
17. 00	Private grants, donations, or endowment income restricted to f	undi na chai	ritv care		0	17.00		
18.00	Government grants, appropriations or transfers for support of				0	18.00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local	ıl indigent	care program	ms (sum of lines	11, 202, 948	19.00		
	8, 12 and 16)							
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	pati ents 2.00	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00			
20. 00	Charity care charges and uninsured discounts for the entire fa	ncility	11, 736, 1	98 2, 232, 034	13, 968, 232	20.00		
	(see instructions)		,,	_,,,				
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	3, 549, 6	48 2, 232, 034	5, 781, 682	21.00		
	instructions)							
22. 00	Payments received from patients for amounts previously writter	n off as		0	0	22. 00		
22 00	charity care		2 540 /	40 2 222 024	F 701 /00	22.00		
23. 00	Cost of charity care (line 21 minus line 22)		3, 549, 6	48 2, 232, 034	5, 781, 682	23.00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patie	ent days be	vond a Lengtl	n of stay limit	N 1.00	24. 00		
	imposed on patients covered by Medicaid or other indigent care		,	J	•			
25.00	If line 24 is yes, enter the charges for patient days beyond t	he indigen	t care progra	am's length of	0	25. 00		
	stay limit							
26.00	Total bad debt expense for the entire hospital complex (see in				24, 015, 183			
27. 00	Medicare reimbursable bad debts for the entire hospital complex				1, 651, 329			
			THORSE		/ 5/411 5/15			

2, 540, 505 27. 01

7, 384, 257 29, 00 13, 165, 939 24, 368, 887 31, 00

28.00

21, 474, 678

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

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

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)
30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

28.00 Non-Medicare bad debt expense (see instructions)

		HUSPITAL & HEAL	Provider CC			Worksheet A	2332-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JF EXPENSES	Provider CC		Period: From 01/01/2018	worksneet A	
					o 12/31/2018	Date/Time Pre	pared:
						5/22/2019 7:5	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		0	(		19, 800, 290	1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE		0	(	6, 563, 534	6, 563, 534	1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(	0	0	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 061, 325	31, 596, 670	33, 657, 995	13, 508, 241	47, 166, 236	4.00
5. 01	00540 NONPATI ENT TELEPHONES	271, 841	22, 298	294, 139	655	294, 794	5. 01
5. 02	00550 DATA PROCESSING	4, 140, 920	25, 260, 858	29, 401, 778	-2, 246	29, 399, 532	5.02
5.03	00560 PURCHASING RECEIVING AND STORES	913, 443	804, 289	1, 717, 732	1, 455	1, 719, 187	
5.04	00570 ADMI TTI NG	2, 185, 965	1, 187, 403	3, 373, 368	-9, 906	3, 363, 462	5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 444, 634	5, 250, 708	8, 695, 342	-207, 080	8, 488, 262	5. 05
5.06	00590 OTHER A&G	10, 296, 545	34, 824, 066	45, 120, 611	-493, 122	44, 627, 489	5.06
7.00	00700 OPERATION OF PLANT	2, 757, 758	1, 083, 995	3, 841, 753	-17, 651	3, 824, 102	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	452, 918	427, 902	880, 820	-229, 991	650, 829	8.00
9.00	00900 HOUSEKEEPI NG	1, 697, 662	592, 412	2, 290, 074	4, 093	2, 294, 167	9.00
10.00	01000 DI ETARY	2, 701, 438	2, 996, 431	5, 697, 869	-4, 647, 258	1, 050, 611	10.00
11.00	01100 CAFETERI A	o	o	(	4, 653, 677	4, 653, 677	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	o	O	(	216, 509	216, 509	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	581, 592	3, 100, 070	3, 681, 662	1, 402	3, 683, 064	14.00
15.00	01500 PHARMACY	3, 910, 478	27, 093, 583	31, 004, 061		31, 007, 823	
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 683, 356	1, 610, 279	5, 293, 635		5, 293, 631	
17. 00	01700 SOCI AL SERVI CE	2, 161, 861	513, 401	2, 675, 262		2, 680, 474	1
17. 01	01701 I NSERVI CE EDUCATION	1, 109, 099	1, 534, 565	2, 643, 664		2, 646, 338	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	_, , (			
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	1, 589, 123	990, 856	2, 579, 979		1, 105, 413	
23. 00	02300 PARAMED ED PRGM	213, 239	30, 932	244, 171		244, 685	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2.0,20,	30, 702	21., 17.	0	211,000	20.00
30.00	03000 ADULTS & PEDIATRICS	18, 828, 019	9, 460, 070	28, 288, 089	-379, 009	27, 909, 080	30.00
31. 00	03100   NTENSI VE CARE UNI T	3, 825, 880	2, 485, 432	6, 311, 312		6, 320, 536	•
40. 00	04000 SUBPROVI DER – I PF	3, 763, 675	537, 796	4, 301, 471		4, 310, 545	1
41. 00	04100 SUBPROVI DER - I RF	1, 330, 301	345, 720	1, 676, 021		1, 679, 228	1
43. 00	04300 NURSERY	464, 695	115, 029	579, 724			1
10.00	ANCILLARY SERVICE COST CENTERS	1017070	1.107.02.7	0,,,,2	, , , , , , , , , , , , , , , , , , , ,	3337 131	10.00
50.00	05000 OPERATING ROOM	1, 213, 170	39, 179, 887	40, 393, 057	-9, 049, 925	31, 343, 132	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	736, 922	298, 101	1, 035, 023		1, 033, 278	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 766, 008	6, 279, 519	12, 045, 527		11, 922, 717	
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 817, 573	9, 826, 216	11, 643, 789			
60.00	06000 LABORATORY	3, 490, 614	7, 279, 912	10, 770, 526		10, 742, 166	
65. 00	06500 RESPI RATORY THERAPY	1, 310, 361	498, 797	1, 809, 158		1, 812, 012	1
66.00	06600 PHYSI CAL THERAPY	5, 300, 671	1, 385, 618	6, 686, 289		6, 480, 064	1
69. 00	06900 ELECTROCARDI OLOGY	824, 008	754, 662	1, 578, 670		1, 580, 555	
70.00	07000 ELECTROENCEPHALOGRAPHY	337, 529	78, 520	416, 049		416, 863	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	70, 320	410,047		0	1
	07200 IMPL. DEV. CHARGED TO PATIENT	o	o	(	1		
	07300 DRUGS CHARGED TO PATIENTS	o o	o o	(	0		73.00
	07400 RENAL DIALYSIS	o	773, 055	773, 055		773, 055	
76.00	03950 ANCI LLARY - OTHER	o o	770,000	770,000		0	1
	07697 CARDI AC REHABI LI TATI ON	218, 237	81, 096	299, 333	-37, 295	262, 038	
70. 77	OUTPATIENT SERVICE COST CENTERS	210, 237	01,070	277, 330	37, 273	202, 030	1 70. 77
91.00	09100 EMERGENCY	5, 115, 166	2, 313, 577	7, 428, 743	-271, 865	7, 156, 878	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,110,100	2,010,077	7, 120, 710	271,000	7, 100, 070	92.00
93. 00	04040 FAMILY PRACTICE	1, 776, 572	415, 116	2, 191, 688	-147, 361	2, 044, 327	•
75.00	OTHER REIMBURSABLE COST CENTERS	1,770,372	413, 110	2, 171, 000	147, 301	2,044,321	/3.00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	137, 647	370, 804	508, 451	314	508, 765	96 00
70.00	SPECIAL PURPOSE COST CENTERS	137,047	370,004	300, 43	314	300, 703	70.00
113 00	11300 I NTEREST EXPENSE		8, 109, 706	8, 109, 706	-8, 109, 706	0	113.00
	11600 HOSPI CE	930, 183	1, 489, 156	2, 419, 339			
118.00		101, 360, 428	230, 998, 507	332, 358, 935		362, 678, 691	1
110.00	NONREI MBURSABLE COST CENTERS	101, 300, 420	230, 770, 307	332, 330, 730	0 30, 317, 730	302, 070, 071	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	n	(		0	190. 00
100.00	19200 PHYSI CI ANS' PRI VATE OFFI CES		9, 231, 926	9, 231, 926			
10/ 00	07950 RENTAL SPACE	o	14, 977, 856	14, 977, 856		4, 025, 451	
	07951 FOUNDATION	179, 415	288, 897	468, 312		468, 745	1
	07951 FOUNDATION 07952 RETAIL SERVICES	124, 080	17, 383	141, 463		141, 762	1
	07953 REID CONTRACTED SERVICES	124,000	17, 303	141, 403		231, 083	1
	07954 REID CONTRACTED SERVICES	73, 596, 288	43, 156, 039	116, 752, 327		103, 068, 990	1
	07955 OTHER NRCC	73, 390, 200	73, 130, 039	110, 752, 327			194. 04
	07956 VACANT SPACE		0	(			194. 05
	07958 CAMBRI DGE RHC	1, 034, 363	284, 292	1, 318, 655			
200.00		176, 294, 574	298, 954, 900	475, 249, 474			
200. UC	TOTAL (SOM OF LINES TTO HILDUGH 199)	170, 274, 374	270, 704, 700	713, 477, 4/2	'ı Y	7,3,247,4/4	<sub>1</sub> =00.00

Health Financial Systems		HOSPITAL & HEA				of Form CMS-	2552-10
RECLASSIFICATION AND ADJUST	TMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der C	CN: 15-0048	Peri od: From 01/01/2018	Worksheet A	
						Date/Time Pre	
Cost Center De	scription	Adjustments	Net Expenses			5/22/2019 7:5	og am
	P. C.	(See A-8)	For				
		/ 00	Allocation	1			
GENERAL SERVICE COST	CENTERS	6. 00	7. 00				
1. 00 00100 NEW CAP REL CO		-8, 109, 706	11, 690, 584	l .			1.00
1.01   00101 NEW CAP BLDG &		0	6, 563, 534	·			1. 01
2. 00   00200   NEW CAP REL CO		0	00.000.440				2.00
4. 00   00400 EMPLOYEE BENEF 5. 01   00540 NONPATIENT TEL		-16, 183, 796	30, 982, 440 294, 794	1			4. 00 5. 01
5. 02 00550 DATA PROCESSI N		-472, 008	28, 927, 524				5. 02
5. 03 00560 PURCHASING REC		-367, 459	1, 351, 728				5. 03
5. 04   00570 ADMITTING		0	3, 363, 462				5. 04
5. 05 00580 CASHI ERI NG/ACC	OUNTS RECEIVABLE	-11, 685	8, 476, 577				5.05
5. 06   00590 OTHER A&G 7. 00   00700 OPERATION OF P	LANT	-15, 884, 439 -839	28, 743, 050 3, 823, 263				5. 06 7. 00
8. 00   00800   LAUNDRY & LINE		-037	650, 829				8.00
9. 00 00900 HOUSEKEEPI NG		0	2, 294, 167				9.00
10. 00  01000 DI ETARY		-566, 269	484, 342				10.00
11. 00   01100   CAFETERI A		-3, 168, 889	1, 484, 788	1			11.00
13. 00   01300   NURSI NG   ADMI NI		0	216, 509	1			13.00
14. 00   01400   CENTRAL SERVI C 15. 00   01500   PHARMACY	ES & SUPPLY	-374 -237, 806	3, 682, 690 30, 770, 017	1			14. 00 15. 00
16. 00 01600 MEDICAL RECORD	S & LIBRARY	-52, 704	5, 240, 927				16.00
17.00 01700 SOCIAL SERVICE		0	2, 680, 474	1			17.00
17. 01 01701 I NSERVI CE EDUC		-1, 168, 137	1, 478, 201				17. 01
1 1	ALARY & FRINGES APPRVD	0	1, 478, 397				21.00
22. 00   02200   1 &R SERVICES-0 23. 00   02300   PARAMED ED PRG	THER PRGM. COSTS APPRVD	-689, 386 -48, 209	416, 027 196, 476	1			22. 00 23. 00
I NPATI ENT ROUTINE SE		-40, 207	170, 470	'I			23.00
30. 00 03000 ADULTS & PEDIA		-5, 551, 758	22, 357, 322	2			30.00
31. 00   03100   INTENSIVE CARE		-85	6, 320, 451	1			31.00
40. 00   04000   SUBPROVI DER -		-35	4, 310, 510	1			40.00
41. 00   04100   SUBPROVI DER - 43. 00   04300   NURSERY	IKF	-3, 931 0	1, 675, 297 580, 454	1			41. 00 43. 00
ANCILLARY SERVICE CO	OST CENTERS	<u> </u>	550, 10				10.00
50. 00 05000 OPERATING ROOM		-8, 992, 677	22, 350, 455				50.00
52. 00   05200   DELI VERY ROOM		-489	1, 032, 789				52.00
54. 00   05400   RADI OLOGY-DI AG 59. 00   05900   CARDI AC   CATHET		-204, 300 -7, 765	11, 718, 417 6, 527, 931				54. 00 59. 00
60. 00   06000 LABORATORY	ERI ZATI ON	-868, 294	9, 873, 872				60.00
65. 00 06500 RESPIRATORY TH	ERAPY	0	1, 812, 012	1			65.00
66. 00 06600 PHYSI CAL THERA		-58, 121	6, 421, 943	1			66.00
69. 00   06900   ELECTROCARDI OL		-56, 070	1, 524, 485				69.00
70. 00   07000   ELECTROENCEPHA 71. 00   07100   MEDI CAL SUPPLI	ES CHARGED TO PATIENTS	-522 0	416, 341 (	1			70.00
72. 00 07200 I MPL. DEV. CHA		0	14, 187, 239	•			72.00
73.00 07300 DRUGS CHARGED		0	C				73.00
74. 00   07400   RENAL DI ALYSI S		0	773, 055	5			74.00
76. 00 03950 ANCILLARY - 0T		0	250 (02				76.00
76. 97 O7697 CARDI AC REHABI OUTPATI ENT SERVI CE C		-2, 345	259, 693	0			76. 97
91. 00 09100 EMERGENCY	JOST GENTERS	-910, 423	6, 246, 455	i i			91.00
	DS (NON-DISTINCT PART)						92.00
93. 00 04040 FAMILY PRACTIC		-1, 122	2, 043, 205	5			93. 00
96. 00 09600 DURABLE MEDICA		-336, 706	172, 059				96.00
SPECIAL PURPOSE COST		330, 700	172,003				1 /0.00
113.00 11300 INTEREST EXPEN		0	C				113.00
116. 00 11600 HOSPI CE		-1, 298					116.00
118.00 SUBTOTALS (SUM NONREI MBURSABLE COST	OF LINES 1 through 117)	-63, 957, 647	298, 721, 044	<u> </u>			118. 00
190. 00 19000 GIFT, FLOWER,		O	C				190.00
192. 00 19200 PHYSI CI ANS' PR		0	3, 314, 807	1			192.00
194.00 07950 RENTAL SPACE		0	4, 025, 451				194.00
194. 01 07951 FOUNDATI ON		0	468, 745				194. 01
194. 02 07952 RETAIL SERVICE		0	141, 762				194. 02
194. 03 07953 REID CONTRACTE 194. 04 07954 REID PHYSICIAN			231, 083 103, 068, 990				194. 03 194. 04
194. 04 07954 RETURN 194. 05 07955 OTHER NRCC	N0000.		103, 000, 990	1			194.04
194. 06 07956 VACANT SPACE		o o	C				194.06
194. 08 07958 CAMBRI DGE RHC		0	1, 319, 945				194. 08
200.00   TOTAL (SUM OF	LINES 118 through 199)	-63, 957, 647	411, 291, 827	Ί			200.00

	Financial Systems	REI D	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS	
RECLAS	SI FI CATI ONS			Provi der C	CN: 15-0048	Peri od: From 01/01/2018	Worksheet A-	6
						To 12/31/2018	Date/Time Pr 5/22/2019 7:	
		Increases					3/22/2019 7.	77 2111
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00				
	A - CAPITAL EXPENSE RECLASS							
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	11, 651, 155				1.00
2. 00	NEW CAP BLDG & FIXT -	1. 01	О	6, 031, 898				2. 00
3. 00	OFFSITE NEW CAP REL COSTS-BLDG &	1. 00	o	7, 410				3.00
	FIXT							
4. 00	NEW CAP BLDG & FIXT - OFFSITE	1. 01	0	272, 859				4.00
5. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	32, 019				5. 00
6. 00	NEW CAP BLDG & FLXT - OFFSLTE	1. 01	0	258, 777				6. 00
7. 00		0.00	О	0				7. 00
8. 00 9. 00		0. 00 0. 00	0	0				8. 00 9. 00
10.00		0.00	Ö	Ö				10.00
11. 00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13. 00 14. 00		0. 00 0. 00	0	0				13. 00 14. 00
15. 00		0.00	Ö	Ö				15. 00
16. 00		0.00	0	0				16. 00
17.00		0.00	0	0				17.00
18. 00 19. 00		0. 00 0. 00	0	0				18. 00 19. 00
20.00		0. 00	Ö	Ö				20.00
21.00		0.00	0	0				21.00
22. 00 23. 00		0.00	0	0				22.00
24. 00		0. 00 0. 00	0	0				23. 00 24. 00
25. 00		0.00	0	0				25. 00
	O DA CAFETERIA DEGLACO		0	18, 254, 118				4
1. 00	B - CAFETERIA RECLASS CAFETERIA	11. 00	2, 203, 939	2, 444, 424				1.00
1.00	0		2, 203, 939	2, 444, 424				1.00
	C - LAUNDRY RECLASS							
1. 00	REID CONTRACTED SERVICES	194.03	109, 277 109, 277	12 <u>1, 5</u> 43 121, 543				1.00
	D - NURSING VP RECLASS		107, 277	121, 545				1
1. 00	NURSING ADMINISTRATION	1300	215, 988	0				1.00
	O   E - OCCUPATIONAL MEDICINE REC	1 100	215, 988	0				-
1. 00	OTHER A&G	5. 06	160, 993	122, 817				1.00
	0		160, 993	122, 817				
1. 00	F - IMPLANTABLE DEVICES RECLA	72. 00	O	14, 187, 239				1.00
1.00	PATI ENT	72.00		11, 107, 207				
2.00		0.00	0	0				2.00
3. 00 4. 00		0. 00 0. 00	0	0				3. 00 4. 00
5. 00		0.00	0	0				5.00
	0			14, 187, 239				_
1 00	G - INTEREST RECLASS NEW CAP REL COSTS-BLDG &	1 00	٥	0 100 704				1 00
1. 00	FIXT	1. 00	0	8, 109, 706				1.00
	0			8, 109, 706				_
4 00	J - INTERN AND RESIDENT	24 00	4 405 070	(0.44)				4 00
1. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	21. 00	1, 405, 363	69, 646				1.00
	0	+	1, 405, 363	69, 646				
	K - WORKERS COMP RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	755, 230				1.00
2. 00			0	000				2.00
	L - RHPA BENEFITS RECLASS			, 55, 250				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 180, 654				1.00
	M - LT RECOGNITION RECLASS		0	13, 180, 654				-
1. 00	NONPATIENT TELEPHONES	5. 01	655	0				1.00
2. 00	DATA PROCESSING	5. 02	9, 984	Ö				2. 00
3. 00	PURCHASING RECEIVING AND	5. 03	2, 202	0				3. 00
4. 00	STORES ADMI TTI NG	5. 04	5, 270	0				4.00
	r ==	3. 04	5,210	<u> </u>				1 1.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0048

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
5.00	CASHI ERI NG/ACCOUNTS	5. 05	8, 305	0	5.
	RECEI VABLE				
6.00	OTHER A&G	5. 06	24, 693	0	6.
7.00	OPERATION OF PLANT	7. 00	6, 649	0	7.
8.00	LAUNDRY & LINEN SERVICE	8. 00	829	0	8.
9.00	HOUSEKEEPI NG	9. 00	4, 093	0	9.
10.00	DI ETARY	10.00	1, 199	0	10.
11. 00	CAFETERI A	11.00	5, 314	0	11.
12.00	NURSING ADMINISTRATION	13. 00	521	0	12.
13.00	CENTRAL SERVICES & SUPPLY	14. 00	1, 402	0	13.
14. 00	PHARMACY	15. 00	9, 428	0	14.
15. 00	MEDICAL RECORDS & LIBRARY	16, 00	8, 881	0	15.
16. 00	SOCIAL SERVICE	17. 00	5, 212	Ö	16.
17. 00	INSERVICE EDUCATION	17. 01	2, 674	Ö	17.
18. 00	I&R SERVICES-SALARY &	21. 00	3, 388	Ö	18.
10.00	FRI NGES APPRVD	21.00	0,000	J	10.
19. 00	I&R SERVICES-OTHER PRGM.	22. 00	443	О	19.
17.00	COSTS APPRVD	22.00	773	J	17.
20. 00	PARAMED ED PRGM	23. 00	514	0	20.
21. 00	ADULTS & PEDIATRICS	30.00	44, 535	o	21.
22. 00	INTENSIVE CARE UNIT	31.00	9, 224	o	22.
23. 00	SUBPROVI DER - I PF	40.00	9, 074	0	23.
24. 00	SUBPROVI DER - I RF	41. 00	3, 207	0	24.
25. 00	NURSERY	43. 00	1, 120	0	25.
26. 00	OPERATING ROOM	50.00	2, 925	0	25.
28. 00 27. 00	DELIVERY ROOM & LABOR ROOM	52. 00	1, 777	0	20.
27. 00 28. 00		•		0	27.
	RADI OLOGY-DI AGNOSTI C	54.00	13, 902	-	
29. 00	CARDI AC CATHETERI ZATI ON	59.00	4, 382	0	29.
30.00	LABORATORY	60.00	8, 416	0	30.
31.00	RESPI RATORY THERAPY	65. 00	3, 159	0	31.
32.00	PHYSI CAL THERAPY	66.00	12, 780	0	32.
33. 00	ELECTROCARDI OLOGY	69.00	1, 987	0	33.
34. 00	ELECTROENCEPHALOGRAPHY	70.00	814	0	34.
35. 00	CARDI AC REHABI LI TATI ON	76. 97	526	0	35.
36. 00	EMERGENCY	91. 00	11, 945	0	36.
37. 00	FAMILY PRACTICE	93. 00	4, 283	0	37.
38. 00	DURABLE MEDICAL EQUIP-RENTED	96. 00	332	0	38.
39. 00	HOSPI CE	116. 00	3, 103	0	39.
40. 00	FOUNDATI ON	194. 01	433	0	40.
41. 00	RETAIL SERVICES	194. 02	299	0	41.
42.00	REID CONTRACTED SERVICES	194. 03	263	0	42.
43. 00	REID PHYSICIAN ASSOC.	194. 04	177, 444	0	43.
44. 00	CAMBRI DGE_RHC	194. 08	2, 494	0	44.
	TOTALS		420, 080	0	
	N - HOSPICE				
1. 00	HOSPI CE	116. 00	356, 956	49, 809	1.
	TOTALS		356, 956	49, 809	
500.00	Grand Total: Increases		4, 872, 596	57, 295, 186	500.

	Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERV		In Lieu of Form	CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der (	CCN: 15-0048	Period: Worksheet From 01/01/2018	t A-6
						To 12/31/2018 Date/Time	
		Decreases				5/22/2019	7:59 am
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	I	
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAPITAL EXPENSE RECLASS		_1		1 _	-1	
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING	4. 00 5. 02	0	7, 563 12, 230			1. 00 2. 00
3. 00	PURCHASING RECEIVING AND	5. 02	0	12, 230 747		•	3.00
0.00	STORES	0.00	Ğ	, , ,			0.00
4.00	ADMI TTI NG	5. 04	О	15, 176		•	4.00
5. 00	CASHI ERI NG/ACCOUNTS	5. 05	0	215, 385	10		5. 00
6. 00	RECEI VABLE OTHER A&G	5. 06	o	61, 858	10		6. 00
7. 00	OPERATION OF PLANT	7. 00	o	24, 300		•	7.00
8. 00	DI ETARY	10.00	o	94		•	8.00
9.00	PHARMACY	15. 00	0	5, 666	C		9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	0	8, 885		•	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	16, 779		1	11.00
12. 00 13. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	3, 036 115, 674		1	12. 00 13. 00
14. 00	LABORATORY	60.00	o	36, 776		1	14.00
15. 00	RESPIRATORY THERAPY	65. 00	o	305		1	15. 00
16.00	PHYSI CAL THERAPY	66. 00	О	219, 005	C		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	0	102	-	1	17. 00
18.00	CARDIAC REHABILITATION	76. 97	0	37, 821	C	1	18.00
19. 00 20. 00	FAMILY PRACTICE DURABLE MEDICAL EQUIP-RENTED	93. 00 96. 00	0	151, 644 18		1	19. 00 20. 00
21. 00	HOSPI CE	116.00	o	1, 650	_	1	21.00
22. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	Ō	5, 917, 119		1	22. 00
23.00	RENTAL SPACE	194. 00	0	10, 952, 405		1	23. 00
24. 00	REID PHYSICIAN ASSOC.	194. 04	0	448, 676		1	24.00
25. 00	CAMBRIDGE_RHC	194.08		<u>1, 204</u> 18, 254, 118		<u>)</u>	25. 00
	B - CAFETERIA RECLASS		UU	10, 234, 110			
1. 00	DI ETARY	10.00	2, 203, 939	2, 444, 424	C		1.00
	0		2, 203, 939	2, 444, 424			
1. 00	C - LAUNDRY RECLASS LAUNDRY & LINEN SERVICE	8. 00	109, 277	121, 543			1.00
1.00	0		109, 277	121, 543		2	1.00
	D - NURSING VP RECLASS			,			
1.00	OTHER A&G		21 <u>5, 9</u> 88	0	<del></del>	<u> </u>	1.00
	E - OCCUPATIONAL MEDICINE REC	1 ΔSS	215, 988	0			
1. 00	EMERGENCY	91.00	160, 993	122, 817	C		1.00
			160, 993	122, 817			
4.00	F - IMPLANTABLE DEVICES RECLA		ما ا	200	1		4 00
1. 00 2. 00	NURSERY OPERATING ROOM	43. 00 50. 00	0	390 9, 049, 814			1. 00 2. 00
3. 00	DELIVERY ROOM & LABOR ROOM	52. 00	o	3, 522	_	1	3.00
4. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	21, 038		•	4. 00
5.00	CARDI AC CATHETERI ZATI ON	59. 00	0_	5, 112, 475	c		5. 00
	0		0	14, 187, 239			
1. 00	G - INTEREST RECLASS INTEREST EXPENSE	113. 00	0	8, 109, 706	11		1.00
1.00	0			8, 109, 706		<u>'</u>	1.00
	J - INTERN AND RESIDENT						
1.00	I&R SERVICES-OTHER PRGM.	22. 00	1, 405, 363	69, 646	C		1.00
	COSTS APPRVD	+	1, 405, 363			4	
	K - WORKERS COMP RECLASS		1, 400, 303	69, 646			
1.00	OTHER A&G	5. 06	0	523, 779	C		1.00
2.00	REID PHYSICIAN ASSOC.	194. 04	0_	23 <u>1, 4</u> 51	C		2. 00
	0		0	755, 230			
1. 00	L - RHPA BENEFITS RECLASS REID PHYSICIAN ASSOC.	194. 04	0	13, 180, 654	C		1.00
1.00	0 FITT ST CT ANY ASSOC.	174.04		13, 180, 654		2	1.00
	M - LT RECOGNITION RECLASS	I	<u> </u>	107 1007 00 1			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	420, 080	0	_	1	1.00
2.00		0. 00	0	0	-	1	2. 00
3.00		0.00	0	0	C		3.00
4. 00 5. 00		0. 00 0. 00		0		ار ادا	4. 00 5. 00
6. 00		0.00	ol	0	0	ó	6.00
7. 00		0. 00	ő	Ö	C		7.00
8.00		0. 00	o	0	C	1	8. 00
9.00		0.00	0	0	C	•	9.00
10. 00 11. 00		0. 00 0. 00	0	0	C	•	10. 00 11. 00
11.00	1	0.00	·		1	1	1 11.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0048

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/22/2019 7:59 am

						5/22/2019 7: 59	<del>1</del> am
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
12.00		0.00	0	0			12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	o	0	0		16.00
17.00		0.00	o	0	0		17.00
18.00		0.00	O	0	0		18.00
19.00		0.00	o	0	0		19.00
20.00		0.00	o	0	0		20.00
21.00		0.00	0	0	0		21.00
22. 00		0.00	o	0		1	22. 00
23. 00		0.00	0	0		1	23.00
24. 00		0.00	o	0		1	24. 00
25. 00		0.00	0	0			25. 00
26. 00		0.00	Ö	0	_	1	26.00
27. 00		0.00	0	0			27. 00
28. 00		0.00	0	0		1	28.00
29. 00		0.00	0	0	_	1	29. 00
30.00		0.00	0	0	_	1	30.00
31. 00		0.00	0	0			31.00
32.00		0.00	0	0			32.00
33. 00				0		1	33. 00
		0. 00 0. 00	0	-	_	1	
34.00			0	0		1	34.00
35.00		0.00	0	0		1	35.00
36.00		0.00	0	0		1	36.00
37.00		0.00	0	0	_	1	37.00
38. 00		0.00	0	0	_	1	38.00
39. 00		0.00	0	0	_		39.00
40.00		0.00	0	0	_		40.00
41.00		0.00	0	0	_		41.00
42.00		0.00	0	0	_		42.00
43.00		0.00	0	0	_		43.00
44.00	L	0.00	0_	0			44.00
	TOTALS		420, 080				
	N - HOSPICE						
1.00	ADULTS & PEDIATRICS	30.00	35 <u>6, 9</u> 56	4 <u>9, 8</u> 09			1.00
	TOTALS		356, 956	49, 809			
500.00	Grand Total: Decreases		4, 872, 596	57, 295, 186			500.00
		·					

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0048 Worksheet A-7 Peri od: From 01/01/2018 To 12/31/2018 Part I Date/Time Prepared: 5/22/2019 7:59 am Acqui si ti ons 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 ASSET BALANCES 1.00 14, 477, 094 0 1.00 Land 38, 224, 615 2.00 Land Improvements 0 0 0 ol 23, 235, 405 2.00 292, 529, 105 4, 681, 533 3.00 Buildings and Fixtures 4, 681, 533 3.00 Building Improvements 4.00 12, 484, 100 25, 653 4.00 5.00 Fixed Equipment 2, 103, 825 78, 410 0 78, 410 5.00 0 6.00 Movabl e Equi pment 173, 697, 797 8, 854, 403 0 0 0 8, 854, 403 6.00 0 HIT designated Assets 7.00 0 7.00 8.00 Subtotal (sum of lines 1-7) 533, 516, 536 13, 614, 346 13, 614, 346 23, 261, 058 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 533, 516, 536 0 13, 614, 346 23, 261, 058 13, 614, 346 10.00 10.00 Endi ng Ful I y

			Assets							
		6. 00	7. 00							
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES									
1.00	Land	14, 477, 094	0		1.00					
2.00	Land Improvements	14, 989, 210	0		2.00					
3.00	Buildings and Fixtures	297, 210, 638	0		3.00					
4.00	Building Improvements	12, 458, 447	0		4.00					
5.00	Fixed Equipment	2, 182, 235	0		5.00					
6.00	Movable Equipment	182, 552, 200	0		6.00					
7.00	HIT designated Assets	0	0		7.00					
8.00	Subtotal (sum of lines 1-7)	523, 869, 824	0		8.00					
9.00	Reconciling Items	0	0		9.00					
10.00	Total (line 8 minus line 9)	523, 869, 824	0		10.00					

Depreci ated

Bal ance

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0048 Peri od: Worksheet A-7 From 01/01/2018 Part II Date/Time Prepared: 5/22/2019 7:59 am То 12/31/2018 SUMMARY OF CAPITAL Insurance Interest Taxes (see Cost Center Description Depreciation Lease instructions) (see instructions) 9. 00 10.00 13.00 11.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1.00 0 0 NEW CAP BLDG & FIXT - OFFSITE 1.01 0 0 1.01 NEW CAP REL COSTS-MVBLE EQUIP 0 2.00 0 0 0 2.00 Total (sum of lines 1-2) 0 0 3.00 3.00 SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) Capital-Relat (sum of cols. ed Costs (see 9 through 14) instructions) 15. 00 14.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 NEW CAP BLDG & FIXT - OFFSITE 1.01 0 0 NEW CAP REL COSTS-MVBLE EQUIP 2.00 0 2.00 3.00 Total (sum of lines 1-2) 0 3.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0048	Peri od:	Worksheet A-7			

Heal th	Financial Systems REID	HOSPITAL & HEA	LIH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		eriod: Worksheet A-7			
				F	rom 01/01/2018			
				T	To 12/31/2018 Date/Time Prepar			
					5/22/2019 7:59 8			
		COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
			Leases	for Ratio	instructions)			
				(col. 1 -				
				col. 2)				
		1. 00	2. 00	3. 00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00	NEW CAP REL COSTS-BLDG & FIXT	341, 317, 624	0	341, 317, 624	0. 651531	0	1.00	
1.01	NEW CAP BLDG & FIXT - OFFSITE	182, 552, 200	0	182, 552, 200	0. 348469	0	1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	ol	2.00	
3.00	Total (sum of lines 1-2)	523, 869, 824	l	523, 869, 824	1.000000	l ol	3.00	
			TION OF OTHER (			F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
	•		Capi tal -Rel at					
			ed Costs	through 7)				
		6, 00	7.00	8, 00	9, 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			<u> </u>			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	C	11, 651, 155	32, 019	1.00	
1. 01	NEW CAP BLDG & FIXT - OFFSITE	0	l o	l o	6, 031, 898	258, 777	1. 01	
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	ol	2.00	
3.00	Total (sum of lines 1-2)	0	0	1	17, 683, 053		3. 00	
0.00	Total (Sam of Titles 1 2)	Ů	SI	JMMARY OF CAPIT		270,770	0.00	
			0.0	Juliu 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/\L			
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
	5551 551161 25551 Pt. 511	111101001	(see	instructions)		(sum of cols.		
			instructions)	Instructions)	ed Costs (see			
			Thistractions)		instructions)	/ till ough 14)		
		11. 00	12. 00	13. 00	14. 00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00		
1. 00	NEW CAP REL COSTS-BLDG & FLXT	0		7, 410	0	11, 690, 584	1.00	
1. 00	NEW CAP BLDG & FIXT - OFFSITE	0		272, 859			1. 00	
2. 00	NEW CAP BLDG & FIXT - OFFSITE			212,009	0	1	2.00	
3. 00		0		200 240		۱		
3.00	Total (sum of lines 1-2)	1	0	280, 269	0	18, 254, 118	3.00	

In Lieu of Form CMS-2552-10
Period: Worksheet A-8
From 01/01/2018

7.000012.110					From 01/01/2018 To 12/31/2018		pared:
				Expense Classification o To/From Which the Amount is		5/22/2019 7:5	9 alli
					·		
Cost Cent	er Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00 Investment inco	omo NEW CAD	1. 00	2. 00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5. 00 0	1.00
	& FLXT (chapter			FLXT	1.00	0	1.00
	ome - NEW CAP OFFSITE (chapter			NEW CAP BLDG & FLXT - OFFSLTE	1. 01	0	1. 01
2) 2.00   Investment incorrect   REL COSTS-MVBLE   2)	ome - NEW CAP E EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00 Investment inco	ome - other		О		0. 00	0	3. 00
(chapter 2) 4.00 Trade, quantity	y, and time	В	-287, 959	PURCHASING RECEIVING AND	5. 03	0	4.00
discounts (chap 5.00 Refunds and rel expenses (chapt	oates of		o	STORES	0.00	0	5.00
6.00 Rental of provi	der space by		0		0.00	0	6. 00
7.00 suppliers (chap Telephone servi stations exclud	ces (pay		0		0.00	0	7. 00
8.00 Tel evi si on and	radi o servi ce		О		0.00	0	8. 00
(chapter 21) 9.00 Parking Lot (ch	napter 21)		o		0.00	0	9.00
10.00 Provi der-based adj ustment	physi ci an	A-8-2	-11, 557, 816			0	10.00
11.00 Sale of scrap, (chapter 23)			U		0.00	0	11.00
12.00 Related organiz		A-8-1	-5, 511, 298			0	12.00
13.00 Laundry and lir	nen servi ce		0	OAFETED! A	0.00	0	
	oyees and guests ters to employee	В	-3, 168, 889 0	CAFETERTA	11. 00 0. 00	0	
and others  16.00 Sale of medical supplies to oth		В		PURCHASING RECEIVING AND STORES	5. 03	0	16. 00
patients 17.00 Sale of drugs 1	to other than	В	-15, 797	PHARMACY	15. 00	0	17. 00
patients 18.00 Sale of medical	records and	В	-52 704	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
abstracts		Ь		WEDI CAL RECORDS & LI BRART			
19.00 Nursing and all education (tuit books, etc.)			0		0.00	0	19.00
20.00 Vending machine 21.00 Income from imp		В	-15, 339 0	DI ETARY	10. 00 0. 00	0	
interest, finar	nce or penalty		Ö		0.00	O	21.00
	se on Medicare nd borrowings to		0		0.00	0	22. 00
repay Medicare 23.00 Adjustment for therapy costs i	respiratory n excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24.00   limitation (cha Adjustment for therapy costs i	physi cal	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
25.00 Utilization (cha physicians' com	∕iew -		0	*** Cost Center Deleted ***	* 114.00		25. 00
(chapter 21) 26.00 Depreciation -	NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
COSTS-BLDG & FI				FIXT NEW CAP BLDG & FIXT -	1. 01	0	
FIXT - OFFSITE				OFFSI TE			
27.00 Depreciation - COSTS-MVBLE EQU				NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28.00 Non-physician A	Anesthetist		o	*** Cost Center Deleted ***		2	28.00
29.00   Physicians' ass	si Stant		O		0.00		29. 00

Provider CCN: 15-0048

Peri od:

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 30.00 Adjustment for occupational A-8-3 0 \*\*\* Cost Center Deleted \*\*\* 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDLATRICS 30.99 Hospice (non-distinct) (see 30.00 30.99 instructions) Adjustment for speech 0 \*\*\* Cost Center Deleted \*\*\* 31.00 A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest MISCELLANEOUS INCOME -549, 488 DI ETARY 10.00 33.00 33. 01 MISCELLANEOUS INCOME -497, 252 EMPLOYEE BENEFITS DEPARTMENT 33.01 В 4.00 MISCELLANEOUS INCOME -472, 008 DATA PROCESSING 33 02 R 5.02 0 33.02 33.03 MISCELLANEOUS INCOME В -1, 323, 534 OTHER A&G 5.06 33.03 MISCELLANEOUS INCOME -839 OPERATION OF PLANT 33.04 В 7.00 33.04 -222, 009 PHARMACY 33.05 MISCELLANEOUS INCOME 15.00 33.05 В MISCELLANEOUS INCOME -97, 499 I NSERVI CE EDUCATION 33.06 В 17.01 33.06 33.07 MISCELLANEOUS INCOME В -44, 230 PARAMED ED PRGM 23.00 33.07 -12,000 ADULTS & PEDIATRICS 33.08 MISCELLANEOUS INCOME В 30.00 33.08 MISCELLANEOUS INCOME -53, 500 PHYSI CAL THERAPY 66.00 33 09 В 0 33 09 MISCELLANEOUS INCOME -162, 266 RADI OLOGY-DI AGNOSTI C 33.10 В 54.00 33.10 MISCELLANEOUS INCOME -15, 940 LABORATORY 60.00 33.11 33.11 В 33. 12 MISCELLANEOUS INCOME В -336, 718 DURABLE MEDICAL EQUIP-RENTED 96.00 33.12 0 MISCELLANEOUS INCOME -6, 775 CARDI AC CATHETERI ZATI ON 33 13 59 00 33 13 B -3, 531, 777 NEW CAP REL COSTS-BLDG & 33.14 INTEREST INCOME В 1.00 11 33.14 FLXT UNNECESSARY BORROWING -4, 577, 929 NEW CAP REL COSTS-BLDG & 33. 15 Α 1.00 11 33.15 FLXT -15, 658, 246 EMPLOYEE BENEFITS DEPARTMENT 33. 16 SELF INSURANCE ADJUSTMENT 4.00 0 33, 16 Α 33.17 PATIENT ENTERTAINMENT SYSTEM -132, 261 OTHER A&G 5.06 ol 33.17 Α COUNTRY CLUB DUES -6, 553 OTHER A&G 33. 18 Α 5.06 33.18 AHA/IHA LOBBYING -17, 766 OTHER A&G 33.19 5.06 33.19 Α -21, 911 EMPLOYEE BENEFITS DEPARTMENT 33.20 MARKETI NG/ADVERTI SI NG Α 4.00 0 33.20 33. 21 MARKETI NG/ADVERTI SI NG -563 CASHI ERI NG/ACCOUNTS 5.05 33.21 Α RECEI VABLE 33. 22 MARKETI NG/ADVERTI SI NG Α -1, 892, 656 OTHER A&G 5.06 33.22 0 -1. 402 DI ETARY 33 23 MARKETI NG/ADVERTI SI NG 10.00 33 23 Α 0 33. 24 MARKETI NG/ADVERTI SI NG -20, 812 I NSERVI CE EDUCATI ON 17.01 33.24 Α -3, 142 I &R SERVICES-OTHER PRGM. 33. 25 MARKETI NG/ADVERTI SI NG Α 22.00 33.25 COSTS APPRVD 33. 26 MARKETI NG/ADVERTI SI NG -4, 117 ADULTS & PEDIATRICS 30.00 Α 0 33.26 MARKETI NG/ADVERTI SI NG 33.27 Α -3, 338 SUBPROVI DER - I RF 41.00 33.27 MARKETI NG/ADVERTI SI NG -754 RADI OLOGY-DI AGNOSTI C 33.28 Α 54.00 33.28 33, 29 MARKETI NG/ADVERTI SI NG -990 CARDI AC CATHETERI ZATI ON 59.00 33, 29 O Α 33 30 MARKETI NG/ADVERTI SI NG Α -4, 175 PHYSI CAL THERAPY 66.00 33 30 MARKETI NG/ADVERTI SI NG -522 ELECTROENCEPHALOGRAPHY 70.00 33.31 33.31 Α 33. 32 MARKETI NG/ADVERTI SI NG Α -2, 345 CARDIAC REHABILITATION 76. 97 33.32 MARKETI NG/ADVERTI SI NG -13, 024 EMERGENCY 91.00 33.33 0 33.33 Α MARKETI NG/ADVERTI SI NG -1, 112 FAMILY PRACTICE 33.34 Α 93.00 33.34 96.00 33.35 MARKETI NG/ADVERTI SI NG Α 12 DURABLE MEDICAL EQUIP-RENTED 33.35 MARKETI NG/ADVERTI SI NG -982 HOSPI CE 33.36 33.36 Α 116.00 33.37 NON-ALLOWABLE EXPENSES -6, 387 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 Α 33.37 33.38 NON-ALLOWABLE EXPENSES Α -11, 122 CASHI ERI NG/ACCOUNTS 5.05 33.38 RECEI VABLE -1, 498, 982 OTHER A&G 33.39 NON-ALLOWABLE EXPENSES Α 5.06 0 33.39 NON-ALLOWABLE EXPENSES -40DI ETARY o 33 40 10.00 33 40 Α NON-ALLOWABLE EXPENSES 33.41 Α -374 CENTRAL SERVICES & SUPPLY 14.00 33.41 NON-ALLOWABLE EXPENSES -964, 886 I NSERVI CE EDUCATION 17.01 33.42 33.42 Α NON-ALLOWABLE EXPENSES -591 &R SERVICES-OTHER PRGM. 33.43 Α 22.00 33.43 COSTS APPRVD 33 44 NON-ALLOWABLE EXPENSES Α -3, 979 PARAMED ED PRGM 23.00 ol 33 44 33. 45 NON-ALLOWABLE EXPENSES -8, 380 ADULTS & PEDIATRICS 30.00 0 33.45 Α 33. 46 NON-ALLOWABLE EXPENSES Α -85 INTENSIVE CARE UNIT 31.00 33.46 NON-ALLOWABLE EXPENSES -35 SUBPROVI DER - I PF 33.47 40.00 0 33.47 Α NON-ALLOWABLE EXPENSES -218 SUBPROVI DER - I RF 33.48 Α 41.00 33.48 33. 49 NON-ALLOWABLE EXPENSES -1, 330 OPERATING ROOM 0 50.00 33.49

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0048 Peri od: Worksheet A-8 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am

				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33.50	NON-ALLOWABLE EXPENSES	Α	-489	DELIVERY ROOM & LABOR ROOM	52.00	0	33.50
33. 51	NON-ALLOWABLE EXPENSES	Α	-446	PHYSI CAL THERAPY	66.00	0	33. 51
33. 52	NON-ALLOWABLE EXPENSES	А	-2, 657	EMERGENCY	91.00	0	33. 52
33. 53	NON-ALLOWABLE EXPENSES	Α	-10	FAMILY PRACTICE	93. 00	0	33. 53
33.54	NON-ALLOWABLE EXPENSES	Α	-316	HOSPI CE	116. 00	0	33. 54
33. 55	HAF EXPENSE	Α	-11, 421, 955	OTHER A&G	5. 06	0	33. 55
33. 56	BOND REFUNDING - 2015 BONDS	Α	401, 531	OTHER A&G	5. 06	0	33. 56
33. 57	BOND REFUNDING - 2016 BONDS	Α	7, 737	OTHER A&G	5. 06	0	33. 57
33. 58	OCC MED - EMPLOYEE COST	Α	-64, 908	EMERGENCY	91.00	0	33. 58
50.00	TOTAL (sum of lines 1 thru 49)		-63, 957, 647				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

From 01/01/2018

				Γο 12/31/2018	B   Date/Time Pre   5/22/2019 7:5						
	Li ne No.	Cost Center	Expense Items	Amount of	Amount						
				Allowable Cost	Included in						
					Wks. A, column						
					5						
	1. 00	2. 00	3. 00	4. 00	5. 00						
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME										
	OFFICE COSTS:										
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	18, 893, 683	24, 404, 981	1.00					
2.00	0.00			0	0	2.00					
3.00	0.00			0	0	3.00					
4.00	0.00			0	0	4.00					
4. 01	0.00			0	0	4.01					
4. 02	0.00			0	0	4.02					
5.00	lo		lo	18, 893, 683	24, 404, 981	5.00					

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

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

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

6.00	A	REID O/P SURGER	55.00	0.00	6.00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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

Heal th	Financial Syste	ems			REID HOSPI	TAL & H	<b>IEALTH</b>	I CARE SER	VI CES	S	In Li	eu of Form	n CMS-	2552-10
STATEME	NT OF COSTS OF	SERVI CES	FROM	RELATED	ORGANI ZATI ON	IS AND F	HOME	Provi der	CCN:	15-0048	Peri od:	Workshe	et A-8	I-1
OFFICE	COSTS										From 01/01/201 To 12/31/201	8   8   Date/Tii	mo Dro	narod:
											10 12/31/201	5/22/20		
	Net	Wkst. A-7	Ref.											
	Adjustments													
	(col. 4 minus													
	col. 5)*													
	6. 00	7.00												
	A. COSTS INCUR	RED AND AD	JUSTM	ENTS REC	QUIRED AS A F	RESULT (	OF TRA	ANSACTI ONS	WI T	H RELATED	ORGANI ZATI ONS O	R CLAIMED	HOME	
	OFFICE COSTS:													
1.00	-5, 511, 298		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 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.

5.00

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	6.0	00
7. 00	7.0	00
8. 00	8.0	00
9. 00	9.0	00
10.00	10.0	00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	100.0	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.
- 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
- 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 In Lieu of Form CMS-2552-10 Provider CCN: 15-0048 

					'	0 12/31/2010	5/22/2019 7:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	17. 01	INSERVICE EDUCATION	141, 738	55, 300	86, 438	179, 000	660	1. 00
2. 00	22. 00	I&R SERVICES-OTHER PRGM.	685, 653		0	179, 000	0	2.00
		COSTS APPRVD						
3.00	30. 00	ADULTS & PEDIATRICS	5, 527, 261	5, 527, 261	0	197, 500	0	3.00
4. 00	41. 00	SUBPROVIDER - IRF	375	375	0	179, 000	0	4.00
5. 00	50. 00	OPERATING ROOM	3, 480, 049	3, 480, 049	0	179, 000	0	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	41, 280	41, 280	0	246, 400	0	6.00
7. 00	60. 00	LABORATORY	852, 354	852, 354	0	260, 300	0	7.00
8. 00	69. 00	ELECTROCARDI OLOGY	56, 070	56, 070	0	260, 300	0	8.00
9. 00	91. 00	EMERGENCY	829, 834	829, 834	0	179, 000	0	9.00
10.00	0. 00		0	0	0	0	0	10.00
200.00			11, 614, 614	11, 528, 176	86, 438			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		ldentifier	Limit	Unadjusted RCE		Component	of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		INSERVICE EDUCATION	56, 798		0	_	0	
2. 00	22. 00	I&R SERVICES-OTHER PRGM.	0	0	0	0	0	2.00
		COSTS APPRVD	_	_	_	_	_	
3. 00		ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00		SUBPROVI DER – I RF	0	0	0	0	0	4.00
5.00		OPERATING ROOM	0	0	0	0	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6.00
7. 00		LABORATORY	0	0	0	0	0	7.00
8.00		ELECTROCARDI OLOGY	0	0	0	0	0	8. 00 9. 00
9.00		EMERGENCY	0	0	0	0		
10. 00 200. 00	0. 00		56, 798	2, 840	0	0	0	10.00 200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Adj ustillerit		
		ruentiffei	Share of col.	LIIIII	Disarrowance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		I NSERVI CE EDUCATI ON	0		29, 640			1. 00
2. 00		I&R SERVICES-OTHER PRGM.	0	0 0	0			2. 00
		COSTS APPRVD	_		_			
3. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	5, 527, 261		3. 00
4. 00	41. 00	SUBPROVI DER - I RF	0	0	0	375		4.00
5. 00		OPERATING ROOM	0	0	0	3, 480, 049		5. 00
6. 00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	41, 280		6.00
7. 00		LABORATORY	0	0	0	852, 354		7. 00
8. 00		ELECTROCARDI OLOGY	0	0	0	56, 070		8. 00
9. 00		EMERGENCY	0	0	0	829, 834		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	56, 798	29, 640	11, 557, 816		200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/22/2019 7:59 am	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0048

for Cost FIXT & FIXT - EQUIP BEI Allocation OFFSLTE DEP, (from Wkst A	PLOYEE NEFITS ARTMENT	
for Cost FIXT & FIXT - EQUIP BEI Allocation OFFSLTE DEPA (from Wkst A	NEFITS	
for Cost FIXT & FIXT - EQUIP BEI Allocation OFFSLTE DEPA (from Wkst A	NEFITS	
Allocation OFFSLTE DEPARTMENT OFFSLTE		
(from Wkst A	ARIMENI	
col. 7)         1.00         1.01         2.00	1. 00	
GENERAL SERVICE COST CENTERS	1. 00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 11, 690, 584 11, 690, 584		1.00
1. 01   00101   NEW CAP BLDG & FIXT - 0FFSITE   6, 563, 534   0   6, 563, 534		1.01
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP   0   0		2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   30, 982, 440   42, 398   9, 531   0   3	, 034, 369	4.00
5. 01   00540   NONPATI ENT TELEPHONES   294, 794   60, 332   0   0	48, 420	5. 01
5. 02   00550   DATA PROCESSI NG   28, 927, 524   198, 851   26, 092   0	737, 578	5.02
5. 03   00560  PURCHASING RECEIVING AND STORES   1, 351, 728   248, 603   0   0	162, 702	5. 03
5. 04   00570   ADMITTING   3, 363, 462   2, 287   44, 892   0	389, 363	5. 04
5. 05   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE   8, 476, 577   12, 946   194, 436   0	613, 556	5.05
	, 824, 219	5.06
7. 00   00700   0PERATI ON OF PLANT   3, 823, 263   2, 893, 778   99, 076   0   8. 00   00800   LAUNDRY & LI NEN SERVI CE   650, 829   195, 944   0   0	491, 210	7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE   650, 829   195, 944   0   0   0   0   0   0   0   0   0	61, 209 302, 387	8. 00 9. 00
10. 00   01000   DI ETARY		10.00
11. 00   01100   CAFETERI A   1, 484, 788   156, 835   0   0		11. 00
13. 00   01300   NURSI NG ADMI NI STRATI ON 216, 509 31, 056 0		13.00
14.00   01400   CENTRAL SERVICES & SUPPLY 3, 682, 690 133, 610 0	/	14. 00
15. 00 01500 PHARMACY 30, 770, 017 115, 501 0		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 5, 240, 927 55, 709 140, 179 0		16.00
17. 00   01700   SOCI AL SERVI CE   2, 680, 474   19, 714   0   0		17.00
17. 01   01701   I NSERVI CE EDUCATI ON   1, 478, 201   165, 349   0   0	197, 552	17.01
21.00   02100   1 &R SERVI CES-SALARY & FRINGES APPRVD   1,478,397   0   0   0	250, 322	21.00
22.00   02200   1 &R SERVI CES-OTHER PRGM. COSTS APPRVD   416,027   0   0   0		22.00
23. 00   <u>02300  PARAMED ED PRGM</u>   <u>196, 476</u>   <u>16, 854</u>   <u>63, 859</u>   <u>0</u>	37, 982	23.00
INPATIENT ROUTINE SERVICE COST CENTERS		
		30.00
31. 00   03100   I NTENSI VE CARE UNI T   6, 320, 451   390, 013   0   0		31.00
40. 00   04000  SUBPROVI DER - I PF   4, 310, 510   354, 875   0   0   0   0   0   0   0   0   0		40. 00 41. 00
41. 00   04100   SUBPROVI DER - I RF   1, 675, 297   284, 313   0   0   0   0   0   0   0   0   0		43.00
ANCI LLARY SERVI CE COST CENTERS	02, 771	43.00
50. 00 05000 0PERATI NG ROOM 22, 350, 455 769, 892 311, 931 0	216, 089	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   1,032,789   132,101   0   0		52.00
54. 00   05400   RADI 0LOGY-DI AGNOSTI C   11, 718, 417   965, 502   38, 125   0	, 027, 038	54.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   6, 527, 931   215, 705   0   0	323, 745	59.00
60. 00   06000   LABORATORY   9, 873, 872   221, 519   0   0		60.00
65. 00   06500   RESPI RATORY THERAPY   1, 812, 012   26, 163   0   0		65.00
66. 00   06600   PHYSI CAL THERAPY   6, 421, 943   128, 416   1, 008, 301   0		66.00
69. 00   06900   ELECTROCARDI OLOGY   1, 524, 485   111, 371   0   0   0   0   0   0   0   0   0		69.00
70. 00   07000  ELECTROENCEPHALOGRAPHY		70. 00 71. 00
71. 00   07/100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0		73.00
74. 00   07400   RENAL DI ALYSI S   773, 055   23, 669   0   0		74.00
76. 00   03950   ANCI LLARY - OTHER   0 0 0		76.00
76. 97   07697   CARDI AC REHABI LI TATI ON   259, 693   71, 849   0   0		76. 97
OUTPATIENT SERVICE COST CENTERS		
91. 00 09100 EMERGENCY 6, 246, 455 361, 738 0 0	882, 434	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93. 00 04040 FAMILY PRACTICE 2, 043, 205 141, 934 20, 182 0	316, 442	93.00
OTHER REIMBURSABLE COST CENTERS		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 172, 059 28, 180 68, 434 0	24, 518	96.00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   I NTEREST EXPENSE	1	13. 00
116. 00   11600   HOSPI CE 2, 826, 259 7, 069 0	229, 264 1	
	7, 667, 631 <sub>1</sub>	
NONREI MBURSABLE COST CENTERS	, 007, 031	10.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	0 1	90.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 314, 807 3, 955 58, 521 0		92.00
194. 00 07950 RENTAL SPACE 4, 025, 451 0 453, 445 0		94.00
194. 01 07951 FOUNDATION 468, 745 3, 272 0 0	31, 957 1	
194. 02 07952 RETAI L SERVI CES 141, 762 37, 171 0 0	22, 101 1	
194. 03 07953 REI D CONTRACTED SERVICES 231, 083 0 0 0	19, 464 1	
	3, 108, 976 1	
194. 05 07955 0THER NRCC 0 8, 451 0 0		94. 05
194. 06 07956 VACANT SPACE 0 22, 001 409, 077 0		94.06
194.08 07958 CAMBRIDGE RHC	184, 240 1	194. 08 200. 00
200.00   01033 1001 Auj ustilicitis	2	

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		eriod: rom 01/01/2018	Worksheet B Part I	
				o 12/31/2018		pared: 9 am
		CAPI	TAL RELATED CO	OSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW CAP BLDG & FIXT - OFFSITE	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	1. 01	2. 00	4. 00	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00   TOTAL (sum lines 118 through 201	411, 291, 827	11, 690, 584	6, 563, 534	0	31, 034, 369	202. 00

5/22/2019 7:59 am

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

Cost Center Description NONPATI ENT PURCHASI NG ADMI TTI NG CASHI ERI NG/AC TELEPHONES RECEIVING AND COUNTS PROCESSI NG **STORES** RECEI VABLE 5. 01 5. 02 5. 04 5 03 5 05 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 403, 546 5.01 5.01 5.02 00550 DATA PROCESSING 42, 487 29, 932, 532 5.02 00560 PURCHASING RECEIVING AND STORES 4, 889, 105 5.03 5.642 3, 120, 430 5.03 6, 402 5.04 00570 ADMITTING 15,867 458, 887 4, 281, 160 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 24, 858 196,666 10, 928 0 9, 529, 967 5.05 00590 OTHER A&G 20, 803 43, 594 367, 109 5.06 5.06 0 0 00700 OPERATION OF PLANT 7.00 10.225 46, 134 0 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1,058 26, 222 888 0 0 8.00 9.00 00900 HOUSEKEEPI NG 1,058 39, 333 86, 036 0 0 9.00 0 01000 DI ETARY 15, 514 10.00 445, 776 67, 556 0 10.00 11.00 01100 CAFETERI A 0 0 0 0 0 0 0 0 0 11.00 01300 NURSING ADMINISTRATION 13.00 3 173 183, 555 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 763 563, 993 14.00 157, 333 0 14.00 01500 PHARMACY 15.00 7.581 524, 442 440.885 0 15.00 01600 MEDICAL RECORDS & LIBRARY 11, 988 1, 101, 328 11, 426 0 16.00 16.00 01700 SOCIAL SERVICE 17.00 5, 994 367, 109 5, 493 0 17.00 01701 INSERVICE EDUCATION 1, 940, 436 11, 289 17.01 8, 110 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 r 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 1, 391 0 0 22.00 02300 PARAMED ED PRGM 529 131, 111 1,000 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 40, 196 3, 120, 430 404, 110 272, 187 605, 850 30.00 03100 INTENSIVE CARE UNIT 48, 603 31.00 9, 167 458, 887 192, 804 108, 182 31.00 04000 SUBPROVIDER - IPF 121, 139 40.00 3.879 48. 124 54, 424 40.00 196,666 04100 SUBPROVIDER - IRF 21, 210 41.00 5,642 367, 109 31, 270 47, 211 41.00 43.00 04300 NURSERY 38, 696 10,850 24, 151 43.00 ANCILLARY SERVICE COST CENTERS 1, 754, 912 50 00 05000 OPERATING ROOM 33 320 1, 140, 662 690, 372 788, 099 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 581 419, 554 60, 126 44,881 99, 900 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 26, 974 1, 992, 880 486, 707 650, 674 1, 448, 306 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 5, 113 131, 111 369, 190 489, 841 1,090,316 59.00 06000 LABORATORY 11, 283 59, 314 949, 028 60 00 760, 441 426, 365 60 00 06500 RESPIRATORY THERAPY 65.00 1,058 157, 333 167, 118 137, 512 306, 083 65.00 15, 867 06600 PHYSI CAL THERAPY 1, 363, 549 22, 622 86, 182 191, 829 66.00 66.00 69 00 06900 ELECTROCARDI OLOGY 1.587 642, 442 64,090 129, 764 288, 837 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 1, 234 104,888 8, 920 19, 256 42,862 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 192 428 71.00 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 C 0 142,053 316, 190 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 191, 068 73 00 0 535, 106 73 00 C 74.00 07400 RENAL DIALYSIS 881 26, 222 10,040 4, 933 10, 981 74.00 76.00 03950 ANCILLARY - OTHER 0 76.00 07697 CARDIAC REHABILITATION 76.97 2, 116 26, 222 5, 279 4, 599 10, 237 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 14, 456 983, 329 198, 734 352, 688 785, 032 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 10.049 35, 510 32, 532 72, 411 93.00 511, 331 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 4, 407 157, 333 48, 958 1, 327 2, 953 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 2, 292 62, 061 116. 00 116. 00 11600 HOSPI CE 39, 333 78, 110 27, 882 SUBTOTALS (SUM OF LINES 1 through 117) 373, 752 21, 659, 459 4, 317, 109 4, 281, 160 9, 529, 967 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 11, 459 13, 111 4,844 0 66, 758 0 194.00 194.00 07950 RENTAL SPACE 17, 101 0 194. 01 07951 FOUNDATI ON 1, 234 78, 666 4, 596 0 0 0 194.01 194. 02 07952 RETAIL SERVICES 0 194, 02 471, 998 1,582 194. 03 07953 REID CONTRACTED SERVICES 0 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. 0 194.04 0 7, 709, 298 484, 477 194. 05 07955 OTHER NRCC 0 0 194, 05 0 0 194.06 194.06 07956 VACANT SPACE 0 0 0 194. 08 07958 CAMBRI DGE RHC 0 0 194.08 C 9,739 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 403, 546 29, 932, 532 4, 889, 105 4, 281, 160 9, 529, 967 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

					5/22/2019 7:5	9 am
Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
, and the second			PLANT	LINEN SERVICE		
	5A. 05	5. 06	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS	07.1. 00	0.00	7.00	0.00	7.00	
						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 NEW CAP BLDG & FLXT - OFFSITE						1. 01
2.00 OO200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					i	4.00
1					i	
5. 01 00540 NONPATI ENT TELEPHONES					i	5. 01
5. 02   00550   DATA   PROCESSI NG					i	5. 02
5.03 00560 PURCHASING RECEIVING AND STORES					i	5. 03
5. 04   00570   ADMI TTI NG						5. 04
1 1					i	
5. 05   00580   CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06   00590   OTHER A&G	31, 565, 409	31, 565, 409				5.06
7.00 00700 OPERATION OF PLANT	7, 363, 686	612, 121	7, 975, 807		i	7.00
1 1		77, 819			i	
8. 00   00800 LAUNDRY & LINEN SERVICE	936, 150	· ·				8. 00
9. 00   00900   HOUSEKEEPI NG	2, 830, 619	235, 301			3, 149, 265	9. 00
10. 00  01000 DI ETARY	1, 301, 447	108, 185	141, 713	ol	71, 880	10.00
11. 00   01100   CAFETERI A	2, 034, 187	169, 096				11.00
1 1					l e	
13.00 O1300 NURSING ADMINISTRATION	472, 765	39, 300			-,	13. 00
14.00  01400  CENTRAL SERVICES & SUPPLY	4, 642, 982	385, 957	108, 015	0	4, 713	14.00
15. 00   01500   PHARMACY	32, 554, 958	2, 706, 196	90, 409	ol	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	7, 217, 634	599, 980	· ·		l	16.00
1					1	
17. 00   01700   SOCIAL SERVICE	3, 463, 853	287, 940			1	17. 00
17. 01  01701 INSERVICE EDUCATION	3, 800, 937	315, 960	119, 714	0	44, 777	17. 01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 728, 719	143, 703	0	0	0	21.00
22.00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	450, 149	37, 420		o	1	22. 00
1				· ·		
23. 00   02300   PARAMED ED PRGM	447, 811	37, 225	36, 048	0	19, 089	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	31, 825, 544	2, 645, 562	1, 388, 747	347, 801	1, 063, 817	30.00
31. 00   03100   I NTENSI VE CARE UNI T	8, 209, 570	682, 437			205, 740	31.00
40. 00  04000   SUBPROVI DER - 1 PF	5, 760, 001	478, 812	286, 893	64, 054	178, 874	40.00
41. 00   04100   SUBPROVI DER -   I RF	2, 669, 004	221, 866	229, 848	32, 706	102, 752	41.00
43. 00   04300 NURSERY	779, 510	64, 798			l	43.00
	777, 310	04, 770	34, 430	U U	3, 277	43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	28, 055, 732	2, 332, 189			277, 149	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 928, 192	160, 285	106, 795	61, 753	45, 013	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 354, 623	1, 525, 765	564, 026	120, 109	129, 854	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 152, 952	760, 857				59.00
1 1						
60. 00  06000  LABORATORY	12, 923, 568	1, 074, 297	174, 319	0	129, 383	60.00
65. 00   06500   RESPI RATORY THERAPY	2, 840, 680	236, 137	15, 333	0	28, 280	65.00
66. 00   06600 PHYSI CAL THERAPY	10, 182, 861	846, 471	619, 247	8, 224	22, 153	66.00
69. 00   06900   ELECTROCARDI OLOGY					l '	69.00
1 1	2, 909, 348	241, 845			47, 841	
70. 00  07000 ELECTROENCEPHALOGRAPHY	746, 360	62, 043	69, 347	4, 891	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	620	52	0	0	25, 452	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 645, 482	1, 217, 435	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 726, 174	143, 492		0		73. 00
1						
74. 00   07400   RENAL DI ALYSI S	849, 781	70, 640				74. 00
76. 00   03950   ANCI LLARY - OTHER	0	0	0	0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	418, 867	34, 819	0	ol	11, 784	76. 97
OUTPATIENT SERVICE COST CENTERS	· .					
91. 00 09100 EMERGENCY	9, 824, 866	816, 712	292, 441	164, 237	249, 104	91.00
	7, 024, 000	010, 712	272, 441	104, 237	247, 104	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	U					92.00
93. 00 04040 FAMILY PRACTICE	3, 183, 596	264, 643	5, 201	34, 295	54, 204	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	508, 169	42, 243	48, 184	0	0	96.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113.00
	0 070 070	070 044			04.044	
116. 00 11600 HOSPI CE	3, 272, 270	272, 014		· ·	,	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	271, 579, 076	19, 951, 617	5, 667, 177	1, 172, 377	2, 893, 327	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	n	0	0	Ω	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 406, 697	283, 189	31, 540	0		192.00
194. 00 07950 RENTAL SPACE	4, 562, 755	379, 288				194.00
194. 01 07951 FOUNDATI ON	588, 470	48, 918	2, 645	0	1, 885	194. 01
194. 02 07952 RETAI L SERVI CES	674, 614	56, 079	8, 784	ol	2, 357	194. 02
194. 03 07953 REID CONTRACTED SERVICES	250, 547	20, 827		ام		194. 03
				ا ا		
194. 04 07954 REID PHYSICIAN ASSOC.	128, 276, 215	10, 663, 106			251, 696	
194. 05 07955 OTHER NRCC	8, 451	703	6, 832	0	0	194. 05
194. 06 07956 VACANT SPACE	431, 078	35, 834	303, 947	o	0	194. 06
194. 08 07958 CAMBRI DGE RHC	1, 513, 924	125, 848		٥		194. 08
		125, 040		١	i	
200.00 Cross Foot Adjustments	0				l	200.00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	411, 291, 827	31, 565, 409	7, 975, 807	1, 172, 377	3, 149, 265	202.00
				. '	•	•

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/22/2019 7:59 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & SUPPLY Ν 10. 00 11.00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER A&G 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 1, 623, 225 10 00 11.00 01100 CAFETERI A 2, 330, 073 11.00 01300 NURSING ADMINISTRATION 13 00 0 1, 218 542, 160 13.00 21, 904 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 0 5, 163, 571 01500 PHARMACY 35, 422, 193 15 00 0 67.987 0 2,643 15.00 01600 MEDICAL RECORDS & LIBRARY 0 109, 352 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 37, 651 0 0 0 17.00 01701 INSERVICE EDUCATION 0 17.01 22,890 11 0 17.01 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 17,657 0 0 21.00 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 4,045 0 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 3.120 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1,049,257 376, 546 235, 663 5,944 4, 279 30.00 03100 INTENSIVE CARE UNIT 162, 381 12,005 31.00 68, 179 42,670 843 31.00 04000 SUBPROVI DER - I PF 295.821 81, 993 51, 315 106 40.00 40.00 164 04100 SUBPROVIDER - IRF 41.00 115, 766 26, 214 16, 406 192 92 41.00 43.00 04300 NURSERY 0 6,869 4, 299 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 26 498 16 584 589 415 127, 869 50 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 10, 909 6,828 10,009 468 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 107, 187 67,084 25, 270 676, 391 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 32, 303 20, 217 869, 172 946 59.00 06000 LABORATORY 86, 530 290, 953 60 00 0 55 60 00 06500 RESPIRATORY THERAPY 16, 721 65.00 26, 716 1,706 6,617 65.00 06600 PHYSI CAL THERAPY 66.00 97,648 336 102 66.00 69 00 06900 ELECTROCARDI OLOGY 00000 15, 951 0 273, 575 69 00 7 07000 ELECTROENCEPHALOGRAPHY 70.00 7, 277 0 8 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 2, 941, 677 0 72.00 07300 DRUGS CHARGED TO PATIENTS 30, 880, 590 0 73 00 73 00 0 0 74.00 07400 RENAL DIALYSIS C 0 0 441 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 76.97 5.437 3.403 76.97 17 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 97, 419 60, 970 4,777 146, 122 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 0 0 7,829 93.00 40, 269 11 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 4, 711 0 55, 255 96.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00116. 00 11600 HOSPI CE 26, 542  $\cap$ 38 178, 223 116. 00 1, 623, 225 542, 160 SUBTOTALS (SUM OF LINES 1 through 117) 1, 431, 022 4, 809, 600 32, 304, 565 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 894, 622 0 0 0 194.00 194. 01 07951 FOUNDATI ON 0 0 0 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 0 194.02 0 0 194. 03 07953 REID CONTRACTED SERVICES 4, 429 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. C 0 353, 971 3, 048, 776 194. 04 194. 05 07955 OTHER NRCC 0 0 194, 05 C 0 0 194.06 07956 VACANT SPACE 0 C 0 0 194.06 194. 08 07958 CAMBRI DGE RHC 0 68, 852 194. 08 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1,623,225 2, 330, 073 542, 160 5, 163, 571 35, 422, 193 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

| Peri od: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: | 5/22/2019 7:59 am

	_				LATERNO	5/22/2019 7:5	9 am
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
	oost conton possinption	RECORDS &	SERVI CE	EDUCATI ON		R PRGM. COSTS	
		LI BRARY					
		16. 00	17. 00	17. 01	21. 00	22. 00	
4 00	GENERAL SERVICE COST CENTERS						4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATIENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5. 04	00570 ADMI TTI NG						5.04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER A&G						5.06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	7, 953, 673					16.00
17.00	01700 SOCI AL SERVI CE	0	3, 812, 980	4 204 200			17.00
17. 01 21. 00	01701   INSERVICE EDUCATION   02100   I&R SERVICES-SALARY & FRINGES APPRVD	0	0	4, 304, 289 0	1 000 070		17. 01 21. 00
22. 00	02200 I&R SERVICES-SALARY & FRINGES APPRVD		0	0	1, 890, 079	491, 614	22.00
23. 00	02300 PARAMED ED PRGM	l ől	o	28, 249		471,014	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-1	==,=			
30.00	03000 ADULTS & PEDIATRICS	505, 626	2, 697, 430	967, 899	1, 461, 474	380, 133	30.00
31.00	03100 INTENSIVE CARE UNIT	90, 286	157, 470	242, 299	130, 689	33, 993	31.00
40.00	04000 SUBPROVI DER - I PF	101, 099	0	205, 722	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	39, 401	0	59, 569	0	0	41.00
43. 00	04300 NURSERY	20, 156	0	12, 763	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	1, 464, 829	ol	62, 800	87, 126	22, 662	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	83, 374	169, 871	21, 060		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 208, 716	0	258, 166		11, 696	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	909, 947	0	63, 180		0	59.00
60.00	06000 LABORATORY	792, 032	0	176, 776	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	255, 448	0	86, 298		0	65.00
66.00	06600 PHYSI CAL THERAPY	160, 095	0	191, 914		0	66.00
69.00	06900 ELECTROCARDI OLOGY	241, 055	0	39, 935	56, 211	14, 620	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 771 357	0	7, 094 0	0	0	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	263, 883	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	994, 033	o	0	0	Ö	73.00
74.00	07400 RENAL DI ALYSI S	9, 164	0	5, 827	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	o	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	8, 544	0	9, 754	0	0	76. 97
04 00	OUTPATIENT SERVICE COST CENTERS	/FE 4//	700 000	000 550	100 (11	00 540	04.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	655, 166	788, 209	230, 550	109, 611	28, 510	91. 00 92. 00
93.00	04040 FAMILY PRACTICE	60, 432	0	49, 499	0	0	92. 00 93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	00, 432	<u> </u>	77, 777	0		73.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 465	0	17, 038	0	0	96.00
	SPECIAL PURPOSE COST CENTERS	·	1	·			
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	51, 794	0	40, 663			116. 00
118.00	9 /	7, 953, 673	3, 812, 980	2, 777, 055	1, 890, 079	491, 614	118. 00
100.00	NONREI MBURSABLE COST CENTERS		ما	0	0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
	07950 RENTAL SPACE		0	0	0		194. 00
	07951 FOUNDATION	o	Ö	1, 140	0		194. 01
	07952 RETAIL SERVICES	o	o	2, 312	0		194. 02
194. 03	07953 REID CONTRACTED SERVICES	o	0	0	0		194. 03
	07954 REID PHYSICIAN ASSOC.	0	0	1, 134, 127	0		194. 04
	07955 OTHER NRCC	0	0	341, 740	0		194.05
	07956 VACANT SPACE	0	0	0 47 01E	0		194.06
194. 08 200. 00	07958 CAMBRIDGE RHC Cross Foot Adjustments		O	47, 915	0		194. 08 200. 00
200.00			0	0	0		200. 00 201. 00
201.00		7, 953, 673	3, 812, 980	4, 304, 289	1, 890, 079		
	(	, , , , , , , , , , , ,	.,, . 50	.,,,	, -, -, -, -,	,	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0048

Control Office   Control						То	12/31/2018	Date/Time Prepared: 5/22/2019 7:59 am
A			Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	3/22/2019 7.39 dill
The color of the			·	PRGM				
DERINGH SERVICE COST CRITICS								
1.00   1.00				23. 00	24. 00		26. 00	
1.01 DOTO) INTO CAP BLICK A FIXT - OFFSITE								
2.00   DOZOG REY CAP REL COSTS-IMPULE DOLPY								
4.00   00000   DEPLOYEE BEREFITS DEPARTMENT								
5.01   0.0046   NOMPATIENT TELEPHONES		1						
DOSED   INTA PRIOR ISS INS		1						
5.04   0.0570   ADMITTH INS   5.06		1						
5.05   0.0580   CASHI ERINK JACCOUNTS RECEIVABLE	5.03	00560	PURCHASING RECEIVING AND STORES					5. 03
0.000   0.0000   CHART ASC		1						
7.00   00000   DOPED TO BERNTIN OF PLANT								
8.00   00800  LAURBYY & LINEN SERVICE								
9.00   0.9900   0.09SERPING   0.00   0.000   0								
10.00   10000   DETARY								
13.00   01300   MURSING ADMINISTRATION								
14.00   14.0		01100	CAFETERI A					11.00
15.00   01500   PHABMACY								
16.00   01-000   MEDI ICAL RECORDS & LIBRARY								
17.00   1700   1700   18FSERVICE EDUCATION		1						
17.0   0.1701   INSERVICE FDUCATION     21.00   220.0   INS. SERVICES-SALARY & FINICES APPRVD   22.00   220.0   INS. SERVICES-COTHER FROM. COSTS APPRVD   22.00   220.0   220.0   220.0   RAS SERVICES-COTHER FROM. COSTS APPRVD   22.00   220.0   2								
21.00		1						
23.00		1						
INPATI ENT ROUTINE SERVICE COST CENTERS		1						
30.00   30000   ADULTS & PEDIATRICS   0   44,955,722   -1,841,607   43,114,115   30.00   40.00   40000   SUBPROVIDER - I PF   0   7,504,854   -164,682   10,666,931   31.00	23.00			571, 542				23. 00
31.00   03100   INTERSIVE CARE UNIT   0   10.431,613   -164,682   10.266,931   31.00								
40.00   04000 SUBPROVIDER - IPF   0   7,504,854   0   7,504,854   40.00   43.00   03.00 SUBPROVIDER - IRF   0   03.513,816   03.513,816   41.00   43.00   43.00 NURSERY   0   920,124   0   920,124   0   920,124   43.00				0				
1.0   0.4100   SUBPROVI DER - IRF   0   3,513,816   0   2,513,816   41,00   30,00   4300				0				
33 00   04300   NURSERY   0   926, 124   0   926, 124   30 00		1		0				
50. 00		1		o				
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   2,604,557   52.00   59.00   05900   RADI DUGGY_DU AGNOSTIC   571,542   23,665,397   -56,664   23,608,393   54,00   59.00   05900   CARDIA CCATHETERIZATION   0   11,973,816   59.00   06000   LABORATORY   0   0,547,913   0   15,647,913   0   15,647,913   0   06000   06500   RESPIRATORY THERAPY   0   3,513,936   0   3,513,936   65.00   06500   DELGETROCAGEDIOLOGY   0   0,200   DELCETROCAGEDIOLOGY   0   0,3847,541   -70,831   3,776,710   69.00   0,900   DELCETROCAGEDIOLOGY   0   3,847,541   -70,831   3,776,710   69.00   0,900   DELCETROCAGEDIOLOGY   0   3,847,541   -70,831   0   32,791   70.00   70.00   0,700   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   26,481   0   26,481   71.00   71.00   0,7100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   26,481   0   26,481   71.00   71.00   0,700   DELICEROCAGEDIOLOGY   0   0,740   0   0,740   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0,740   0   0   0   0   0   0   0   0   0								
54. 00   05400   RADIO LOGY-DI AGNOSTIC   571,542   23,665,397   -56,664   23,608,733   54. 00   59. 00   11. 973.816   59. 00   60. 00		1						
59.00   05900   CARDIAC CATHETERI ZATION   0   11, 973, 816   0   11, 973, 816   59.00				-1		- 1		
60.00   0.0000   LABORATORY				5/1, 542				
65.00   06500   RESPI RATORY THERAPY   0   3,513,936   0   3,513,936   0   0600   070000   070000   070000   070000   070000   070000   0700000   0700000000				0				
66 00 06600 PHYSI CAL THERAPY 0 12, 129, 051 0 12, 129, 051 66, 00 6900 06900 ELECTROCARDI OLOGY 0 3, 847, 541 -70, 831 3, 776, 710 69. 00 7000 ELECTROCARDI OLOGY 0 3, 847, 541 -70, 831 3, 776, 710 69. 00 7000 THO MEDICAL SUPPLIES CHARGED TO PATIENTS 0 26, 481 0 26, 481 71. 00 710 00 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 19, 068, 477 0 19, 068, 477 72. 00 7200 IMPL DEV. CHARGED TO PATIENTS 0 33, 779, 640 0 33, 779, 640 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 394, 581 0 994, 581 74. 00 740 00 7400 PAID ALVSI S 0 994, 581 0 994, 581 74. 00 76. 00 77. 00 76. 00 76. 00 76. 00 77. 00 76. 00 77. 0				ő				
70. 00   07000   CALCENCEPNALOGRAPHY   0   932, 791   0   932, 791   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   26, 481   0   26, 481   71. 00   72. 00   72. 00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   33, 779, 640   0   33, 779, 640   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   33, 779, 640   0   33, 779, 640   0   73. 00   74. 00   7400   FAVA OR RENAL DI ALYSIS   0   994, 581   74. 00   76.				o				66.00
71. 00		1		0	3, 847, 541	-70, 831	3, 776, 710	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   19,068,477   0   19,068,477   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   33,779,640   0   33,779,640   73. 00   74. 00   07400   RENAL DI ALYSIS   0   994,581   0   994,581   74. 00   74. 00   76. 00   0   0   0   0   0   0   0   76. 00   76. 00   0   0   0   0   0   0   0   0   0		1		0				
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   33, 779, 640   0   33, 779, 640   0   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   74. 00   76. 00		1		0				
74. 00 07400 RENAL DI ALYSIS 0 0 994, 581 0 994, 581 76. 00 03950 ANCILLARY - OTHER 0 0 0 0 0 0 0 76. 00 76. 00 76. 00 76. 00 0 0 0 0 0 0 0 76. 00 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   76. 00   76. 00   76. 97   CARDI AC REHABI LITATION   0   492, 632   0   492, 632   0   492, 632   0   76. 97   77. 97				o o				
OUTPAT LENT SERVICE COST CENTERS   O   07100   EMERGENCY   O   07100   EMERGENCY   O   07100   EMERGENCY   O   07100   EMERGENCY   O   07100   O   07200   O85ERVATI ON BEDS (NON-DI STI NCT PART)   O   07200   O85ERVATI ON BEDS (NON-DI STI NCT PART)   O   07100   O   O   O   O   O   O   O   O   O				Ö		Ö	0	
91. 00   09100   EMERGENCY   0   13, 468, 694   -138, 121   13, 330, 573   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   3, 699, 979   0   3, 699, 979   92. 00   93. 00   ODG   ODG	76. 97	07697	CARDIAC REHABILITATION	0	492, 632	0	492, 632	76. 97
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   3,699,979   0   3,699,979   93.00   0   004040   FAMILY PRACTI CE   0   3,699,979   0   3,699,979   93.00   0   0   0   0   0   0   0   0   0								
93. 00   04040   FAMI LY PRACTI CE   0   3, 699, 979   0   3, 699, 979   93. 00   07HER REI MBURSABLE COST CENTERS   96. 00   0678, 065   0   678, 065   0   678, 065   96. 00   0750   07950				0	13, 468, 694		13, 330, 573	
OTHER REIMBURSABLE COST CENTERS   96.00   0678,065   0   678,065   96.00				0	3 600 070		3 600 070	
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   678, 065   0   678, 065   96. 00	70.00			<u> </u>	0,077,777	<u> </u>	0, 0, 7, 7, 7, 7	75. 55
113.00				0	678, 065	0	678, 065	96.00
116.00   11600   HOSPI CE   0   3,873,360   0   3,873,360   116.00   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   571,542   251,502,832   -2,381,693   249,121,139   118.00   11								
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   571,542   251,502,832   -2,381,693   249,121,139   118.00		1			2 072 240		2 072 240	
NONREI MBURSABLE COST CENTERS   NONREI MBURSABLE COST CENTER				- 1				
190. 00	110.00			0717,012	201,002,002	2,001,070	217, 121, 107	116.00
194. 00       07950       RENTAL SPACE       0       6, 124, 585       0       6, 124, 585       194. 00         194. 01       07951       FOUNDATI ON       0       643, 058       0       643, 058       194. 01         194. 02       07952       RETAI L SERVI CES       0       744, 146       0       744, 146       194. 02         194. 03       07953       REI D CONTRACTED SERVI CES       0       275, 803       0       275, 803       194. 03         194. 04       07954       REI D PHYSI CI AN ASSOC.       0       145, 394, 853       0       145, 394, 853       194. 04         194. 05       07955       OTHER NRCC       0       357, 726       0       357, 726       194. 06         194. 06       07956       VACANT SPACE       0       770, 859       0       770, 859       194. 06         194. 08       07958       CAMBRI DGE RHC       0       1,756, 539       0       1,756, 539       0       1,756, 539       0       10       0       200. 00         201. 00       Negati ve Cost Centers       0       0       0       0       0       0       201. 00				0	0	0	0	190.00
194. 01       07951       FOUNDATI ON       0       643,058       0       643,058       194.01         194. 02       07952       RETAI L SERVI CES       0       744,146       0       744,146       194.02         194. 03       07953       REI D CONTRACTED SERVI CES       0       275,803       0       275,803       194.03         194. 04       07954       REI D PHYSI CI AN ASSOC.       0       145,394,853       0       145,394,853       194.04         194. 05       07955       OTHER NRCC       0       357,726       0       357,726       194.05         194. 06       07956       VACANT SPACE       0       770,859       0       770,859       194.08         194. 08       07958       CAMBRI DGE RHC       0       1,756,539       0       1,756,539       0       1,756,539       0       0       0       0       200.00         201. 00       Negati ve Cost Centers       0       0       0       0       0       201.00				0				
194. 02     07952     RETAI L SERVI CES     0     744, 146     0     744, 146     194. 02       194. 03     07953     REI D CONTRACTED SERVI CES     0     275, 803     0     275, 803     194. 03       194. 04     07954     REI D PHYSI CI AN ASSOC.     0     145, 394, 853     0     145, 394, 853     194. 04       194. 05     07955     OTHER NRCC     0     357, 726     0     357, 726     194. 05       194. 06     07956     VACANT SPACE     0     770, 859     0     770, 859     194. 08       194. 08     07958     CAMBRI DGE RHC     0     1, 756, 539     0     1, 756, 539     194. 08       200. 00     Cross Foot Adj ustments     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     201. 00				0				
194. 03     07953     REI D CONTRACTED SERVICES     0     275, 803     0     275, 803     194. 03       194. 04     07954     REI D PHYSI CI AN ASSOC.     0     145, 394, 853     0     145, 394, 853     194. 04       194. 05     07955     OTHER NRCC     0     357, 726     0     357, 726     194. 05       194. 06     07956     VACANT SPACE     0     770, 859     0     770, 859     194. 06       194. 08     07958     CAMBRI DGE RHC     0     1, 756, 539     0     1, 756, 539     194. 08       200. 00     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     201. 00				0				
194. 04     07954     REI D PHYSI CI AN ASSOC.     0     145, 394, 853     0     145, 394, 853     194. 04       194. 05     07955     OTHER NRCC     0     357, 726     0     357, 726     194. 05       194. 06     07956     VACANT SPACE     0     770, 859     0     770, 859     194. 06       194. 08     07958     CAMBRI DGE RHC     0     1, 756, 539     0     1, 756, 539     194. 08       200. 00     Cross Foot Adj ustments     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     201. 00				0				
194. 05     07955     OTHER NRCC     0     357, 726     0     357, 726     194. 05       194. 06     07956     VACANT SPACE     0     770, 859     0     770, 859     194. 06       194. 08     07958     CAMBRI DGE RHC     0     1, 756, 539     0     1, 756, 539     194. 08       200. 00     Cross Foot Adjustments     0     0     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     0     0     201. 00				Ö				
194. 06     07956     VACANT SPACE     0     770, 859     0     770, 859     194. 06       194. 08     07958     CAMBRI DGE RHC     0     1, 756, 539     0     1, 756, 539     194. 08       200. 00     Cross Foot Adjustments     0     0     0     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0     0     201. 00				o			1	
200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00	194. 06	07956	VACANT SPACE	o	770, 859	0	770, 859	194. 06
201.00   Negative Cost Centers   0   0   0   201.00				o		0	1, 756, 539	
				0	0	0	0	
202.00    TOTAL (30   111163 110 till ough 201)   3/1, 342  411, 271, 02/  -2, 301, 073  400, 710, 134    202.00				571 542	0 411 201 ع	2 381 602	408 010 124	
	202.00	<u> </u>	1.5 (54m 111165 116 till 64gil 201)	371, 342	111,271,021	2, 501, 675	100, 710, 104	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048

						5/22/2019 7:5	9 am
			CAP	ITAL RELATED CO	STS		
	Cost Center Description	Directly	NEW BLDG &	NEW CAP BLDG	NEW MVBLE	Subtotal	
	Cost Center Description	Assigned New	FLXT	& FIXT -	EQUI P	Subtotal	
		Capi tal	11771	OFFSI TE	24011		
		Related Costs					
	JOENEDAL OFFICE COOT OFFITTING	0	1. 00	1. 01	2. 00	2A	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 517	42, 398	9, 531	0	60, 446	1
5. 01	00540 NONPATI ENT TELEPHONES	244	60, 332		0		
5. 02	00550 DATA PROCESSING	4, 126, 910	198, 851		0	., ,	1
5. 03	00560 PURCHASING RECEIVING AND STORES	15, 583	248, 603		0		
5. 04 5. 05	00570   ADMI TTI NG   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	16, 162 85, 258	2, 287 12, 946		0	63, 341 292, 640	5. 04 5. 05
5. 06	00590 OTHER A&G	66, 182	398, 528		0		
7. 00	00700 OPERATION OF PLANT	141, 452			0		1
8. 00	00800 LAUNDRY & LINEN SERVICE	76, 232	195, 944		0		1
9. 00	00900 HOUSEKEEPI NG	33, 791	107, 638		0	141, 429	9. 00
10.00	01000 DI ETARY	132, 670	199, 645		0		1
11.00	01100 CAFETERI A	0	156, 835		0	,	
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	454, 073	31, 056 133, 610		0	31, 056 587, 683	
15. 00	01500 PHARMACY	298, 734	115, 501		0	414, 235	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	39, 263	55, 709	1	0		1
17. 00	01700 SOCIAL SERVICE	2, 252	19, 714		0	21, 966	
17. 01	01701 I NSERVI CE EDUCATI ON	28, 168	165, 349	0	0	193, 517	
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	- 1	0		
22. 00 23. 00		35, 736 1, 181	0 16, 854	T	0		1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	1, 101	10, 634	03, 639	0	81, 894	23.00
30. 00	03000 ADULTS & PEDIATRICS	470, 554	1, 735, 394	0	0	2, 205, 948	30.00
31.00	03100 INTENSIVE CARE UNIT	429, 276	390, 013	0	0	819, 289	31.00
40.00	04000 SUBPROVI DER - I PF	36, 243	354, 875	1	0	, ,	1
41.00	04100 SUBPROVI DER - I RF	43, 456			0		1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	7, 557	42, 588	0	0	50, 145	43.00
50. 00	05000 OPERATING ROOM	861, 186	769, 892	311, 931	0	1, 943, 009	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	43, 328	132, 101		0	175, 429	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 129, 930	965, 502		0	,	1
59.00	05900 CARDI AC CATHETERI ZATI ON	276, 169	215, 705		0		1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	408, 260 45, 989	221, 519 26, 163	1	0		1
66. 00	06600 PHYSI CAL THERAPY	102, 283	128, 416		0		1
69. 00	06900 ELECTROCARDI OLOGY	105, 906	111, 371		0		
70.00	07000 ELECTROENCEPHALOGRAPHY	5, 148	0		0	,	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		
74. 00	07400 RENAL DIALYSIS	6, 425	23, 669	1	0	l	1
	03950 ANCI LLARY - OTHER	0	0	1	0		1
76. 97	07697 CARDIAC REHABILITATION	10, 524	71, 849	0	0	82, 373	76. 97
04 00	OUTPATIENT SERVICE COST CENTERS	105 000	2/4 700			FF7 (40	04.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	195, 880	361, 738	0	0	557, 618	91. 00 92. 00
	04040 FAMILY PRACTICE	24, 480	141, 934	20, 182	0	186, 596	1
	OTHER REIMBURSABLE COST CENTERS					1007010	1
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	148	28, 180	68, 434	0	96, 762	96. 00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 I NTEREST EXPENSE	4 405	7. 069		0	11 554	113.00
118.00	)11600 HOSPICE 	4, 485 9, 769, 635			0		116.00
110.00	NONREI MBURSABLE COST CENTERS	7, 707, 033	11,007,007	2, 203, 002		23, 123, 300	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	115, 293	3, 955		0	177, 769	
	07950 RENTAL SPACE	120, 395	0	453, 445	0	573, 840	
	I 07951 FOUNDATI ON 2 07952  RETAI L SERVI CES	929 410	3, 272 37, 171		0		194. 01 194. 02
	307953 REID CONTRACTED SERVICES	0	37, 171	1	0		194. 02
194. 04	1 07954 REID PHYSICIAN ASSOC.	1, 316, 740	547, 865	_	0	5, 221, 214	1
194.05	07955 OTHER NRCC	0	8, 451	0	0	8, 451	194. 05
	6 07956 VACANT SPACE	0	22, 001		0	431, 078	
194. 08 200. 00	307958 CAMBRIDGE RHC Cross Foot Adjustments	27, 882	0	0	0		194. 08 200. 00
200.00	1 1		0	О	0		200.00
	12=	<u> </u>		1 0		1 0	1

Health Financial Systems	REI D	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provi der CO		Period: From 01/01/2018 Fo 12/31/2018	Worksheet B Part II Date/Time Pre 5/22/2019 7:5	pared: 9 am
			CAPI	TAL RELATED C	0STS		
Cost Center Description		Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW CAP BLDG & FLXT - OFFSLTE	NEW MVBLE EQUI P	Subtotal	
		0	1. 00	1. 01	2.00	2A	
202.00 TOTAL (sum lines 118 thro	ugh 201)	11, 351, 284	11, 690, 584	6, 563, 53	1 0	29, 605, 402	202. 00

5/22/2019 7:59 am

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

Cost Center Description **EMPLOYEE** NONPATI ENT DATA PURCHASI NG ADMI TTI NG **BENEFITS** RECEIVING AND **TELEPHONES** PROCESSI NG **DEPARTMENT STORES** 5. 01 5. 02 5. 04 4 00 5.03 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 60, 446 4.00 00540 NONPATIENT TELEPHONES 5.01 94 60,670 5.01 5.02 00550 DATA PROCESSING 1.436 6, 388 4, 359, 677 5.02 00560 PURCHASING RECEIVING AND STORES 719, 842 5.03 317 848 454, 491 5.03 943 5.04 00570 ADMITTING 758 2, 385 66, 837 134, 264 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 1, 195 3, 737 28,644 1,609 0 5.05 00590 OTHER A&G 6, 419 3, 552 53, 470 5.06 3, 128 5.06 0 00700 OPERATION OF PLANT 7 00 956 1,537  $\cap$ 6, 793 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 119 159 3,819 131 0 8.00 9.00 00900 HOUSEKEEPI NG 589 159 5, 729 12, 667 0 9.00 01000 DI ETARY 64, 927 9, 947 10.00 173 0 10.00 2, 332 11.00 01100 CAFETERI A 764 0 0 11.00 01300 NURSING ADMINISTRATION 13 00 75 477 26 735 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 202 22, 916 83, 039 0 14.00 265 01500 PHARMACY 15.00 1.356 1, 140 76, 385 64.913 0 15.00 01600 MEDICAL RECORDS & LIBRARY 1, 278 1, 802 160, 409 0 16.00 1,682 16.00 01700 SOCIAL SERVICE 17.00 750 901 53, 470 809 0 17.00 01701 INSERVICE EDUCATION 282, 625 17.01 385 1, 219 1,662 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 487 r 0 0 0 21.00 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 64 C 0 205 0 22.00 02300 PARAMED ED PRGM 80 19,096 23.00 23.00 74 147 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 406 6,043 454, 491 59, 499 8,535 30.00 03100 INTENSIVE CARE UNIT 31.00 1, 327 1,378 66, 837 28, 387 1,524 31.00 04000 SUBPROVIDER - IPF 28.644 7.085 1,707 40.00 40.00 1.305 583 04100 SUBPROVIDER - IRF 41.00 461 848 53, 470 4,604 665 41.00 43.00 04300 NURSERY 161 0 5, 697 340 43.00 ANCILLARY SERVICE COST CENTERS 24, 727 50 00 05000 OPERATING ROOM 421 5 009 166, 137 101 648 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 256 1, 140 61, 108 8,853 1, 407 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,000 4, 055 290, 263 71,660 20, 404 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 630 769 19,096 54, 357 15, 361 59.00 06000 LABORATORY 1, 696 110, 758 8, 733 13, 370 60 00 60 00 1, 211 06500 RESPIRATORY THERAPY 65.00 454 159 22, 916 24,605 4, 312 65.00 06600 PHYSI CAL THERAPY 1,838 2, 385 198, 601 3, 331 2,703 66.00 66.00 69 00 06900 ELECTROCARDI OLOGY 286 239 93.572 9, 436 4, 069 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 117 186 15, 277 1, 313 604 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 0 ol 4, 455 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 16, 780 73 00 C 0 74.00 07400 RENAL DIALYSIS 0 133 3,819 1, 478 155 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 76 318 3,819 777 144 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1, 718 2, 173 143, 222 29, 260 11, 060 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 74, 475 93.00 616 1,511 5, 228 1,020 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 48 22, 916 7, 208 96.00 663 42 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 446 345 5, 729 11, 500 874 116.00 <u>56</u>, 190 SUBTOTALS (SUM OF LINES 1 through 117) 34, 401 3, 154, 703 635, 625 134, 264 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 723 0 192.00 0 1,910 713 0 194.00 194.00 07950 RENTAL SPACE 0 2, 571 9.829 194. 01 07951 FOUNDATI ON 186 11, 458 677 0 194. 01 62 194. 02 07952 RETAIL SERVICES 0 194, 02 43 C 68, 747 233 194. 03 07953 REID CONTRACTED SERVICES 38 C 0 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 0 194.04 25, 543 0 1, 122, 859 71, 331 194. 05 07955 OTHER NRCC 0 194, 05 0 C C 0 0 194.06 194.06 07956 VACANT SPACE C 0 194. 08 07958 CAMBRI DGE RHC 0 194.08 359 0 1,434 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201, 00 202.00 TOTAL (sum lines 118 through 201) 60, 446 60,670 4, 359, 677 719, 842 134, 264 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048

						5/22/2019 7:5	9 am
	Cost Center Description	CASHI ERI NG/AC	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		COUNTS		PLANT	LINEN SERVICE		
		RECEI VABLE	F 0/	7.00	0.00	0.00	
	CENEDAL CEDVICE COCT CENTEDS	5. 05	5. 06	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1 00
1.00	1						1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1.01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5.04	00570 ADMITTING						5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	327, 825					5. 05
5. 06	00590 OTHER A&G	l ol	699, 385				5.06
7. 00	00700 OPERATION OF PLANT	l ol	13, 564	3, 157, 156			7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE		1, 724	62, 704	340, 832		8.00
9. 00	00900 HOUSEKEEPI NG		5, 214	32, 992	0 10, 002	198, 779	9. 00
10. 00	01000 DI ETARY		2, 397	56, 096	0	4, 537	10.00
11. 00	01100 CAFETERI A		3, 747	50, 189	0	4, 557	11.00
		1	•		0		1
13.00	01300 NURSI NG ADMI NI STRATI ON	0	871	9, 938	٥	238	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	8, 552	42, 757	0	298	1
	01500 PHARMACY	0	59, 966	35, 787	0	0	15.00
	01600 MEDICAL RECORDS & LIBRARY	0	13, 295	5, 907	0	744	16. 00
	01700 SOCI AL SERVI CE	0	6, 380	2, 227	0	1, 131	17. 00
	01701 I NSERVI CE EDUCATI ON	0	7, 001	47, 388	0	2, 826	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	3, 184	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	829	0	0	0	22.00
23.00	02300 PARAMED ED PRGM	0	825	14, 269	0	1, 205	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						Ī
30.00	03000 ADULTS & PEDIATRICS	20, 841	58, 623	549, 724	101, 111	67, 147	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 721	15, 122	124, 809	22, 604	12, 986	31.00
40. 00	04000 SUBPROVI DER – I PF	4, 167	10, 610		18, 622	11, 290	
41. 00	04100 SUBPROVI DER – I RF	1, 624	4, 916	90, 984	9, 508	6, 486	1
	04300 NURSERY	831	1, 436	13, 629	0	208	
43.00	ANCI LLARY SERVI CE COST CENTERS	031	1, 430	13, 027	9	200	45.00
50. 00	05000 OPERATING ROOM	60, 367	51, 679	206, 510	55, 016	17, 493	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 436	3, 552	42, 274	17, 953	2, 841	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	49, 821	33, 809	223, 265	34, 918	8, 196	
59.00	05900 CARDI AC CATHETERI ZATI ON	37, 506	16, 860			2, 395	
60.00	06000 LABORATORY	32, 646	23, 805		0	8, 167	60.00
65.00	06500 RESPI RATORY THERAPY	10, 529	5, 233		0	1, 785	
66. 00	06600 PHYSI CAL THERAPY	6, 599	18, 757	245, 124	2, 391	1, 398	
69. 00	06900 ELECTROCARDI OLOGY	9, 936	5, 359		0	3, 020	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 474	1, 375	27, 451	1, 422	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15	1	0	0	1, 607	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	10, 877	26, 977	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	40, 972	3, 180	0	0	2, 231	73.00
74.00	07400 RENAL DIALYSIS	378	1, 565	7, 574	0	2, 499	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	352	772	0	o	744	76. 97
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
91.00	09100 EMERGENCY	27, 005	18, 097	115, 760	47, 747	15, 723	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , , , ,	,	,	, ,	•	92.00
	04040 FAMILY PRACTICE	2, 491	5, 864	2, 059	9, 970	3, 421	
70.00	OTHER REIMBURSABLE COST CENTERS	2/ 1/1	37 33 1	2,007	77 77 0	0, 12.	70.00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	102	936	19, 073	0	0	96.00
70.00	SPECIAL PURPOSE COST CENTERS	102	700	17,070	٥		70.00
113 00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	2, 135	6, 028	^	o	2 008	116.00
118.00		327, 825			340, 832	182, 624	
116.00	NONREI MBURSABLE COST CENTERS	327, 023	442, 105	2, 243, 300	340, 632	102, 024	1116.00
100.00			0	0	ما	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	6, 275		0		192.00
	07950 RENTAL SPACE	0	8, 405	113, 971	0		194.00
	07951 FOUNDATION	0	1, 084	1, 047	0		194. 01
	07952 RETAIL SERVICES	0	1, 243	3, 477	0		194. 02
	07953 REID CONTRACTED SERVICES	0	462	0	0		194. 03
194. 04	07954 REID PHYSICIAN ASSOC.	0	236, 212	659, 851	0	15, 887	194. 04
194.05	07955 OTHER NRCC	0	16	2, 704	0	0	194. 05
194.06	07956 VACANT SPACE		794		0	0	194. 06
	07958 CAMBRI DGE RHC	0	2, 789	0	0	0	194. 08
200.00		]	, , ,				200.00
201. 00		0	0	ი	o	0	201.00
202.00		327, 825	699, 385	3, 157, 156	340, 832	198, 779	
		, , , , , ,	,		,	-,	

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/22/2019 7:59 am Cost Center Description DI ETARY CAFETERI A NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O SERVICES & **SUPPLY** Ν 10. 00 11.00 15.00 13 00 14 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 2 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER A&G 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 472.724 10.00 11.00 01100 CAFETERI A 211, 535 11.00 01300 NURSING ADMINISTRATION 13 00 0 111 69, 501 13.00 01400 CENTRAL SERVICES & SUPPLY 0 1. 989 747, 701 14.00 14.00 0 01500 PHARMACY 0 660, 337 15.00 6, 172 0 383 15.00 01600 MEDICAL RECORDS & LIBRARY 0 9, 927 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 3, 418 0 0 0 17.00 01701 INSERVICE EDUCATION 0 2 17.01 2.078 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 1,603 0 21.00 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 0 367 0 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 283 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 305, 569 34, 184 30, 211 861 80 30.00 03100 INTENSIVE CARE UNIT 31.00 47, 290 6, 190 5, 470 1,738 16 31.00 04000 SUBPROVI DER - I PF 86, 151 7.444 6.578 2 40.00 40.00 24 04100 SUBPROVIDER - IRF 41.00 33, 714 2, 380 2, 103 28 2 41.00 43.00 04300 NURSERY 0 624 551 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2, 406 2, 126 85, 348 2, 384 50 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 990 875 1, 449 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 9, 731 8,600 3, 659 12, 609 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 2, 933 2, 592 125, 857 18 59.00 06000 LABORATORY 7, 856 60 00 0 42, 130 60 00 06500 RESPIRATORY THERAPY 65.00 2, 425 2, 143 247 123 65.00 06600 PHYSI CAL THERAPY 8, 865 66.00 0 49 66.00 69 00 06900 ELECTROCARDI OLOGY 00000 1.448 0 5, 100 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 661 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 0 425, 968 0 72.00 07300 DRUGS CHARGED TO PATIENTS 575, 672 73 00 0 73 00 C 0 74.00 07400 RENAL DIALYSIS C 0 0 8 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 494 436 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 8, 844 7, 816 692 2, 724 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 0 0 146 93.00 3, 656 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 428 0 8,001 96.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 2.410  $\cap$ 3, 322 116.00 696, 446 SUBTOTALS (SUM OF LINES 1 through 117) 472, 724 129, 917 69, 501 602, 218 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 r 0 0 192.00 194.00 07950 RENTAL SPACE 0 81, 216 0 0 0 194.00 194. 01 07951 FOUNDATI ON 0 0 0 0 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 194, 02 0 194. 03 07953 REID CONTRACTED SERVICES 402 0 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. C 0 51, 255 56, 835 194. 04 194. 05 07955 OTHER NRCC 0 0 194, 05 C 0 194.06 07956 VACANT SPACE 0 C 0 194.06 194. 08 07958 CAMBRI DGE RHC 0 1, 284 194. 08 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 472, 724 211, 535 69, 501 747, 701 660, 337 202. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am

						5/22/2019 7:5 RESIDENTS	
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON		SERVICES-OTHE R PRGM. COSTS	
		LI BRARY					
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	17. 01	21. 00	22. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	-					4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00570 ADMI TTI NG						5.04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06 7. 00	00590 OTHER A&G 00700 OPERATION OF PLANT						5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	<u> </u>					8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	430, 195					16. 00
17.00	01700 SOCIAL SERVICE	0	91, 052				17. 00
17. 01	01701 INSERVICE EDUCATION	0	0	538, 703			17. 01
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	5, 274	27 201	21.00
22. 00 23. 00	02200   &R SERVICES-OTHER PRGM. COSTS APPRVD 02300   PARAMED ED PRGM	0	0	3, 535		37, 201	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	3, 333			23.00
30.00	03000 ADULTS & PEDIATRICS	27, 334	64, 414	121, 137			30.00
31. 00	03100 INTENSIVE CARE UNIT	4, 881	3, 760	30, 325			31.00
40.00	04000 SUBPROVI DER - I PF	5, 465	0	25, 747			40.00
41. 00 43. 00	04100  SUBPROVI DER - I RF 04300  NURSERY	2, 130 1, 090	0	7, 455 1, 597			41. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	1,070	<sub>0</sub>	1,077			10.00
50.00	05000 OPERATING ROOM	79, 412	0	7, 860			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 507	4, 056	2, 636			52.00
54. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	65, 343 49, 191	0	32, 311 7, 907			54. 00 59. 00
60.00	06000 LABORATORY	42, 817	o	22, 124			60.00
65.00	06500 RESPI RATORY THERAPY	13, 809	ō	10, 801			65. 00
66. 00	06600 PHYSI CAL THERAPY	8, 655	0	24, 019			66. 00
69. 00	06900 ELECTROCARDI OLOGY	13, 031	0	4, 998			69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 934 19	0	888 0			70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 265	0	0			71.00
73. 00		53, 737	o	0			73. 00
	07400 RENAL DIALYSIS	495	0	729			74.00
76. 00		0	0	0			76. 00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	462	0	1, 221			76. 97
91. 00		35, 418	18, 822	28, 854			91. 00
92.00		]	,	_==, == .			92.00
93.00	04040 FAMILY PRACTICE	3, 267	0	6, 195			93.00
04 00	OTHER REIMBURSABLE COST CENTERS	122	ما	2 122			07.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	133	0	2, 132			96. 00
113. 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	2, 800	o	5, 089			116. 00
118. 00		430, 195	91, 052	347, 560	0	0	118. 00
100.0	NONREI MBURSABLE COST CENTERS		ما	0	I		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0			190. 00 192. 00
	07950 RENTAL SPACE		0	0			194. 00
	1 07951 FOUNDATI ON	O	0	143			194. 01
	2 07952 RETAIL SERVICES	0	0	289			194. 02
	3 07953 REID CONTRACTED SERVICES	0	0	0			194. 03
	407954 REID PHYSICIAN ASSOC. 507955 OTHER NRCC	0	0	141, 944			194. 04 194. 05
	607956 VACANT SPACE	0	0	42, 770 0			194. 05 194. 06
	B 07958 CAMBRI DGE RHC		o	5, 997			194. 08
200.00	Cross Foot Adjustments				5, 274	37, 201	200. 00
201. 00		0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	430, 195	91, 052	538, 703	5, 274	37, 201	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Cost Center Description PARAMED ED Subtotal Intern & Total PRGM Resi dents Cost & Post Stepdown Adjustments 23. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 17.01 01701 INSERVICE EDUCATION 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22 00 02200 & SERVICES-OTHER PRGM. COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 121, 408 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 122, 158 0 4, 122, 158 30.00 03100 INTENSIVE CARE UNIT 1, 197, 654 0 1, 197, 654 31 00 31 00 04000 SUBPROVI DER - I PF 0 40.00 720, 106 720, 106 40.00 04100 SUBPROVI DER - I RF 549, 147 0 549, 147 41.00 41.00 04300 NURSERY 76, 309 43.00 0 76, 309 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 811, 552 0 2, 811, 552 50.00 05200 DELIVERY ROOM & LABOR ROOM 332, 771 0 332, 771 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3,004,201 3, 004, 201 54.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 59 00 870, 264 870, 264 60.00 06000 LABORATORY 1,014,096 1, 014, 096 60.00 65.00 06500 RESPIRATORY THERAPY 177, 763 0 177, 763 65.00 06600 PHYSI CAL THERAPY 1, 763, 717 0 1, 763, 717 66.00 66,00 06900 ELECTROCARDI OLOGY 69.00 370, 603 370, 603 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 150, 589 150, 589 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 1.648 1.648 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 482, 542 482, 542 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 692, 572 692, 572 73.00 74 00 07400 RENAL DIALYSIS 48, 927 0 48, 927 74.00 0 03950 ANCI LLARY - OTHER 76.00 76.00 07697 CARDI AC REHABI LI TATI ON 91, 989 0 91, 989 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 1, 072, 553 1, 072, 553 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 93.00 04040 FAMILY PRACTICE 306, 517 0 306, 517 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 158, 444 0 158, 444 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 54, 245 54, 245 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 0 118.00 20, 070, 367 20, 070, 367 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 200, 875 200, 875 192.00 194.00 07950 RENTAL SPACE 789.832 0 789.832 194. 00 0 194. 01 07951 FOUNDATI ON 194. 01 18, 977 18, 977 194. 02 07952 RETAIL SERVICES 0 111, 762 194.02 111, 762 194. 03 07953 REID CONTRACTED SERVICES 902 0 902 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 7, 602, 931 0 7, 602, 931 194. 04 194. 05 07955 OTHER NRCC 53, 941 0 53, 941 194.05 194.06 07956 VACANT SPACE 552, 187 552, 187 194.06 194. 08 07958 CAMBRI DGE RHC 39, 745 0 39, 745 194. 08 0 200.00 Cross Foot Adjustments 121, 408 163,883 163, 883 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 121, 408 29, 605, 402 29, 605, 402 202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0048

				T	12/31/2018	Date/Time Pre 5/22/2019 7:5	
		CAP	TAL RELATED CO	OSTS		3/22/2017 7.3	) dili
	Cost Center Description	NEW BLDG &	NEW CAP BLDG	NEW MVBLE	EMPLOYEE	NONPATI ENT	
		FLXT	& FIXT -	EQUI P	BENEFI TS	TELEPHONES	
		(SQUARE FEET)	OFFSITE	(SQUARE FEET)	DEPARTMENT	(PHONES)	
			(SQUARE FEET)		(GROSS SALARI ES)		
		1. 00	1. 01	2.00	4. 00	5. 01	
1. 00	GENERAL SERVICE COST CENTERS  00100 NEW CAP REL COSTS-BLDG & FIXT	735, 942		I			1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE	733, 742	l .				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			0			2.00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	2, 669 3, 798	l .		174, 653, 329 272, 496	2, 289	4. 00 5. 01
5. 02	00550 DATA PROCESSING	12, 518	l .	1	4, 150, 904	241	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	15, 650	l .	1	915, 645		5. 03
5. 04 5. 05	00570   ADMI TTI NG   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	144 815			2, 191, 235 3, 452, 939	90 141	5. 04 5. 05
5. 06	00590 OTHER A&G	25, 088			10, 266, 243	118	5. 06
7.00	00700 OPERATION OF PLANT	182, 168			2, 764, 407	58	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	12, 335 6, 776			344, 470 1, 701, 755	6	8. 00 9. 00
10. 00	01000 DI ETARY	12, 568	l .	Ö	498, 698	88	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	9, 873 1, 955		_	2, 209, 253	0 18	11. 00 13. 00
14. 00		8, 411		1	216, 509 582, 994	10	14.00
15.00	01500 PHARMACY	7, 271	0		3, 919, 906	43	15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	3, 507			3, 692, 237	68	16.00
17. 00	01700 SOCIAL SERVICE 01701 I NSERVI CE EDUCATI ON	1, 241 10, 409	0	0	2, 167, 073 1, 111, 773	34 46	17. 00 17. 01
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	l .	0	1, 408, 751	0	21. 00
22. 00	O2200   I &R SERVICES-OTHER PRGM. COSTS APPRVD   O2300   PARAMED ED PRGM	1, 061	0 2, 680	1	184, 203 213, 753	0	22. 00 23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS	1,001	2,000	0	213, 753	3	23.00
30.00		109, 246	l .	•	18, 515, 598	228	30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	24, 552 22, 340		1	3, 835, 104 3, 772, 749	52 22	31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	17, 898			1, 333, 508	32	41.00
43.00	04300 NURSERY	2, 681	0	0	465, 815	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	48, 466	13, 091	0	1, 216, 095	189	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 316	0		738, 699	43	52.00
54. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C	60, 780	1		5, 779, 910 1, 821, 955	153	54. 00 59. 00
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	13, 579 13, 945	l .		3, 499, 030	29 64	60.00
65.00	06500 RESPI RATORY THERAPY	1, 647	0	0	1, 313, 520	6	65.00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	8, 084 7, 011	42, 316	0	5, 313, 451 825, 995	90 9	66. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	7,011	3, 892	0	338, 343	7	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74. 00		1, 490	_		0	5	74.00
76.00		0	0	0	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	4, 523	0	0	218, 763	12	76. 97
91.00	09100 EMERGENCY	22, 772	0	0	4, 966, 118	82	91.00
92.00		0.005	0.47		1 700 055	F-7	92.00
93. 00	OTHER REIMBURSABLE COST CENTERS	8, 935	847	0	1, 780, 855	57	93.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	1, 774	2, 872	0	137, 979	25	96. 00
112 0	SPECIAL PURPOSE COST CENTERS 0 11300   NTEREST EXPENSE	1	I	I			113. 00
	11600 HOSPI CE	445	O	0	1, 290, 242		116. 00
118. 0	, J ,	696, 741	95, 933	0	99, 428, 973	2, 120	118. 00
100 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	T 0	0	Ο	0	0	190. 00
192. 0	19200 PHYSICIANS' PRIVATE OFFICES	249			0	65	192. 00
194.0	07950 RENTAL SPACE	0	,		0		194.00
	1 07951  FOUNDATION 2 07952  RETALL SERVICES	206 2, 340	l .	0	179, 848 124, 379		194. 01 194. 02
194.0	3 07953 REID CONTRACTED SERVICES	0	0	0	109, 540	0	194. 03
	4 07954 REID PHYSICIAN ASSOC.	34, 489		0	73, 773, 732		194.04
	5 07955 0THER NRCC 5 07956 VACANT SPACE	532 1, 385			0		194. 05 194. 06
194.0	B 07958 CAMBRI DGE RHC	0	0	o o	1, 036, 857	0	194. 08
200.0	Cross Foot Adjustments		l				200. 00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 15-0048	Peri od: From 01/01/2018	Worksheet B-1
				Date/Time Prepared

				Т	o 12/31/2018	Date/Time Pre 5/22/2019 7:5	
		CAPI	TAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG & FLXT	NEW CAP BLDG & FIXT -	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	
		(SQUARE FEET)	OFFSITE (SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS SALARIES)	(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)	11, 690, 584	6, 563, 534	0	31, 034, 369	403, 546	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 885197	23. 827885	0. 000000	0. 177691	176. 297947	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				60, 446	60, 670	204.00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 000346	26. 505024	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00							207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048 

8. 00   00800   LAUNDRY & LI NEN SERVI CE   2   1, 609   0   0   0   0   0   0   0   0   0	1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05
CTERMI NALS  STORES (SUPPLY EXPENSE)   REVENUE   CTOTAL REVENUE   REVENUE   CTOTAL REVENUE   S. 02   S. 03   S. 04   S. 05   SA. 06	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 01 11. 00 01 13. 00 01 15. 00 01 16. 00
CSUPPLY EXPENSE   CTOTAL REVENUE	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 01 11. 00 01 13. 00 01 15. 00 01 16. 00
S. 02   S. 03   S. 04   S. 05   SA. 06	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 01 11. 00 01 13. 00 01 15. 00 01 16. 00
GENERAL SERVICE COST CENTERS   1.00	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 01 11. 00 01 13. 00 01 15. 00 01 16. 00
1. 00	1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 7. 00 8. 00 9. 00 10. 00 11. 00 01 11. 00 01 13. 00 01 15. 00 01 16. 00
2. 00	2.00 4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 01.00 01.00 0
4. 00	4.00 5.01 5.02 5.03 5.04 5.05 7.00 8.00 9.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00
5. 01	5. 01 5. 02 5. 03 5. 04 5. 05 9. 5. 05 0 7. 00 0 8. 00 0 9. 00 0 10. 00 0 11. 00 0 13. 00 0 15. 00 0 16. 00
5. 02	5. 02 5. 03 5. 04 5. 05 6. 7. 00 8. 00 9. 00 11. 00
5. 03	5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
5. 05     00580 CASHI ERI NG/ACCOUNTS RECEI VABLE     15     19, 809     0     823, 670, 284       5. 06     00590 OTHER A&G     28     79, 023     0     0     -31, 565, 40       7. 00     00700 OPERATI ON OF PLANT     0     83, 627     0     0       8. 00     00800 LAUNDRY & LI NEN SERVI CE     2     1, 609     0     0       9. 00     00900 HOUSEKEEPI NG     3     155, 956     0     0       10. 00     01000 DI ETARY     34     122, 458     0     0       11. 00     01100 CAFETERI A     0     0     0     0	5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
5. 06	9 5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
7. 00     00700     OPERATI ON OF PLANT     0     83,627     0     0       8. 00     00800     LAUNDRY & LI NEN SERVI CE     2     1,609     0     0       9. 00     00900     HOUSEKEEPI NG     3     155,956     0     0       10. 00     01000     DI ETARY     34     122,458     0     0       11. 00     01100     CAFETERI A     0     0     0     0	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE   2   1, 609   0   0   0   0   0   0   0   0   0	8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
9. 00   00900   HOUSEKEEPI NG   3   155, 956   0   0   0   0   0   0   0   0   0	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
11. 00   01100   CAFETERI A   0   0   0   0	11.00 13.00 14.00 15.00 16.00
	13. 00 14. 00 15. 00 16. 00
13.00   01300   NURSING ADMINISTRATION   14  0  0  0	14. 00 15. 00 16. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY   12   1, 022, 343   0   0	15. 00 16. 00
	16.00
	17.00
	17. 01
	21.00
	22.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 23.00
	30.00
	31.00
	40.00
	41.00
ANCILLARY SERVICE COST CENTERS	10.00
	50.00
	52.00
	54.00
	60.00
	65.00
	66.00
	69.00
	70.00
	71.00
	73.00
	74.00
	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 2 9, 569 884, 812 884, 812 0UTPATI ENT SERVI CE COST CENTERS	76. 97
	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
	93.00
OTHER REI MBURSABLE COST CENTERS         12         88, 745         255, 265         255, 265	96.00
96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED   12   88, 745   255, 265   255, 265   SPECI AL PURPOSE COST CENTERS	96.00
113. 00 11300   INTEREST EXPENSE	113.00
116. 00 11600 HOSPI CE 3 141, 589 5, 363, 942 5, 363, 942	116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 652 7, 825, 562 823, 670, 284 823, 670, 284 -31, 565, 40	<u>)</u> 118. 00
NONREI MBURSABLE COST CENTERS	1400 00
	190. 00 192. 00
	194.00
	194. 01
194. 02 07952 RETAIL SERVICES 36 2, 868 0 0	194. 02
	194. 03
	194.04
	194. 05 194. 06
	194.08
200. 00 Cross Foot Adjustments	200.00
201.00 Negative Cost Centers	201 00
	201.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0048	Peri od:	Worksheet B-1

					rom 01/01/2018		
				7	o 12/31/2018		
						5/22/2019 7:5	9 am
	Cost Center Description	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/AC	Reconciliatio	
		PROCESSI NG	RECEIVING AND	(TOTAL	COUNTS	n	
		(TERMI NALS)	STORES	REVENUE)	RECEI VABLE		
			(SUPPLY		(TOTAL		
			EXPENSE)		RÈVENUE)		
		5. 02	5. 03	5. 04	5. 05	5A. 06	
202.00	Cost to be allocated (per Wkst. B,	29, 932, 532	4, 889, 105	4, 281, 160	9, 529, 967		202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	13, 111. 052124	0. 551667	0. 005198	0. 011570		203. 00
204.00	Cost to be allocated (per Wkst. B,	4, 359, 677	719, 842	134, 264	327, 825		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1, 909. 626369	0. 081224	0. 000163	0.000398		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)						
	1	ļi	1	1	II.	•	

Provider CCN: 15-0048

Peri od:

COST ALLOCATION - STATISTICAL BASIS

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Cost Center Description OTHER A&G OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (HOURS OF (MEALS (ACCUM. COST) PLANT (SQUARE FEET) (POUNDS OF SERVICE) SERVED) LAUNDRY) 7. 00 9. 00 10.00 5.06 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1 01 1 01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5 02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 00590 OTHER A&G 379, 726, 418 5.06 5.06 7.00 00700 OPERATION OF PLANT 7, 363, 686 621, 066 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 936, 150 12, 335 1, 891, 761 8.00 6, 490 00900 HOUSEKEEPI NG 2, 830, 619 9.00 9.00 0 13, 363 10.00 01000 DI ETARY 1, 301, 447 11,035 0 305 52, 441 10.00 11.00 01100 CAFETERI A 2, 034, 187 0 11.00 9,873 0 01300 NURSING ADMINISTRATION 13.00 472, 765 1, 955 0 0 16 13.00 01400 CENTRAL SERVICES & SUPPLY 0 4, 642, 982 14 00 8.411 20 0 14 00 15.00 01500 PHARMACY 32, 554, 958 7,040 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 217, 634 0 50 16.00 1, 162 0 16.00 76 01700 SOCIAL SERVICE 3, 463, 853 0 17.00 438 0 17.00 01701 INSERVICE EDUCATION 0 17.01 3, 800, 937 9, 322 190 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 1, 728, 719 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 450, 149 0 0 0 22.00 23 00 02300 PARAMED ED PRGM 447, 811 2 807 O 81 Ω 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 825, 544 108, 140 561, 216 4, 514 33, 898 30.00 31.00 03100 INTENSIVE CARE UNIT 8, 209, 570 125, 460 873 5. 246 31.00 24, 552 04000 SUBPROVI DER - I PF 5, 760, 001 103, 358 9, 557 40.00 22, 340 759 40.00 04100 SUBPROVI DER - I RF 41.00 2, 669, 004 17,898 52, 774 436 3,740 41.00 04300 NURSERY 2, 681 43.00 779, 510 0 14 0 43.00 ANCILLARY SERVICE COST CENTERS 1, 176 50.00 05000 OPERATING ROOM 28, 055, 732 40,624 305, 361 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 928, 192 8, 316 99, 646 191 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 18, 354, 623 43, 920 193, 809 551 0 54.00 05900 CARDI AC CATHETERI ZATI ON 9, 152, 952 4, 593 108, 620 59 00 59 00 0 161 13, 574 60.00 06000 LABORATORY 12, 923, 568 C 549 0 60.00 1, 194 06500 RESPIRATORY THERAPY 2, 840, 680 0 65.00 65.00 120 66.00 06600 PHYSI CAL THERAPY 10, 182, 861 48, 220 13, 271 94 0 66.00 06900 ELECTROCARDI OLOGY 2, 909, 348 69 00 69 00 557 0 203 0 07000 ELECTROENCEPHALOGRAPHY 70.00 746, 360 5, 400 7,892 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 620 C 0 108 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 14, 645, 482 72.00 0 72.00 0 0 C 07300 DRUGS CHARGED TO PATIENTS 1, 726, 174 73.00 C 0 150 0 73.00 74.00 07400 RENAL DIALYSIS 849, 781 1,490 0 168 0 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 418, 867 0 0 0 50 76.97 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 9, 824, 866 265, 015 1, 057 91.00 91.00 22,772 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 93.00 3, 183, 596 405 55, 339 230 0 OTHER REIMBURSABLE COST CENTERS 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 508, 169 3, 752 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3, 272, 270 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 240, 013, 667 441, 296 1, 891, 761 12, 277 52, 441 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 3, 406, 697 2, 456 0 0 0 194.00 07950 RENTAL SPACE 4, 562, 755 22, 420 0 0 194.00 194. 01 07951 FOUNDATI ON 588.470 0 8 0 194.01 206 194. 02 07952 RETAIL SERVICES 674, 614 684 10 0 194.02 194. 03 07953 REID CONTRACTED SERVICES 0 0 194.03 250, 547 0 194. 04 07954 REID PHYSICIAN ASSOC. 128, 276, 215 129, 804 0 1.068 0 194.04 194. 05 07955 OTHER NRCC 8, 451 0 194.05 0 532 0 194.06 07956 VACANT SPACE 431, 078 0 0 0 194.06 23,668 194. 08 07958 CAMBRI DGE RHC 1, 513, 924 0 0 0 194.08 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 31, 565, 409 7, 975, 807 1, 172, 377 3, 149, 265 1, 623, 225 202. 00 Part I)

Health Fin	ancial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/22/2019 7:5	
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
			(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)	
				LAUNDRY)			
		5. 06	7. 00	8. 00	9. 00	10.00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 083127	12. 842125	0. 619728	235. 670508	30. 953357	203.00
204.00	Cost to be allocated (per Wkst. B,	699, 385	3, 157, 156	340, 832	198, 779	472, 724	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 001842	5. 083447	0. 18016	14. 875327	9. 014397	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)						

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & (DRUGS) RECORDS & (MANHOURS) **SUPPLY** LI BRARY (DI RECT (MFD (TOTAL NURSING HRS) SUPPLI ES) REVENUE) 11. 00 13. 00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 00550 DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 3, 980, 244 11.00 01300 NURSING ADMINISTRATION 2,080 1, 479, 766 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 37, 417 20, 033, 021 14.00 01500 PHARMACY 15.00 116, 136 10, 254 28, 536, 423 15.00 01600 MEDICAL RECORDS & LIBRARY 186, 796 823, 670, 284 16.00 0 16.00 0 01700 SOCIAL SERVICE 64, 315 17.00 0 0 Λ 17.00 17.01 01701 INSERVICE EDUCATION 39, 100 C 42 0 0 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 30, 162 0 0 0 21.00 6, 910 22 00 02200 & SERVICES-OTHER PRGM. COSTS APPRVD C 0 0 Ω 22 00 02300 PARAMED ED PRGM 23.00 5, 330 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 643, 217 643, 217 23, 060 3, 447 52, 363, 887 30.00 03100 INTENSIVE CARE UNIT 679 31 00 116, 464 46, 575 9, 350, 237 31 00 116, 464 04000 SUBPROVI DER - I PF 40.00 140,060 140,060 637 85 10, 470, 112 40.00 04100 SUBPROVI DER - I RF 44, 779 44, 779 745 4, 080, 441 41.00 74 41.00 43.00 04300 NURSERY 11, 733 11,733 0 0 2, 087, 423 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 45, 264 45, 264 2, 286, 744 103, 012 151, 669, 006 50.00 05200 DELIVERY ROOM & LABOR ROOM 8, 634, 375 52.00 18,635 18, 635 38, 831 377 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 183, 098 183, 098 98, 039 544, 906 125, 177, 677 54.00 05900 CARDI AC CATHETERI ZATI ON 59 00 55, 180 55, 180 3, 372, 114 762 94, 236, 463 59 00 60.00 06000 LABORATORY 147, 811 1, 128, 804 82, 024, 877 60.00 44 65.00 06500 RESPIRATORY THERAPY 45, 637 45, 637 6,619 5, 331 26, 454, 860 65 00 06600 PHYSI CAL THERAPY 166, 802 16, 579, 833 1, 302 66.00 66,00 82 06900 ELECTROCARDI OLOGY 220, 394 69.00 27, 248 r 26 24, 964, 279 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 12, 431 32 3, 704, 586 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 37,010 71.00 71.00 0 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 0 11, 412, 784 27, 328, 422 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 24, 877, 672 102, 944, 551 73.00 74 00 07400 RENAL DIALYSIS 0 0 355 949, 063 74.00 03950 ANCI LLARY - OTHER 76.00 0 76.00 0 0 07697 CARDI AC REHABI LI TATI ON 9, 288 9, 288 76.97 26 14 884, 812 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 166, 411 18, 535 117, 717 67, 850, 634 91.00 166, 411 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 93.00 04040 FAMILY PRACTICE 68, 787 0 41 6, 307 6, 258, 529 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 8, 048 0 214, 370 0 255, 265 96.00 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 143, 578 5, 363, 942 116. 00 45, 339 147 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 1, 479, 766 26, 024, 836 18, 659, 727 823, 670, 284 118. 00 118.00 2, 444, 478 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 C 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 194. 00 07950 RENTAL SPACE 1, 528, 200 0 0 0 0 194.00 0 194.01 194. 01 07951 FOUNDATI ON 0 0 0 194. 02 07952 RETAIL SERVICES 0 0 0 194.02 0 194. 03 07953 REID CONTRACTED SERVICES 7,566 0 0 0 0 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 1, 373, 294 2, 456, 119 0 194, 04 0 0 194. 05 07955 OTHER NRCC 0 C 0 194.05 0 194.06 07956 VACANT SPACE 0 0 0 194.06 194. 08 07958 CAMBRI DGE RHC 0 O 0 194.08 55, 468

200.00

201.00

Cross Foot Adjustments

Negative Cost Centers

200.00

201.00

Health Financial Systems REI	D HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co	CN: 15-0048	Peri od:	Worksheet B-1	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					5/22/2019 7:5	9 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(MANHOURS)	ADMI NI STRATI O	SERVICES &	(DRUGS)	RECORDS &	
		N	SUPPLY		LI BRARY	
		(DI RECT	(MED		(TOTAL	
		NURSING HRS)	SUPPLI ES)		RÈVENUE)	
	11. 00	13. 00	14.00	15. 00	16. 00	
202.00 Cost to be allocated (per Wkst. B,	2, 330, 073	542, 160	5, 163, 57	1 35, 422, 193	7, 953, 673	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part	0. 585410	0. 366382	0. 25775	3 1. 241298	0. 009656	203.00
204.00 Cost to be allocated (per Wkst. B,	211, 535	69, 501	747.70	660, 337	430, 195	204.00
Part II)	,				,	
	1	1				1

0. 053146

0. 046968

0. 037323

0. 023140

0. 000522 205. 00

206. 00

207. 00

205.00

206.00

207.00

11)

Unit cost multiplier (Wkst. B, Part

(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)

NAHE adjustment amount to be allocated

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am INTERNS & RESIDENTS PARAMED ED SOCI AL I NSERVI CE SERVI CES-SALA | SERVI CES-OTHE Cost Center Description SERVI CE **FDUCATION** RY & FRINGES R PRGM COSTS PRGM (ASSI GNED (TIME SPENT) (TIME SPENT) (IN HOUSE ED) (ASSI GNED TIME) TIME) 17. 00 17. 01 23.00 21.00 22.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00570 ADMITTING 5.04 5 04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 16 00 17.00 01700 SOCIAL SERVICE 48,888 17.00 01701 INSERVICE EDUCATION 135, 915 17.01 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 1.345 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 1, 345 22 00 22 00 0 23.00 02300 PARAMED ED PRGM 892 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 34, 585 30, 563 1. 040 1.040 0 31 00 03100 INTENSIVE CARE UNIT 2.019 7.651 93 93 0 31.00 40.00 04000 SUBPROVI DER - I PF 6, 496 0 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 0 1,881 0 ol 0 41.00 04300 NURSERY 0 43.00 0 403 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,983 62 62 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 178 0 0 0 52.00 665 05400 RADI OLOGY-DI AGNOSTI C 32 32 100 54.00 0 8. 152 54.00 1, 995 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 59.00 60 00 06000 LABORATORY 0 5, 582 0 0 0 60.00 0 06500 RESPIRATORY THERAPY 0 2.725 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 6,060 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 1, 261 40 40 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 224 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 C 0 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 0 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 184 ol 03950 ANCI LLARY - OTHER o 0 76.00 0 76.00 76. 97 07697 CARDIAC REHABILITATION 308 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 78 78 0 91.00 10, 106 7. 280 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 93.00 04040 FAMILY PRACTICE 0 1,563 0 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96 00 0 0 96.00 538 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1. 284 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 48, 888 87, 690 1, 345 1, 345 100 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES О 0 0 190.00 0 0 0 C 0 0 192.00 194.00|07950|RENTAL SPACE 0 C 0 194, 00 194. 01 07951 FOUNDATI ON 0 0 0 0 194. 01 36 0 194. 02 07952 RETAIL SERVICES 73 0 0 0 0 194. 02 194. 03 07953 REID CONTRACTED SERVICES 0 0 194. 03 C 194. 04 07954 REID PHYSICIAN ASSOC. 0 35, 812 0 0 194, 04

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10, 791

1, 513

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0 194.05

0 194.06

0 194.08

200.00

201.00

200.00

201.00

194. 05 07955 OTHER NRCC

194.06 07956 VACANT SPACE

194. 08 07958 CAMBRI DGE RHC

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2552	2-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0048	Peri od: Worksheet B-1	

					o 12/31/2018	Date/Time Pre 5/22/2019 7:5	
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	I NSERVI CE EDUCATI ON (I N HOUSE ED)	RY & FRINGES	SERVI CES-OTHE R PRGM. COSTS (ASSI GNED	PARAMED ED PRGM (TIME SPENT)	
				TIME)	TIME)		
		17. 00	17. 01	21.00	22. 00	23. 00	
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 812, 980	4, 304, 289	1, 890, 079	491, 614	571, 542	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	77. 994191	31. 668977	1, 405. 263197	365. 512268	5, 715. 420000	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	91, 052	538, 703	5, 274	37, 201	121, 408	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	1. 862461	3. 963529	3. 921190	27. 658736	1, 214. 080000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0. 000000	207. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 43, 114, 115 43, 114, 115 0 43, 114, 115 30.00 03100 INTENSIVE CARE UNIT 10, 266, 931 10, 266, 931 0 10, 266, 931 31.00 31.00 40.00 04000 SUBPROVI DER - I PF 7, 504, 854 7, 504, 854 0 7, 504, 854 40.00 04100 SUBPROVI DER - I RF 3, 513, 816 3, 513, 816 0 3, 513, 816 41.00 41.00 43.00 04300 NURSERY 926, 124 926, 124 926, 124 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 33, 664, 004 50.00 33, 664, 004 33, 664, 004 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 2, 604, 557 2, 604, 557 2, 604, 557 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 608, 733 23, 608, 733 0 23, 608, 733 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 11, 973, 816 11, 973, 816 0 11, 973, 816 59.00 0 06000 LABORATORY 15, 647, 913 15, 647, 913 60.00 15, 647, 913 60.00 06500 RESPIRATORY THERAPY 65.00 3, 513, 936 0 3, 513, 936 3, 513, 936 65.00 06600 PHYSI CAL THERAPY 12, 129, 051 12, 129, 051 0 12, 129, 051 66.00 66.00 06900 ELECTROCARDI OLOGY 69.00 3, 776, 710 3, 776, 710 0 0 3, 776, 710 69.00 07000 ELECTROENCEPHALOGRAPHY 932.791 932.791 932. 791 70 00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 481 26, 481 26, 481 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 19, 068, 477 19, 068, 477 19, 068, 477 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 33, 779, 640 33, 779, 640 33, 779, 640 73.00 73.00 07400 RENAL DIALYSIS 994, 581 74.00 994, 581 994, 581 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 492, 632 492, 632 76.97 0 492, 632 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 13, 330, 573 13, 330, 573 0 13, 330, 573 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 4, 448, 444 4, 448, 444 4, 448, 444 92.00 04040 FAMILY PRACTICE 3, 699, 979 3, 699, 979 3, 699, 979 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 678, 065 678, 065 0 678, 065 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3, 873, 360 3, 873, 360 3, 873, 360 116. 00 200.00 Subtotal (see instructions) 253, 569, 583 0 253, 569, 583 0 253, 569, 583 200. 00 4, 448, 444 201. 00 201.00 Less Observation Beds 4, 448, 444 4, 448, 444 202.00 249, 121, 139 249, 121, 139 0 249, 121, 139 202. 00 Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 45, 151, 769 30.00 03000 ADULTS & PEDIATRICS 45, 151, 769 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 350, 237 9, 350, 237 31.00 04000 SUBPROVI DER - I PF 10, 470, 112 10, 470, 112 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4, 080, 441 4, 080, 441 41.00 04300 NURSERY 2, 087, 423 43.00 2, 087, 423 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 54, 670, 875 96, 998, 131 151, 669, 006 0.221957 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 928, 468 0. 301650 0.000000 52.00 7, 705, 907 8, 634, 375 52.00 05400 RADI OLOGY-DI AGNOSTI C 29, 002, 655 96, 175, 022 0.188602 0.000000 54.00 125, 177, 677 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 36, 838, 482 57, 397, 981 94, 236, 463 0.127061 0.000000 59.00 60.00 06000 LABORATORY 32, 839, 660 49, 185, 217 82, 024, 877 0. 190770 0.000000 60.00 06500 RESPIRATORY THERAPY 23, 610, 522 65.00 26, 454, 860 0.000000 65.00 2, 844, 338 0. 132828 66.00 06600 PHYSI CAL THERAPY 6, 820, 693 9, 759, 140 16, 579, 833 0.731554 0.000000 66.00 06900 ELECTROCARDI OLOGY 5, 357, 055 19, 607, 224 24, 964, 279 0.151285 69 00 0.000000 69.00 38, 955 3, 704, 586 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 3, 665, 631 0.251794 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.715509 71.00 36, 875 135 37, 010 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 17, 163, 965 10, 164, 457 27, 328, 422 0.697753 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 999, 139 57, 945, 412 73.00 102, 944, 551 0.328134 0.000000 73.00 07400 RENAL DIALYSIS 890, 101 1.047961 74.00 58, 962 949, 063 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0 0.000000 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 6, 362 878, 450 884, 812 0.556765 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 15, 467, 468 52, 383, 166 67, 850, 634 0.196469 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 924, 453 5, 287, 665 7, 212, 118 0.616801 0.000000 92.00 04040 FAMILY PRACTICE 12,868 0.591190 93.00 6, 245, 661 6, 258, 529 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 255, 265 0.000000 96.00 0 255, 265 2. 656318 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1 265 305 4, 098, 637 5 363 942 116 00 200.00 Subtotal (see instructions) 349, 791, 322 473, 878, 962 823, 670, 284 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 349, 791, 322 473, 878, 962 823, 670, 284 202.00

				To 12/31/2018	Date/Time Prepared:   5/22/2019 7:59 am	:
			Title XVIII	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·		
	<b>'</b>	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					_
30.00	03000 ADULTS & PEDIATRICS				30.0	)()
31.00	03100 INTENSIVE CARE UNIT				31.0	)()
40.00	04000 SUBPROVI DER - I PF				40.0	)()
41.00	04100 SUBPROVI DER - I RF				41.0	)()
43.00	04300 NURSERY				43.0	)()
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 221957			50.0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 301650			52.0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 188602			54.0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 127061			59.0	)()
60.00	06000 LABORATORY	0. 190770			60.0	)()
65.00	06500 RESPI RATORY THERAPY	0. 132828			65.0	)()
66.00	06600 PHYSI CAL THERAPY	0. 731554			66.0	)()
69.00	06900 ELECTROCARDI OLOGY	0. 151285			69. 0	)()
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 251794			70.0	)()
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 715509			71.0	)()
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 697753			72.0	)()
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 328134			73.0	)()
74.00	07400 RENAL DIALYSIS	1. 047961			74.0	)()
76.00	03950 ANCI LLARY - OTHER	0. 000000			76.0	)()
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 556765			76. 9	₽7
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY	0. 196469			91. 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 616801			92.0	
93.00	04040 FAMILY PRACTICE	0. 591190			93. 0	)()
	OTHER REIMBURSABLE COST CENTERS					
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	2. 656318			96. 0	)()
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE				113. 0	
	11600 H0SPI CE				116. 0	
200.00	,				200. 0	
201.00					201. 0	
202.00	Total (see instructions)				202. 0	)O

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Title XIX Hospi tal Cost Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 43, 114, 115 43, 114, 115 0 43, 114, 115 30.00 03100 INTENSIVE CARE UNIT 10, 266, 931 10, 266, 931 0 10, 266, 931 31.00 31.00 40.00 04000 SUBPROVI DER - I PF 7, 504, 854 7, 504, 854 0 7, 504, 854 40.00 04100 SUBPROVI DER - I RF 3, 513, 816 3, 513, 816 0 3, 513, 816 41.00 41.00 43.00 04300 NURSERY 926, 124 926, 124 926, 124 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 33, 664, 004 50.00 33, 664, 004 33, 664, 004 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 2, 604, 557 2, 604, 557 2, 604, 557 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 608, 733 23, 608, 733 0 23, 608, 733 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 11, 973, 816 11, 973, 816 0 11, 973, 816 59.00 0 06000 LABORATORY 15, 647, 913 15, 647, 913 15, 647, 913 60.00 60.00 06500 RESPIRATORY THERAPY 65.00 3, 513, 936 0 3, 513, 936 3, 513, 936 65.00 06600 PHYSI CAL THERAPY 12, 129, 051 12, 129, 051 0 12, 129, 051 66.00 66.00 06900 ELECTROCARDI OLOGY 69.00 3, 776, 710 3, 776, 710 0 0 3, 776, 710 69.00 07000 ELECTROENCEPHALOGRAPHY 932.791 932.791 932. 791 70 00 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 481 26, 481 26, 481 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 19, 068, 477 19, 068, 477 19, 068, 477 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 33, 779, 640 33, 779, 640 33, 779, 640 73.00 73.00 07400 RENAL DIALYSIS 994, 581 74.00 994, 581 994, 581 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 492, 632 492, 632 76.97 0 492, 632 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 13, 330, 573 13, 330, 573 0 13, 330, 573 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 4, 448, 444 4, 448, 444 4, 448, 444 92.00 04040 FAMILY PRACTICE 3, 699, 979 3, 699, 979 3, 699, 979 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 678, 065 678, 065 0 678, 065 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3, 873, 360 3, 873, 360 3, 873, 360 116. 00 200.00 Subtotal (see instructions) 253, 569, 583 0 253, 569, 583 0 253, 569, 583 200. 00 4, 448, 444 201. 00 201.00 Less Observation Beds 4, 448, 444 4, 448, 444 202.00 249, 121, 139 249, 121, 139 0 249, 121, 139 202. 00 Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 45, 151, 769 30.00 03000 ADULTS & PEDIATRICS 45, 151, 769 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 350, 237 9, 350, 237 31.00 04000 SUBPROVI DER - I PF 10, 470, 112 10, 470, 112 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 4, 080, 441 4, 080, 441 41.00 04300 NURSERY 2, 087, 423 43.00 2, 087, 423 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 54, 670, 875 96, 998, 131 151, 669, 006 0.221957 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 928, 468 0. 301650 0.000000 52.00 7, 705, 907 8, 634, 375 52.00 05400 RADI OLOGY-DI AGNOSTI C 29, 002, 655 96, 175, 022 0.188602 0.000000 54.00 125, 177, 677 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 36, 838, 482 57, 397, 981 94, 236, 463 0.127061 0.000000 59.00 60.00 06000 LABORATORY 32, 839, 660 49, 185, 217 82, 024, 877 0. 190770 0.000000 60.00 06500 RESPIRATORY THERAPY 23, 610, 522 65.00 26, 454, 860 0.000000 65.00 2, 844, 338 0. 132828 66.00 06600 PHYSI CAL THERAPY 6, 820, 693 9, 759, 140 16, 579, 833 0.731554 0.000000 66.00 06900 ELECTROCARDI OLOGY 5, 357, 055 19, 607, 224 24, 964, 279 0.151285 69 00 0.000000 69.00 38, 955 3, 704, 586 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 3, 665, 631 0.251794 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.715509 71.00 36, 875 135 37, 010 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 17, 163, 965 10, 164, 457 27, 328, 422 0.697753 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 44, 999, 139 57, 945, 412 73.00 102, 944, 551 0.328134 0.000000 73.00 07400 RENAL DIALYSIS 890, 101 1.047961 74.00 58, 962 949, 063 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0 0.000000 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 6, 362 878, 450 884, 812 0.556765 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 15, 467, 468 52, 383, 166 67, 850, 634 0.196469 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 924, 453 5, 287, 665 7, 212, 118 0.616801 0.000000 92.00 04040 FAMILY PRACTICE 12,868 0.591190 93.00 6, 245, 661 6, 258, 529 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 255, 265 0.000000 96.00 0 255, 265 2. 656318 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1 265 305 4, 098, 637 5 363 942 116 00 200.00 Subtotal (see instructions) 349, 791, 322 473, 878, 962 823, 670, 284 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 349, 791, 322 473, 878, 962 823, 670, 284 202.00

				To 12/31/2018	Date/Time Prepared 5/22/2019 7:59 am	
			Title XIX	Hospi tal	Cost	_
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.0	00
31.00	03100 INTENSIVE CARE UNIT				31. (	00
40.00	04000 SUBPROVI DER - I PF				40.0	00
41.00	04100 SUBPROVI DER - I RF				41. (	00
43.00	04300 NURSERY				43.0	00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000			50. (	00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0	00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0	00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. (	00
60.00	06000 LABORATORY	0. 000000			60.0	00
65.00	06500 RESPIRATORY THERAPY	0. 000000			65. (	00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66. (	00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69. (	00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. (	00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. (	00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. (	00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. (	00
74.00	07400 RENAL DIALYSIS	0. 000000			74. (	00
76.00	03950 ANCI LLARY - OTHER	0. 000000			76. (	00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76.9	97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0. 000000			91. (	00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. (	00
93.00	04040 FAMILY PRACTICE	0. 000000			93.0	00
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. (	00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>				
113.00	11300   NTEREST EXPENSE				113. (	00
116.00	11600 HOSPI CE				116. (	00
200.00	Subtotal (see instructions)				200. (	00
201.00	Less Observation Beds				201. (	00
202.00	Total (see instructions)				202. (	00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre	
		Ti +I o	: XVIII	Hospi tal	5/22/2019 7: 5 PPS	9 am
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
cost center bescription	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Auj ustilierit	Related Cost		col . 4)	
	B, Part II,		(col . 1 -		COI. 4)	
	col. 26)		col . 2)			
	1, 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					<u> </u>	
30. 00 ADULTS & PEDIATRICS	4, 122, 158	0	4, 122, 158	35, 996	114. 52	30.00
31.00 INTENSIVE CARE UNIT	1, 197, 654		1, 197, 654		228. 30	31.00
40. 00 SUBPROVIDER - IPF	720, 106	0	720, 100	9, 557	75. 35	40.00
41. 00 SUBPROVI DER - I RF	549, 147	0	549, 14	3, 725	147. 42	41.00
43. 00 NURSERY	76, 309		76, 309	2, 015	37. 87	43.00
200.00 Total (lines 30 through 199)	6, 665, 374		6, 665, 374	56, 539		200.00
Cost Center Description	Inpatient	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	18, 584					30.00
31.00   INTENSIVE CARE UNIT	2, 657					31.00
40. 00 SUBPROVI DER - I PF	5, 396					40.00
41. 00 SUBPROVI DER – I RF	2, 289		•			41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	28, 926	3, 478, 866	I			200. 00

Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
	1	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	2, 811, 552		l .			
52.00	05200 DELIVERY ROOM & LABOR ROOM	332, 771					52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 004, 201		l .			
59. 00	05900 CARDI AC CATHETERI ZATI ON	870, 264		l .			59.00
60.00	06000 LABORATORY	1, 014, 096					60.00
65.00	06500 RESPI RATORY THERAPY	177, 763					
66.00	06600 PHYSI CAL THERAPY	1, 763, 717		l .			66.00
69. 00	06900 ELECTROCARDI OLOGY	370, 603		l .			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	150, 589	3, 704, 586	0. 04064	19 31, 150	1, 266	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 648					
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	482, 542	27, 328, 422	0. 01765	10, 690, 092	188, 755	
73.00	07300 DRUGS CHARGED TO PATIENTS	692, 572	102, 944, 551	0. 00672	28 23, 459, 925	157, 838	73.00
74.00	07400 RENAL DIALYSIS	48, 927	949, 063	0. 05155	574, 330	29, 608	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0. 00000	00	0	76.00
76. 97	07697 CARDIAC REHABILITATION	91, 989	884, 812	0. 10396	6, 362	661	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 072, 553	67, 850, 634	0. 01580	11, 583, 677	183, 115	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	425, 316	7, 212, 118	0. 05897	1, 247, 212	73, 551	92.00
93.00	04040 FAMILY PRACTICE	306, 517	6, 258, 529	0. 04897	76 12, 175	596	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	158, 444	255, 265	0. 62070	04 0	0	96.00
200.00	Total (lines 50 through 199)	13, 776, 064	747, 166, 360		156, 089, 765	2, 452, 261	200.00

	HOSPITAL & HEA			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	Provider Co	F	Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		1		Cost	
	1A	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	C	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00   04000   SUBPROVI DER - I PF	0	0		0	0	40.00
41. 00   04100   SUBPROVI DER -   RF	0	0	l c	0	0	41.00
43. 00 04300 NURSERY	0	0	l c	0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)			Í		
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•	•	•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	35, 996	0.00	18, 584	30.00
31.00 03100 INTENSIVE CARE UNIT		0	5, 246	0.00	2, 657	31.00
40. 00   04000   SUBPROVI DER - I PF	0	0	9, 557	0.00	5, 396	40.00
41. 00   04100   SUBPROVI DER -   RF	0	0	3, 725	0.00	2, 289	41.00
43. 00 04300 NURSERY		l o	2, 015		0	43.00
200.00 Total (lines 30 through 199)		l o	56, 539		28, 926	200.00
Cost Center Description	Inpatient		<u> </u>			
•	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT POLITINE SERVICE COST CENTERS						

30. 00 31. 00 40. 00

41. 00 43. 00

200.00

MCRI F32 - 15. 5. 166. 1

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY

Total (lines 30 through 199)

200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

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

					10 12/31/2016	5/22/2019 7:5	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	571, 542	54.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
	06000 LABORATORY	0	0		0	0	60.00
	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	07400 RENAL DIALYSIS	0	0		0	0	74.00
	03950 ANCI LLARY - OTHER	0	0		0	0	76.00
	07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	04040 FAMILY PRACTICE	0	0		0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
200.00	Total (lines 50 through 199)	0	0		0 0	571, 542	200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0048 | Peri od: | Worksheet D | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time | Prepared: THROUGH COSTS

Title XVIII   Hospital   PPS
Medical Education Cost   Sum of cols.   Cost (sum of cols.   Cost (sum of cols.   Cost (sum of cols.   Cost (sum of cols.   Col.   Sum of cols.   Col.
Education   1, 2, 3, and   Cost (sum of col s. 2, 3, and 4)   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and 4, 3   Cost (sum of col s. 2, 3, and and 4, and 4
Cost   4)   Cols. 2, 3, and 4, and
ANCI LLARY SERVI CE COST CENTERS
ANCILLARY SERVICE COST CENTERS   SOUNT   SOU
ANCI LLARY SERVI CE COST CENTERS   S0.00   O   O   O   O   O   O   O   O   O
50. 00         05000         OPERATI NG ROOM         0         0         151, 669, 006         0.000000         50.00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         8, 634, 375         0.000000         52.00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         571, 542         571, 542         125, 177, 677         0.004566         54.00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         94, 236, 463         0.000000         59.00           60. 00         06000         LABORATORY         0         0         0         82, 024, 877         0.000000         60.00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         26, 454, 860         0.000000         65.00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         16, 579, 833         0.000000         65.00           69. 00         06900         ELECTROCARDI OLOGY         0         0         0         24, 964, 279         0.000000         69.00           70. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0
52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         8, 634, 375         0.000000         52. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         571, 542         125, 177, 677         0.004566         54. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         94, 236, 463         0.000000         59. 00           60. 00         06000         LABORATORY         0         0         0         82, 024, 877         0.000000         60. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         26, 454, 860         0.000000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         16, 579, 833         0.000000         66. 00           69. 00         06900         ELECTROCARDI OLOGY         0         0         0         24, 964, 279         0.000000         69. 00           70. 00         07000         ELECTROCARDI OLOGY         0         0         3, 704, 586         0.000000         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0
54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         571, 542         125, 177, 677         0.004566         54. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         94, 236, 463         0.000000         59. 00           60. 00         06000         LABORATORY         0         0         0         82, 024, 877         0.000000         60. 00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         26, 454, 860         0.00000         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         16, 579, 833         0.000000         66. 00           69. 00         06900         ELECTROCARDI OLOGY         0         0         0         24, 964, 279         0.000000         66. 00           70. 00         07000         ELECTROCARDI OLOGY         0         0         0         3, 704, 586         0.000000         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         37, 010         0.000000         72. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0
59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       94, 236, 463       0.000000       59. 00         60. 00       06000       LABORATORY       0       0       0       82, 024, 877       0.000000       60. 00         65. 00       06500       RESPI RATORY THERAPY       0       0       0       26, 454, 860       0.000000       65. 00         66. 00       06600       PHYSI CAL THERAPY       0       0       0       16, 579, 833       0.000000       66. 00         69. 00       06900       ELECTROCARDI OLOGY       0       0       0       24, 964, 279       0.000000       69. 00         70. 00       07000       ELECTROCARDI OLOGY       0       0       0       3, 704, 586       0.000000       70.00         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       37, 010       0.000000       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       27, 328, 422       0.000000       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       0       102, 944, 551       0.000000       73. 00
60. 00 06000 LABORATORY 0 0 0 0 82, 024, 877 0. 000000 60. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 26, 454, 860 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 16, 579, 833 0. 000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 24, 964, 279 0. 000000 69. 00 0 0 24, 964, 279 0. 000000 69. 00 0 0 3, 704, 586 0. 000000 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 27, 328, 422 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 102, 944, 551 0. 000000 73. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 26, 454, 860 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 16, 579, 833 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 24, 964, 279 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 3, 704, 586 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 27, 328, 422 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 102, 944, 551 0.000000 73. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 16, 579, 833 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 24, 964, 279 0.000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 3, 704, 586 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 37, 010 0.000000 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 102, 944, 551 0.000000 73. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 24, 964, 279 0. 000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 3, 704, 586 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 37, 010 0. 000000 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 102, 944, 551 0. 000000 73. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   3,704,586   0.000000   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   37,010   0.000000   71.00   72.00   07200   MPL. DEV. CHARGED TO PATIENT   0   0   0   102,944,551   0.000000   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   102,944,551   0.000000   73.00   0   0   0   0   0   0   0   0   0
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   37,010   0.000000   71.00   72.00   07200   MPL. DEV. CHARGED TO PATIENT   0   0   0   102,944,551   0.000000   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   102,944,551   0.000000   73.00   7
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT 0 0 0 27, 328, 422 0.000000 72. 00 73. 00   07300   DRUGS CHARGED TO PATIENTS 0 0 0 102, 944, 551 0.000000 73. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 102, 944, 551 0. 000000 73. 00
74. 00   07400  RENAL DI ALYSI S 0 0 0 949, 063 0. 000000   74. 00
76. 00   03950  ANCI LLARY - 0THER   0  0  0  0  0. 000000  76. 00
76. 97   O7697   CARDI AC REHABI LI TATI ON   O   O   884, 812   O. 000000   76. 97
OUTPATIENT SERVICE COST CENTERS
91. 00   09100  EMERGENCY   0   0   67, 850, 634   0. 000000   91. 00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   7, 212, 118   0.000000   92. 00
93. 00   04040  FAMILY PRACTICE   0   0   6, 258, 529   0. 000000   93. 00
OTHER REIMBURSABLE COST CENTERS
96. 00   09600  DURABLE MEDI CAL EQUI P-RENTED   0   0   255, 265   0. 000000   96. 00
200.00   Total (Lines 50 through 199)   0  571,542  571,542  747,166,360   200.00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0048	From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/22/2019 7:59 am	

				T	o 12/31/2018	Date/Time Pre 5/22/2019 7:5	
			Title	XVIII	Hospi tal	PPS	, am
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	-	Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000  OPERATI NG ROOM	0. 000000	31, 584, 295	0	34, 918, 836	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	25, 856		15, 900		52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0. 004566	18, 162, 532	82, 930	44, 908, 880	205, 054	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	21, 187, 036		33, 522, 175	0	59.00
60.00	06000 LABORATORY	0. 000000	18, 176, 123		8, 869, 791	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	13, 909, 553		1, 313, 471	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 179, 098		58, 900	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	3, 244, 263	0	6, 275, 552	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	31, 150		1, 834, 188	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	16, 086		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	10, 690, 092	0	5, 216, 566	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	23, 459, 925	0	26, 973, 571	0	73.00
	07400 RENAL DIALYSIS	0. 000000	574, 330	0	50, 439	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	6, 362	0	527, 491	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 000000	11, 583, 677	0	13, 990, 751	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 247, 212	0	1, 492, 599	0	92.00
93.00	04040 FAMILY PRACTICE	0. 000000	12, 175	0	3, 042, 372	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	-	0	, , , , , ,
200.00	Total (lines 50 through 199)		156, 089, 765	82, 930	183, 011, 482	205, 054	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 5/22/2019 7:59 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 34, 918, 836 0. 221957 7, 750, 480 50.00 05200 DELIVERY ROOM & LABOR ROOM 0. 301650 0 0 52.00 15, 900 4, 796 52.00 05400 RADI OLOGY-DI AGNOSTI C 44, 908, 880 0 54.00 0. 188602 8, 469, 905 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.127061 33, 522, 175 0 4, 259, 361 59.00 60.00 06000 LABORATORY 0. 190770 8, 869, 791 1, 692, 090 60.00 0 06500 RESPIRATORY THERAPY 1, 313, 471 65.00 0.132828 0 174, 466 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0. 731554 58, 900 43,089 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 151285 6, 275, 552 0 0 949, 397 69.00 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 251794 1, 834, 188 461, 838 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.715509 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.697753 5, 216, 566 0 0 3, 639, 875 72.00 07300 DRUGS CHARGED TO PATIENTS 26, 973, 571 8, 850, 946 73.00 0.328134 118 42, 229 73.00 07400 RENAL DIALYSIS 74 00 1 047961 50, 439 0 0 52, 858 74 00 0 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0. 556765 527, 491 0 293, 689 76.97 OUTPATIENT SERVICE COST CENTERS 13, 990, 751 91.00 91 00 0. 196469 2, 748, 749 09100 EMERGENCY 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.616801 1, 492, 599 0 920, 637 92.00 04040 FAMILY PRACTICE 0. 591190 3, 042, 372 0 0 1, 798, 620 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 2.656318 96.00 Ωl 200.00 Subtotal (see instructions) 183, 011, 482 118 42, 229 42, 110, 796 200. 00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 Only Charges Net Charges (line 200 - line 201) 202.00 183, 011, 482 42, 110, 796 202. 00 118 42, 229

Health Financial Systems In Lieu of Form CMS-2552-10 REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0048 Peri od: Worksheet D From 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 5/22/2019 7:59 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 52.00 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06900 ELECTROCARDI OLOGY 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 39 13, 857 73.00 0 07400 RENAL DIALYSIS 74.00 Ω 74 00 76.00 03950 ANCI LLARY - OTHER 0 76.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 0 n 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 92.00 93.00 04040 FAMILY PRACTICE 0 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 200.00 Subtotal (see instructions) 39 13,857 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

39

13, 857

202.00

202.00

Net Charges (line 200 - line 201)

Hool +b	Financial Systems DELD	HOSPITAL & HEA	ITH CADE SERVI	CEC	In Lie	u of Form CMS-2	neen 10
	Financial Systems REID FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Peri od:	Worksheet D	2332-10
ALLOK	TOWNENT OF THE ATTENT AND LEAKT SERVICE CALLED	AL 00313			From 01/01/2018 To 12/31/2018	Part II	
			Title	: XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	·	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)	ŕ	,			
		1. 00	2.00	3.00	4. 00	5. 00	
-	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 811, 552	151, 669, 006	0. 01853	7 104, 316	1, 934	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	332, 771	8, 634, 375	0. 03854	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 004, 201	125, 177, 677	0. 02399	9 411, 160	9, 867	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	870, 264	94, 236, 463	0. 00923	5 23, 713	219	59.00
60.00	06000 LABORATORY	1, 014, 096	82, 024, 877	0. 01236	3 713, 207	8, 817	60.00
65.00	06500 RESPIRATORY THERAPY	177, 763	26, 454, 860	0. 00671	9 425, 481	2, 859	65.00
66.00	06600 PHYSI CAL THERAPY	1, 763, 717	16, 579, 833	0. 10637	7 236, 989	25, 210	66.00
69. 00	06900 ELECTROCARDI OLOGY	370, 603	24, 964, 279	0. 01484	5 16, 404	244	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	150, 589	3, 704, 586	0. 04064	9 2, 586	105	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 648	37, 010	0. 04452	9 63	3	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	482, 542	27, 328, 422	0. 01765	7 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	692, 572	102, 944, 551	0. 00672	8 1, 143, 079	7, 691	73.00
74.00	07400 RENAL DIALYSIS	48, 927	949, 063	0. 05155	3 4, 244	219	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0. 00000	0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	91, 989	884, 812	0. 10396	4 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 072, 553	67, 850, 634	0. 01580	8 558, 105	8, 823	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7, 212, 118	0.00000	0	0	92.00
93.00	04040 FAMILY PRACTICE	306, 517	6, 258, 529	0. 04897	6 125	6	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00		158, 444					,
200.00	Total (lines 50 through 199)	13, 350, 748	747, 166, 360	l	3, 639, 472	65, 997	200.00

Hoal th	Financial Systems REID	HOSPITAL & HEA	NITH CAPE SEDVI	CES	In Lie	eu of Form CMS-	2552_10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI				Peri od:	Worksheet D	2332-10
	CH COSTS	WICE OTHER TAC			From 01/01/2018	Part IV	
			Component	CCN: 15-S048	To 12/31/2018	B Date/Time Pre 5/22/2019 7:5	pared:
			T: +1 a	· XVIII	Subprovi der -	5/22/2019 7:5	9 am
			11116	XVIII	I PF	PP3	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	5051 501161 50501 Pt. 611	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 (	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	571, 542	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59.00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	74. 00
76. 00	03950 ANCI LLARY - OTHER	0	0	1	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 (	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		1	ı			
	09100 EMERGENCY	0	0	1	0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
93. 00	04040 FAMILY PRACTICE	0	0		0 (	) 0	93.00
04 00	OTHER REIMBURSABLE COST CENTERS  O9600 DURABLE MEDICAL EQUIP-RENTED	0		1		0	96.00
200.00			0		0 0		
200.00		1		TI .	o <sub>l</sub>	رار 371,342	1200.00

	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10									
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co		Peri od:	Worksheet D				
THROUG	H COSTS		Component (		From 01/01/2018 To 12/31/2018		pared: 9 am			
			Title	XVIII	Subprovi der -	PPS				
					I PF					
	Cost Center Description	All Other	Total Cost	Total	Total Charges					
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges				
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷				
		Cost	4)	col s. 2, 3, and 4)	col. 8)	col . 7)				
		4. 00	5. 00	6.00	7. 00	8. 00				
	ANCILLARY SERVICE COST CENTERS			•						
50.00	05000 OPERATING ROOM	0	0	(	151, 669, 006	0.000000	50.00			
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	8, 634, 375	0.000000	52.00			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	571, 542	571, 542	125, 177, 677	0. 004566	54.00			
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	94, 236, 463	0.000000	59.00			
60.00	06000 LABORATORY	0	0	(	82, 024, 877	0.000000	60.00			
65.00	06500 RESPI RATORY THERAPY	0	0	(	26, 454, 860	0.000000	65.00			
66.00	06600 PHYSI CAL THERAPY	0	0	(	16, 579, 833	0.000000	66.00			
69.00	06900 ELECTROCARDI OLOGY	0	0	(	24, 964, 279	0.000000	69.00			
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	3, 704, 586	0.000000				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	37, 010	0.000000	71.00			
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	2.,020, .22	0.000000				
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	102, 944, 551	0.000000				
74.00	07400 RENAL DI ALYSI S	0	0	(	949, 063					
76.00	03950 ANCI LLARY - OTHER	0	0	(	0	0. 000000				
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(	884, 812	0.000000	76. 97			
	OUTPATIENT SERVICE COST CENTERS									
91.00	09100 EMERGENCY	0	0	(	67, 850, 634					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	7, 212, 118					
93.00	04040 FAMILY PRACTICE	0	0	(	6, 258, 529	0.000000	93.00			
	OTHER REIMBURSABLE COST CENTERS									
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		255, 265		1			
200.00	Total (lines 50 through 199)	0	571, 542	571, 542	747, 166, 360		200. 00			

Heal th	Financial Systems REID	HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUG	SH COSTS		Component (		From 01/01/2018 Fo 12/31/2018		narod:
			Component	JCN. 13-3046	10 12/31/2010	5/22/2019 7:5	
			Title	XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)	40.00	x col . 10)	40.00	x col . 12)	
	ANOULL ARV CERVI OF COCT OFNITERS	9. 00	10. 00	11. 00	12. 00	13. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.000000	104 217			0	F0 00
50.00	05000 OPERATING ROOM	0. 000000	104, 316		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	l `	9	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 004566	411, 160	1, 87			54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	23, 713	(	0	0	59.00
60.00	06000 LABORATORY	0. 000000	713, 207	(	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	425, 481	(	44	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	236, 989	(	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	16, 404	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 586	(	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	63	(	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	0	(	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 143, 079	(	49	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	4, 244	(	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000	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	558, 105		3, 158		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
93. 00	04040 FAMILY PRACTICE	0. 000000	125	(	0 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS		_		_1	_	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	
200. 00	Total (lines 50 through 199)	1	3, 639, 472	1, 87	7 3, 526	1	200. 00

Heal th	Financial Systems REI	D HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 01/01/2018		
			Component	CCN: 15-S048	To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
-			Ti +Lo	XVIII	Subprovi der -	PPS	9 alli
			11116	XVIII	I PF	113	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	555 551151 25551 Pt. 511	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	( , , , , , , , , , , , , , , , , , , ,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	ĺ	Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 221957	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 301650	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 188602	275		0	52	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 127061	0		0	0	59.00
60.00	06000 LABORATORY	0. 190770	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 132828	44		0 0	6	65.00
66.00	06600 PHYSI CAL THERAPY	0. 731554	0		0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 151285	0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 251794	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 715509	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 697753	1		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 328134	49		0 1, 712	16	73.00
74.00	07400 RENAL DI ALYSI S	1. 047961	0		0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000			0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 556765	0		0 0	0	76. 97

0. 196469 0. 616801

0. 591190

2. 656318

0

3, 158

3,526

3, 526

0

0

1, 712

1, 712

0 0

0 0 0

0

620

0 93.00

91.00

92.00 0

96.00 0 694 200. 00 201. 00

694 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

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

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

04040 FAMILY PRACTICE

93.00

200.00

201.00

	Component	CCN: 15-S048	From 01/01/2018 To 12/31/2018		epared: 59 am
	Title	XVIII	Subprovi der - I PF	PPS	
Cost Reimbursed Services Subject To Ded. & Coins. [ (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
6. 00	7. 00				
0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 562				50. 00 52. 00 54. 00 59. 00 60. 00 65. 00 66. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00
0 0 0		•			91. 0 92. 0 93. 0
0 0		1			96. 00 200. 00 201. 00
	Cost Rei mbursed Servi ces Subj ect To Ded. & Coi ns. (see i nst.) 6.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Rei mbursed Servi ces Subj ect To Ded. & Coi ns. (see i nst.) 6.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Rei mbursed Servi ces Subject To Ded. & Coins. (see inst.)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)  O O O O O O O O O O O O O O O O O O O	Costs  Cost Rei mbursed Servi ces Subj ect To Ded. & Coi ns. (see i nst.)  See i nst.)  O O O O O O O O O O O O O O O O O O O

Uool +b	Financial Systems REID	HOSPITAL & HEA	ITH CADE SERVI	CEC	In Lio	u of Form CMS-2	neen 10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period:	Worksheet D	2332-10
ALLOK	TOWNENT OF THEATTENT ANGIELANT SERVICE CALLED	AL 00313		F	From 01/01/2018 To 12/31/2018	Part II	pared: 9 am
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 811, 552	151, 669, 006	0. 018537	88, 398	1, 639	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	332, 771	8, 634, 375	0. 038540		0	52.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	3, 004, 201	125, 177, 677	0. 023999			54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	870, 264	94, 236, 463	0. 009235	17, 762	164	59.00
60.00	06000 LABORATORY	1, 014, 096	82, 024, 877	0. 012363	274, 761	3, 397	60.00
65.00	06500 RESPI RATORY THERAPY	177, 763	26, 454, 860	0. 006719	507, 849	3, 412	65.00
66.00	06600 PHYSI CAL THERAPY	1, 763, 717	16, 579, 833	0. 106377	1, 847, 217	196, 501	66.00
69.00	06900 ELECTROCARDI OLOGY	370, 603	24, 964, 279	0. 014845	585	9	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	150, 589	3, 704, 586	0. 040649	671	27	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 648	37, 010	0. 044529	135	6	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	482, 542	27, 328, 422	0. 017657	7 15	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	692, 572	102, 944, 551	0. 006728	552, 558	3, 718	73.00
74.00	07400 RENAL DIALYSIS	48, 927	949, 063	0. 051553	16, 718	862	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0. 000000	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	91, 989	884, 812	0. 103964	1 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 072, 553	67, 850, 634	0. 015808	2, 152	34	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7, 212, 118	0. 000000	0	0	92.00
93.00	04040 FAMILY PRACTICE	306, 517	6, 258, 529	0. 048976	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	158, 444	255, 265	0. 620704	1 0	0	96. 00
200.00	Total (lines 50 through 199)	13, 350, 748	747, 166, 360		3, 414, 634	212, 308	200. 00

Hoal th	Financial Systems REID	HOSPITAL & HEA	NITH CAPE SEDVI	CES	In Lie	eu of Form CMS-:	2552_10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI				Peri od:	Worksheet D	2332-10
	GH COSTS	WICE OTHER TAC			From 01/01/2018	B Part IV	
			Component	CCN: 15-T048	To 12/31/2018	B Date/Time Pre 5/22/2019 7:5	epared:
			T: +1 a	· XVIII	Subprovi der -		9 am
			11116	XVIII	I RF	PP3	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	cost conten boson per on	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 (	0 0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0 (0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	571, 542	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0 (0	
60.00	06000 LABORATORY	0	0	1	0	0 (0	
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0 (0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0 (0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	1	0	0	1 / 00
76. 00	03950 ANCI LLARY - OTHER	0	0		0	0	1 , 0, 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1	0 (	0 0	76. 97
01 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY			J			01 00
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0		
93.00	04040 FAMILY PRACTICE	0	0		0 (	0 0	
93.00	OTHER REIMBURSABLE COST CENTERS			1	U C	<u>J</u>	93.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 (	0 0	96. 00
200.00						571, 542	
200.00	Trocal (Trios of through 177)	1	1	1	٠,	71 371, 342	1-30.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10									
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co		Peri od:	Worksheet D			
THROUG	H COSTS		Component (		From 01/01/2018 To 12/31/2018		pared: 9 am		
			Title	XVIII	Subprovi der -	PPS			
					I RF				
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost			
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges			
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷			
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)			
		4.00	F 00	and 4)	7.00	0.00			
	ANOLLI ADV. CEDVI OF COCT OFNITEDO	4. 00	5. 00	6. 00	7. 00	8. 00			
FO 00	ANCILLARY SERVICE COST CENTERS			Γ ,	151 //0 00/	0.000000	F0 00		
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		151, 669, 006 8, 634, 375		50. 00 52. 00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	571, 542	571, 54		0.004566			
59.00	05900 CARDI AC CATHETERI ZATI ON	0	5/1, 542	5/1,54.	1 '				
60.00	06000 LABORATORY	0	0	)	94, 236, 463 82, 024, 877	0.000000			
65.00	06500 RESPIRATORY THERAPY	0	0	)	26, 454, 860		65.00		
66.00	06600 PHYSI CAL THERAPY	0	0	)	16, 579, 833				
69.00	06900 ELECTROCARDI OLOGY	0	0	}	24, 964, 279				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	ì	3, 704, 586				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l '	37, 010				
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		27, 328, 422	0.000000			
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	l o	l i	102, 944, 551	0. 000000			
74.00	07400 RENAL DIALYSIS	0	0		949, 063				
76.00	03950 ANCI LLARY - OTHER	0	0		0 717,000	0.000000			
	07697 CARDI AC REHABI LI TATI ON	0	0		884, 812	0. 000000			
, 0. , ,	OUTPATIENT SERVICE COST CENTERS		<u> </u>		5 0017012	0.00000	70.77		
91. 00	09100 EMERGENCY	0	0	(	67, 850, 634	0.000000	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	Ö		7, 212, 118				
93. 00	04040 FAMILY PRACTICE	0	0		6, 258, 529				
	OTHER REIMBURSABLE COST CENTERS				2,200,027	21000000	1		
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	255, 265	0.000000	96.00		
200.00		Ō		571, 542			200.00		
		1				•			

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10									
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider Co		Peri od:	Worksheet D			
THROUG	GH COSTS		Component (		From 01/01/2018 To 12/31/2018				
			Title	XVIII	Subprovi der - I RF	PPS			
	Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent			
		Ratio of Cost	Program	Program	Program	Program			
		to Charges	Charges	Pass-Through	Charges	Pass-Through			
		(col. 6 ÷		Costs (col. 8		Costs (col. 9			
		col. 7)		x col. 10)		x col. 12)			
		9. 00	10. 00	11. 00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0. 000000	88, 398	(	0	0	50.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(	-	0	52.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 004566	105, 813	483	0	0	54.00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	17, 762	(	0	0	59.00		
60.00	06000 LABORATORY	0. 000000	274, 761	(	0	0	60.00		
65.00	06500 RESPI RATORY THERAPY	0. 000000	507, 849	(	0	0	65.00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 847, 217	(	0	0	66.00		
69.00	06900 ELECTROCARDI OLOGY	0. 000000	585	(	0	0	69.00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	671	(	0	0	70.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	135	(	0	0	71.00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	15	(	0	0	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	552, 558	(	0	0	73.00		
74.00	07400 RENAL DIALYSIS	0. 000000	16, 718	(	0	0	74.00		
76.00	03950 ANCI LLARY - OTHER	0. 000000	0	(	0	0	76.00		
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	(	0	0	76. 97		
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.000000	2, 152	(	880	0	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00		
93.00	04040 FAMILY PRACTICE	0. 000000	0		0	0	93.00		
	OTHER REIMBURSABLE COST CENTERS	·							
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	(	0	0	96. 00		
200.00	Total (lines 50 through 199)		3, 414, 634	483	880	0	200. 00		

111-4-	Financial Contant	D HOCDITAL & HE	NITH CARE CERVI	ore.	1-11-		0550 10
	Financial Systems REI TONMENT OF MEDICAL, OTHER HEALTH SERVICES A	D HOSPITAL & HEA	Provider C		Period:	u of Form CMS-2 Worksheet D	2552-10
AFFORT	TOWMENT OF WEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	FI OVI dei C		From 01/01/2018		
			Component		To 12/31/2018	Date/Time Pre	pared:
						5/22/2019 7:5	9 am
	Title XVIII Subprovider - PPS						
				Charges	I RF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Cost Center Description	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not	(See Hist.)	
		Worksheet C.	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1, 00	2, 00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 221957	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 301650	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 188602	. 0		0 0	0	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 127061	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 190770	0		0 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0. 132828	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 731554	. 0		0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0. 151285	0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 251794	. 0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 715509	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 697753	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 328134	. 0		0 1, 364	0	73.00
	07400 RENAL DIALYSIS	1. 047961			0 0	0	74.00
	03950 ANCI LLARY - OTHER	0. 000000			0 0	0	,
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 556765	0		0	0	76. 97

0. 196469

0. 616801

0. 591190

2. 656318

880

880

880

173

0

0 93.00

0 0

0

0 0 0

0

0

0

1, 364

1, 364

91.00

92.00

96.00

173 200. 00 201. 00

173 202. 00

09100 EMERGENCY

04040 FAMILY PRACTICE

Only Charges

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09200 OBSERVATION BEDS (NON-DISTINCT PART)

91. 00

92.00

93.00

96. 00

200.00

201.00

ealth Financial Systems REID PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	HOSPITAL & HEAD VACCINE COST	Provi der C		Peri od:	worksheet D	2002 10
		Component	CCN: 15-T048	From 01/01/2018 To 12/31/2018	Part V Date/Time Pro 5/22/2019 7:	epared: 59 am
		Title	: XVIII	Subprovi der - I RF	PPS	
	Cos	sts		110		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANOLLI ADV. CEDIU CE. COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM		0	I			
	0	0				50.00 52.00
2. 00   05200   DELI VERY ROOM & LABOR ROOM 4. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
9. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0				59.00
0. 00   06000   LABORATORY	0	0				60.00
5. 00   06500   RESPI RATORY THERAPY	0	0				65.00
6. 00 06600 PHYSI CAL THERAPY	0	0				66.00
9. 00   06900   ELECTROCARDI OLOGY	0	0				69.00
0.00 07000 ELECTROCARDI OLOGI 0.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1			72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	448	1			73.00
4. 00 07400 RENAL DIALYSIS	0	0				74.00
6. 00   03950   ANCI LLARY - OTHER	0	0				76.00
6. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
OUTPATIENT SERVICE COST CENTERS						10.77
1. 00 09100 EMERGENCY	0	0				91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
3. 00 04040 FAMILY PRACTICE	0	0				93.00
OTHER REIMBURSABLE COST CENTERS						
6. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
00.00 Subtotal (see instructions)	0	448				200.00
01.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
02.00 Net Charges (line 200 - line 201)	0	448				202.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 5/22/2019 7:59 am Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 191, 217 50.00 0. 221957 05200 DELIVERY ROOM & LABOR ROOM 0. 301650 0 52.00 46, 503 52.00 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 188602 0 1, 376, 230 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.127061 185, 136 0 0 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0. 190770 967, 471 0 60.00 06500 RESPIRATORY THERAPY 44, 414 65.00 0.132828 0 65.00 06600 PHYSI CAL THERAPY 647, 910 66.00 0. 731554 0 66.00 06900 ELECTROCARDI OLOGY 0. 151285 163, 931 69.00 44, 349 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 251794 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.715509 71.00 71.00 0 0

Heal th FinancialSystemsREID HOSPITAL & HEAAPPORTIONMENT OFMEDICAL, OTHER HEALTH SERVICES AND VACCINE COST In Lieu of Form CMS-2552-10 Peri od: Worksheet D From 01/01/2018 Part V To 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Provider CCN: 15-0048

					5/22/2019 7:59 am
			e XIX	Hospi tal	Cost
	Cos				
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	264, 399	0			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	14, 028	0			52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	259, 560	0			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	23, 524	0			59.00
60. 00   06000   LABORATORY	184, 564	0			60.00
65. 00 06500 RESPIRATORY THERAPY	5, 899	0			65.00
66. 00 06600 PHYSI CAL THERAPY	473, 981	0			66.00
69. 00 06900 ELECTROCARDI OLOGY	24, 800	0			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	11, 167	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	59, 551	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	216, 465	0			73.00
74.00 07400 RENAL DIALYSIS	3, 760	0			74.00
76. 00 03950 ANCI LLARY - OTHER	o	0			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	5, 706	0			76. 97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·				
91. 00 09100 EMERGENCY	248, 860	0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	118, 463	0			92.00
93. 00 04040 FAMILY PRACTICE	42, 651	0			93.00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0			96.00
200.00 Subtotal (see instructions)	1, 957, 378	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					
202.00 Net Charges (line 200 - line 201)	1, 957, 378	0			202. 00
	, , , , , , ,		1		,

Health Financial Systems	REID HOSPITAL & HEALTH (	CARE SERVICES	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	F		Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prep 5/22/2019 7:59	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					

		T: +1 - W// 1 1	11: +-1	5/22/2019 7:5	9 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		35, 996	1.00
2. 00	Inpatient days (including private room days, excluding swing-			35, 996	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	32, 282 0	4. 00 5. 00
3.00	reporting period	om days) thi odgir becembe	er or the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		04 6 11		7 00
7. 00	Total swing-bed NF type inpatient days (including private rooreporting period	m days) through December	31 OF the COST	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	18, 584	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private d	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc		days)	· ·	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (frictualing prival	le room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (	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
10.00	reporting period		11.0 0001	0.00	.0.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of i	the cost	0.00	20.00
20.00	reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			43, 114, 115	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ line 17)	er 31 of the cost report	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
	x line 18)	·			
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24.00
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)		, , , , , , , , , , , , , , , , , , , ,		
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(1: 21 -: 1: 2()		0	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 III HUS TTHE 26)		43, 114, 115	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	. Lima 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 20)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
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)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HETMENTE			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 197. 75	38 00
39. 00				22, 258, 986	
	Medically necessary private room cost applicable to the Progr	,		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		22, 258, 986	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HUSPITAL & HEA	Provider C		In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST				From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospi tal Program Days	PPS Program Cost	
	Cost Center Description	Inpati ent	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
10.00	AND DEPTH AND A WAY IN A	1. 00	2. 00	3.00	4.00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	U	42.00
43.00	INTENSIVE CARE UNIT	10, 266, 931	5, 246	1, 957. 1	0 2, 657	5, 200, 015	43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description					1 00	17100
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	3 Line 200)			1. 00 39, 369, 789	48.00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		66, 828, 790	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sui	n of Parts I and	2, 734, 833	50.00
51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	2, 535, 191	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				5, 270, 024	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	ysician anestl	netist, and	61, 558, 766	
	medical education costs (line 49 minus line	52)					-
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)	ing coot and to	anget emerint (	lino E/ minuo	Line E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	ine so minus	11 ne 53)	0	57.00 58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	_	•
(0.00	market basket					0.00	/ 0 00
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	1
01.00	which operating costs (line 53) are less than					Ü	01.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)				0	/
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ing period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 (	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				)		   70.00
71.00	Adjusted general inpatient routine service c				,		71.00
72.00	Program routine service cost (line 9 x line	71)		,			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
75.00	Capital-related cost allocated to inpatient	•			Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77.00
	Inpatient routine service cost (line 74 minu	.*	anavi dan	de)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79.00 80.00
81.00	Inpatient routine service cost per diem limi	tati on		, , ,			81.00
	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		15)				83.00
85. 00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th	,				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					3, 714	   87. 00
			1: 2)			· ·	
	Adjusted general inpatient routine cost per	arem (rine 27 -	÷ iine 2)			1, 197. 75	00.00

Health Financial Systems REI	O HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	4, 122, 158	43, 114, 115	0. 09561	0 4, 448, 444	425, 316	90.00
91.00 Nursing School cost	0	43, 114, 115	0.00000	0 4, 448, 444	0	91.00
92.00 Allied health cost	0	43, 114, 115	0.00000	0 4, 448, 444	0	92.00
93.00 All other Medical Education	0	43, 114, 115	0. 00000	0 4, 448, 444	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S048		
	Title XVIII	Subprovi der -	PPS
		I PF	

		THE STATE OF THE S	I PF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			11.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			9, 557 9, 557	1.0
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		ivate room days	9, 557	
3. 00	do not complete this line.	ys). It you have omly pr	rvate room days,	Ü	0. 1
1. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		9, 557	4. (
. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6. (
. 00	reporting period (if calendar year, enter 0 on this line)	oll days) at tel becellber	31 Of the Cost	U	0.1
. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. (
	reporting period				
. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8.
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing_hed and	5, 396	9.
. 00	newborn days)	o the rrogram (exertaining	Swifig bed and	3, 370	/.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.
	through December 31 of the cost reporting period (see instruc			_	
1. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, etc.)		oom days) after	0	11.
2. 00	Swing-bed NF type inpatient days applicable to titles V or XII		e room days)	0	12.
	through December 31 of the cost reporting period			_	
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13.
4 00	after December 31 of the cost reporting period (if calendar y				
4. 00 5. 00	Medically necessary private room days applicable to the Progr. Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 15.
	Nursery days (title V or XIX only)			0	1
	SWING BED ADJUSTMENT			, i	1
7. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0.00	17.
	reporting period	6. 6			
3. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18.
9. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19.
	reporting period	3			
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.
1. 00	reporting period Total general inpatient routine service cost (see instruction	e)		7, 504, 854	21.
2. 00	Swing-bed cost applicable to SNF type services through December		ing period (line		1
	5 x line 17)		9   (		
3. 00	$\operatorname{Swing-bed}$ cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23.
4 00	x line 18)	- 21 -6 +6+	(1:	0	24
4. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (iine	0	24.
5. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.
	x line 20)	,			
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 504, 854	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arnes)	0	28.
	Private room charges (excluding swing-bed charges)	a and observation bea cr	lai gcs)	0	
0. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.
1.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	1
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
3. 00 4. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)/eaa instruc	tions)	0. 00 0. 00	1
5. 00	Average per diem private room cost differential (line 34 x li		Li Ulis)	0.00	1
5. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.
7. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 504, 854	1
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			1
3. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see		T	785. 27	20
9. 00 9. 00	Program general inpatient routine service cost per diem (see			4, 237, 317	1
	J J	,	ŀ		1
	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)	I	0	40.

Component Code 15.500.48   From 01/10/2018   Data/Three Program   Data		Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL		CES CN: 15-0048	In Lie	u of Form CMS-2 Worksheet D-1	
The North Paper   Program Logs   P						From 01/01/2018	Date/Time Pre	pared:
Cost Center Description				Title	e XVIII	Subprovi der -		9 am
1,00   2.00   3.00   4.00   5.00   4.00   5.00   4.00   0.00		Cost Center Description		Total	Average Per	Program Days		
All						4.00		
INTERSIVE CARE UNIT   0   0   0.00   0   0.4	42. 00	NURSERY (title V & XIX only)						42.00
44.00   CORDINATE ARE UNIT   46.00   SURGICAL INTERSIVE CARE UNIT   47.00   DIRES POPCIAL CARE (SPICITY)   47.00   DIRES POPCIAL CARE (SPICITY)   47.00   DIRES POPCIAL CARE (SPICITY)   48.00   Program inpatient ancillary service cost (first. D-3, col. 3, line 200)   902,099   49.00   Total Program inpatient costs (sum of lines 41 through 48) (see Instructions)   5, 199,407   49.00   Program inpatient costs (sum of lines 41 through 48) (see Instructions)   5, 199,407   49.00   Program inpatient costs (sum of lines 51 and 17)   76.874   5 and 17)   76.874   5 and 17)   76.874   76.	43 00		ol	C	0	00 0	<u> </u>	43.00
4.6.00 SURGICAL INTERSIVE CARE UNIT  Cost Center Description  Cost Cent	44.00	CORONARY CARE UNIT		C		0	Ĭ	44.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 49.00 Iotal Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 49.00 Iotal Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 49.00 Iotal Program inpatient ancillary service (From Wkst. D, sum of Parts I and 400, 589) 49.00 Total Program spatient operating ost excluding applicable to Program inpatient ancillary services (From Wkst. D, sum of Parts I and IV) 50.00 Total Program excludable cost (sum of Ilnes 50 and 51) 51.00 Pass through costs sapplicable to Program inpatient ancillary services (From Wkst. D, sum of Parts I and IV) 52.00 Total Program excludable cost (sum of Ilnes 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and molecular collections and ivolutions and i								45. 00 46. 00
1.00   Program inpatient anciliary service cost (Wkst. D-3, col. 3, line 200)   9.62,000   49.00   Total Program inpatient costs (sum of lines 4) through 48) (see instructions)   9.62,000   47.00								47. 00
Program inpatient ancillary service cost (Wist. D-3, col. 3, line 200)   992,090   49,000   Total Program inpatient costs (sum of lines 41 through 48); see instructions)   5,199,407   59.00   Pass through costs applicable to Program inpatient routine services (from Wist. D, sum of Parts I and 10,589   50.00   Pass through costs applicable to Program inpatient ancillary services (from Wist. D, sum of Parts II   67,874   50.00   Pass through costs applicable to Program inpatient ancillary services (from Wist. D, sum of Parts II   67,874   50.00   Total Program excludable cost (sum of lines 50 and 51)   474,463   50.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and   47,24,944   50.00   Total Program discharges   47,24,944   50.00   Total Review of the second discharges   47,24,944   50.00		Cost Center Description					1 00	
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts I and 406,589 bf 111)  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 406,589 bf 111)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,724,944 bf 1014 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4,724,944 bf 1014 Program in state of Constitution (Constitution)  54.00 Total Program in state of Constitution (Constitution)  55.00 Total Program discharges  60.00 Esperat amount per discharges  60.00 Esperat amount per discharges  60.00 Esperat of Ilines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Esperat of Ilines 53/54 or 55 from prior year cost report, updated by the market basket ending the part of the part of Ilines 55, 59 or 60 enter the lesser of 105 or 16 the target amount (Iline 56), otherwise enter zero (See Instructions)  60.00 Esperat of Ilines 53/54 is less than the lower of Ilines 55, 59 or 60 enter the lesser of 105 or 16 the target amount (Iline 56), otherwise enter zero (See Instructions)  60.00 Esperat of Ilines 50/54 is less than the lower of Ilines 55, 59 or 60 enter the lesser of 105 or 16 the target amount (Iline 56), otherwise enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See Instructions)  60.00 For an instructions (Iline 50) enter see enter zero (See							962, 090	1
50.00 Pass through costs applicable to Program inpatient routine services (from Wist. D. sum of Parts I and 10.11 p. 11.11 p. 11.	49. 00		41 through 48)(	see instructi	ons)		5, 199, 407	49. 00
51.00 Pass through costs applicable to Program Inpatient anciliary services (from Wkst. D., sum of Parts II and IV)  77. Total Program excludable cost (sum of lines 50 and 51)  78. 30.00 Total Program excludable cost (sum of lines 50 and 51)  78. 30.00 Total Program excludable cost (sum of lines 50 and 51)  78. 30.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  78. 40.00 Program discharges  79. 40.00 Program discharges  80.00 Target amount per discharge  80.00 Target amount per discharge  80.00 Target amount (line 54 x line 55)  80.00 Target amount (line 56)  80.00 Target amount (line 5	50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sı	um of Parts I and	406, 589	50.00
174, 463   5.00   Total Program excludable cost (sum of lines 50 and 51)   374, 463   5.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 ninus line 52)   7.24, 944   5.00   7.24, 944   5.00   7.24, 944   5.00   7.24, 944   5.00   7.24, 944   5.00   7.24, 945   9.00   9.0	51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	67, 874	51.00
medical education costs (line 49 minus line 52)  FARCET AMOUNT AMO LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount per discharge  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable lipatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only). For OAM (See instructions)  65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For OAM (See instructions)  67.00 If lie Vor XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For OAM (See instructions)  68.00 If lie Vor XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tile XVIII only). For OAM (See instructions)  69.00 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total Hille Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total file vor XIX swing-bed NF inpatient routine costs (line 70 + line 2)  70.00 Skilled unrising facility/other nursing facility/other line 73)  71.00 Aljusted general inpatient routine service costs (line 70 + line 2)  72.00 Program routine service cost (line 71 + line 73)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 25)  74.00 Total Program engenal inpatient routine se	52. 00		50 and 51)				474, 463	52.00
54.00   Program discharges   0   5   5   5   0   Target amount fer discharge   0   0   5   5   5   0   Target amount fer discharge   0   5   5   0   5   5   0   5   5   0   5   5	53. 00	medical education costs (line 49 minus line		lated, non-ph	ysician anest	thetist, and	4, 724, 944	53.00
56.00 Target amount (IIne 54 x line 55) 58.00 Bonus payment (see instructions) 59.00 Lesser of IInes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 60.01 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 61.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 62.00 Relief payment (see instructions) 63.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 64.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 65.00 Relief payment (see instructions) 66.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 66.00 Lesser of IInes 53/54 or 55 from prior year cost report, updated by the market basket 67.00 Relief payment (see instructions) 68.00 Relief payment (see instructions) 69.00 Relief payment (see instructions) 60.01 All owable Inpatient cost plus incentive payment (see instructions) 60.02 Relief payment (see instructions) 60.03 All owable Inpatient coutine costs through December 31 of the cost reporting period (see instructions) (s		Program di scharges						
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   O   55 minus payment (see instructions)   O   55 minus payment (see instructions)   O   55 minus payment (see instructions)   O   56 minus payment (see instructions)   O   66 minus payment (see instructions)   O   67 minus payment (see instructions)   O   68 minus payment (see instructions)   O   69							l	55.00
Desper of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00 55 more to basket   0.00 61	57.00	Difference between adjusted inpatient operat	ing cost and ta	irget amount (	line 56 minus	s line 53)	0	57.00
60.00   Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   61.00   Irine 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see Instructions)   0.63.00   Relief payment (see instructions)   0.63.00   Allowable Inpatient cost plus incentive payment (see instructions)   0.63.00   Allowable Inpatient cost plus incentive payment (see instructions)   0.64.00   Relief payment (see instructions)   0.65.00   Allowable Inpatient cost plus incentive payment (see instructions)   0.66.00   Regional Payment (see instructions)   0.66		Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and o	compounded by the		
amount (line 56), otherwise enter zero (see instructions)  62. 00 Relief payment (see instructions)  63. 00 Allowable Inpatient cost plus incentive payment (see instructions)  64. 00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65. 00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66. 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67. 00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY  70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72. 00 Program routine service cost (line 9 x line 71)  73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75. 00 Capital-related costs (line 75 + line 2)  77. 00 Program capital-related costs (line 9 x line 76)  78. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  88. 00 Uniquitant routine service cost (see instructions)  89. 00 Total Program inpatient countine service costs (see instructions		Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	ser of 50% of	f the amount by	1	60. 00 61. 00
Allowable   Inpatient cost plus incentive payment (see instructions)   PROGRAM INPATIENT ROUTINE SWING BED COST		amount (line 56), otherwise enter zero (see		.5 (111165 04 X	60), OI 1% C	of the target		
Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)				62. 00 63. 00
Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   CAH (see instructions)	64. 00		ts through Dece	mber 31 of th	e cost report	ting period (See	0	64.00
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/CF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 75 + line 2)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.01 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost limitation (line 9 x line 81)  81.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Inpatient routine service cost see instructions)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient poperating costs (sum of l	65. 00	, ,	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Program capital-related costs (line 75 ÷ line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	66. 00	, , , , , , , , , , , , , , , , , , , ,	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital -related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Reasonable inpatient routine services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	67. 00	, ,	e costs through	December 31	of the cost r	reporting period	0	67.00
69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  70.01 Inpatient routine service cost per diem limitation  80.00 Inpatient routine service cost per diem limitation  81.00 Inpatient routine service cost (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  83.00 Reasonable inpatient routine service (see instructions)  84.00 Program inpatient ancillary services (see instructions)  75.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		(line 12 x line 19)	-					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00   Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)   70.00   71.00   71.00   72.00   72.00   72.00   72.00   73.00   74.00   75.00   76.00	69. 00		routine costs (	line 67 + lin	e 68)	0 .	0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.00 Total Program routine service cost per diem limitation 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY	7)		
Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						<i>( )</i>		70.00
Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		Program routine service cost (line 9 x line	71)					72.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  18.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				•				73. 00 74. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		Capital-related cost allocated to inpatient				Part II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		Per diem capital-related costs (line 75 ÷ li						76.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								77. 00 78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					*.	I ! 70)		79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ost ilmitatio	ıı (ııne /8 mi	nus iine 79)		80.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				is)				83. 00 84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	85.00	Utilization review - physician compensation	(see instructio					85.00
	86. 00			rough 85)				86.00
00 00 Adjusted general impatient routine cost as diem (line 37 : line 3)		Total observation bed days (see instructions	)	line 2)			l	1
88.00   Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  89.00   Observation bed cost (line 87 x line 88) (see instructions)  0.00   88		,	•	,			l	89.00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	720, 106	7, 504, 854	0. 09595	2 0	0	90.00
91.00 Nursing School cost	0	7, 504, 854	0.00000	0	0	91.00
92.00 Allied health cost	0	7, 504, 854	0.00000	0	0	92.00
93.00 All other Medical Education	0	7, 504, 854	0. 00000	0 0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T048		
	Title XVIII	Subprovi der -	PPS
		LRF	

			. I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 725	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	3, 725 0	2. 00 3. 00
0.00	do not complete this line.	ye, yeu nave emy p.	. varo i com dajo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation b			3, 725	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) through Dagambar	21 of the cost	0	7 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	ili days) through beceiliber	31 OF the Cost	U	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	- the December (could will be		2 200	0.00
9. 00	Total inpatient days including private room days applicable t newborn days)	o the Program (excluding	swing-bed and	2, 289	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
44 00	through December 31 of the cost reporting period (see instruc				44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		oom 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
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	3 - 3 - 3		0	15.00
16. 00	3 3 1			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
17.00	reporting period	es through becomber 31 o	THE COST	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0 00	19. 00
	reporting period	o in ough becomes or or		0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00		s)		3, 513, 816	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
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line A	0	23. 00
23.00	x line 18)	or the cost reportin	g perroa (rriie d	O	25.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 513, 816	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
	Pri vate room charges (excluding swing-bed charges)			0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	+ 111le 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li		5115)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			943. 31	38 00
39. 00	Program general inpatient routine service cost per drem (see	•		2, 159, 237	
	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 159, 237	41.00

Health Financial Systems REID I COMPUTATION OF INPATIENT OPERATING COST	HOSPITAL & HEAI		CES CN: 15-0048	In Lie Period:	u of Form CMS-2 Worksheet D-1	
		Component	CCN: 15-T048	From 01/01/2018 To 12/31/2018		
		Title	× XVIII	Subprovi der -	5/22/2019 7:5 PPS	<u>9 am</u>
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	0	Program Cost (col. 3 x col. 4)	
42.00 NUDSEDY (+i +l o V & VI V only)	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	υ <sub>լ</sub>		0.1	50  0	0	42.00
43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description	0	C	0. (	00 0	0	43.00 44.00 45.00 46.00 47.00
·					1.00	10.00
48.00 Program inpatient ancillary service cost (Wks 49.00 Total Program inpatient costs (sum of lines 4			ons)		1, 712, 668 3, 871, 905	1
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, su	ım of Parts I and	337, 444	50.00
51.00 Pass through costs applicable to Program inpaland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	212, 791	51.00
52.00 Total Program excludable cost (sum of lines 5 53.00 Total Program inpatient operating cost excluded medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated, non-ph	ysician anest	hetist, and	550, 235 3, 321, 670	1
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0	55. 00 56. 00
57.00 Difference between adjusted inpatient operati 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost rep market basket	· ·			•	0.00	57. 00 58. 00 59. 00
60.00 Lesser of lines 53/54 or 55 from prior year of 1.00 If line 53/54 is less than the lower of lines which operating costs (line 53) are less than	s 55, 59 or 60 n expected cost	enter the les	ser of 50% of	the amount by	0. 00 0	60. 00 61. 00
amount (line 56), otherwise enter zero (see i 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payme	ŕ	ucti ons)				62. 00 63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportir	ng period (See	0	65. 00
66.00 Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31	of the cost r	reporting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [	December 31 of	the cost rep	oorting period	0	
69.00 Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00 Skilled nursing facility/other nursing facili 71.00 Adjusted general inpatient routine service co 72.00 Program routine service cost (line 9 x line 7 73.00 Medically necessary private room cost applica 74.00 Total Program general inpatient routine servi 75.00 Capital-related cost allocated to inpatient r	ost per diem (1 71) able to Program ce costs (line	ine 70 ÷ line n (line 14 x l e 72 + line 73	2) i ne 35) )			70.00 71.00 72.00 73.00 74.00 75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ lin 77.00 Program capital-related costs (line 9 x line 78.00 Inpatient routine service cost (line 74 minus	76)					76.00 77.00 78.00
79.00 Aggregate charges to beneficiaries for excess 80.00 Total Program routine service costs for compa 81.00 Inpatient routine service cost per diem limit 82.00 Inpatient routine service cost limitation (li 83.00 Reasonable inpatient routine service costs (s	s costs (from parison to the c tation ne 9 x line 81 see instruction	cost limitatio	*.	nus line 79)		79. 00 80. 00 81. 00 82. 00 83. 00 84. 00
85.00 Utilization review - physician compensation ( 86.00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	(see instruction of lines 83 the THROUGH COST					85. 00 86. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per c 89.00 Observation bed cost (line 87 x line 88) (see	diem (line 27 ÷					87. 00 88. 00 89. 00

Health Financial Systems REII	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	549, 147	3, 513, 816	0. 15628	2 0	0	90.00
91.00 Nursing School cost	0	3, 513, 816	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 513, 816	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 513, 816	0. 00000	0 0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH CAR	RE SERVICES	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro		From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prep 5/22/2019 7:59	
		Title XIX	Hospi tal	Cost	
0 1 0 1 1					

				5/22/2019 7:5	<u>9 am</u>
		Title XIX	Hospi tal	Cost	
Cost	Center Description			1. 00	
PART I - A	ALL PROVIDER COMPONENTS			1.00	
I NPATI ENT					
1.00 Inpatient	days (including private room days and swing-bed day	ys, excluding newborn)		35, 996	1.00
	days (including private room days, excluding swing-			35, 996	2.00
3.00 Private r	oom days (excluding swing-bed and observation bed da	ays). If you have only pr	rivate room days,	0	3.00
	nplete this line.				
	ate room days (excluding swing-bed and observation b			32, 282	4.00
	ng-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	0	5. 00
reporting	·		21 -6 -1	0	/ 00
	ng-bed SNF type inpatient days (including private ro period (if calendar year, enter 0 on this line)	dolli days) ai ter becelliber	31 Of the Cost	0	6.00
	ng-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7.00
reporting		om days) trii odgir becember	01 01 110 0031	Ü	7.00
	ng-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.00
reporti ng	period (if calendar year, enter 0 on this line)	3 7			
	atient days including private room days applicable t	to the Program (excluding	g swing-bed and	716	9.00
newborn d	<i>3</i> /				
	SNF type inpatient days applicable to title XVIII of		room days)	0	10.00
	ecember 31 of the cost reporting period (see instruc		soom dovo) often	0	11 00
	SNF type inpatient days applicable to title XVIII of the cost reporting period (if calendar year, e		oom days) arter	0	11.00
	NF type inpatient days applicable to titles V or XI		te room days)	0	12.00
	ecember 31 of the cost reporting period	ix only (mercuring privat	ic room days)	Ü	12.00
	NF type inpatient days applicable to titles V or XI	IX only (including privat	te room days)	0	13.00
	ember 31 of the cost reporting period (if calendar y				
	necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
	sery days (title V or XIX only)				15.00
	ays (title V or XIX only)			45	16. 00
	ADJUSTMENT				
	rate for swing-bed SNF services applicable to services.	ces through December 31 o	of the cost	0.00	17. 00
reporting 18.00 Medicare	period rate for swing-bed SNF services applicable to servic	oos after December 21 of	the cost	0.00	18. 00
reporting		ces al tel beceiliber 31 01	the cost	0.00	10.00
	rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.00
reporti ng		3			
	rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0. 00	20.00
reporti ng	·				
	eral inpatient routine service cost (see instruction			43, 114, 115	
	cost applicable to SNF type services through Decemb	ber 31 of the cost report	ting period (line	. 0	22.00
5 x line 23.00 Swing-bed	,	r 21 of the cost reportin	na ported (line 4	0	23. 00
x line 18	cost applicable to SNF type services after December	i 31 of the cost reportin	ig period (Title d	0	23.00
	, cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24.00
7 x line		o. o. o ooot . opo	ing porroa (iiiia	J.	
25. 00 Swi ng-bed	cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
x line 20					
	ng-bed cost (see instructions)			0	
	npatient routine service cost net of swing-bed cost	(line 21 minus line 26)		43, 114, 115	27.00
	OM DIFFERENTIAL ADJUSTMENT			0	20.00
	npatient routine service charges (excluding swing-be oom charges (excluding swing-bed charges)	ed and observation bed cr	narges)	0	28. 00 29. 00
•	ate room charges (excluding swing-bed charges)			0	30.00
, ,	npatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	ł
1	rivate room per diem charge (line 29 ÷ line 3)	11110 20)		0. 00	1
, ,	emi-private room per diem charge (line 30 ÷ line 4)			0. 00	1
	er diem private room charge differential (line 32 mi	inus line 33)(see instrud	ctions)	0. 00	1
	er diem private room cost differential (line 34 x li		•	0. 00	•
	pom cost differential adjustment (line 3 x line 35)			0	36. 00
	npatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	43, 114, 115	37.00
27 mi nus					
	HOSPITAL AND SUBPROVIDERS ONLY	HICTMENTS			
	IPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ general inpatient routine service cost per diem (see			1 107 75	20 00
'				1, 197. 75 857, 589	
o /. oo ji i oyi aiii y					J J 7. UU
40.00 Medically	eneral inpatient routine service cost (line 9 x line necessary private room cost applicable to the Progr	*			40 00
	necessary private room cost applicable to the Progr gram general inpatient routine service cost (line 39	ram (line 14 x line 35)		0 857, 589	

			Provi der C	314. 13 0040	Period: From 01/01/2018		
					To 12/31/2018	5/22/2019 7:5	
	Cost Center Description	Total	Total	e XIX Average Per		Cost Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 926, 124	2. 00 2, 015	3. 00 459.	4. 00 61 45	5. 00 20, 682	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	10, 266, 931	5, 246	1, 957.	10 117	228, 981	43. 00 44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT				ļ		45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wks					1, 181, 940	
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		2, 289, 192	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, sı	um of Parts I and	0	50.00
51. 00	III) Pass through costs applicable to Program inpa	atient ancillar	v services (fi	rom Wkst D	sum of Parts II	o	51.00
	and IV)		,				
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclude states and the states are supported by the states		lated, non-ph	ysician anes <sup>1</sup>	thetist, and	0	52.00 53.00
	medical education costs (line 49 minus line !						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	rget amount (	line 56 minus	s line 53)	0 0	56.00 57.00
58. 00	Bonus payment (see instructions)	· ·			,	0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	l
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
(2.00	amount (line 56), otherwise enter zero (see i	instructions)			,	o	42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doco	mbor 21 of the	o cost ropori	ting poriod (Soc	0	64.00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the (	cost reportir	ng period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	reporting period	0	67.00
	(line 12 x line 19)					0	40.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after t	ecember 31 of	the cost rep	on tring perrou		68.00
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70. 00	Skilled nursing facility/other nursing facili				7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 1		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applica		(line 14 x li	ine 35)			73.00
74.00	Total Program general inpatient routine servi	•					74.00
75. 00	Capital-related cost allocated to inpatient a 26, line 45)	routine service	costs (from )	Worksheet B,	Part II, column		75.00
76. 00	Per diem capital related costs (line 75 ÷ lin	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		rovi der recor	(sb			79. 00
	Total Program routine service costs for compa		ost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				81.00 82.00
83. 00	Reasonable inpatient routine service costs (s	see instruction	* .				83.00
84. 00	Program inpatient ancillary services (see ins						84.00
85.00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.00
							07.00
87. 00	Total observation bed days (see instructions)	)			1	3, 714	87.00

Health Financial Systems RE	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		pared: 9 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUG	H COST					
90.00 Capital-related cost	4, 122, 158	43, 114, 115	0. 09561	0 4, 448, 444	425, 316	90.00
91.00 Nursing School cost	0	43, 114, 115	0.00000	0 4, 448, 444	0	91.00
92.00 Allied health cost	0	43, 114, 115	0.00000	0 4, 448, 444	0	92.00
93.00 All other Medical Education	0	43, 114, 115	0.00000	0 4, 448, 444	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S048		
	Title XIX	Subprovi der -	Cost
		I PF	

Cost Center Description		1. 00	
DART I ALL DROWNER COMPONENTS			
PART I - ALL PROVIDER COMPONENTS		11.00	
INPATIENT DAYS			
1.00 Inpatient days (including private room days and swing-bed days, excluding 2.00 Inpatient days (including private room days, excluding swing-bed and newbounds)		9, 557 9, 557	1. 00 2. 00
2.00 Inpatient days (including private room days, excluding swing-bed and newbases). If you have room days (excluding swing-bed and observation bed days). If you have room days (excluding swing-bed and observation bed days).		9, 557	3.00
do not complete this line.	are emy private reem days,	, and the second	0.00
4.00 Semi-private room days (excluding swing-bed and observation bed days)		9, 557	4. 00
5.00 Total swing-bed SNF type inpatient days (including private room days) through reporting period	ough December 31 of the cost	0	5. 00
6.00 Total swing-bed SNF type inpatient days (including private room days) after	er 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 days) throu	ugh Docombor 21 of the cost	0	7. 00
reporting period	ight becember 31 of the cost	O	7.00
8.00 Total swing-bed NF type inpatient days (including private room days) after	December 31 of the cost	0	8. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program	e (excluding swing-hed and	254	9. 00
newborn days)	(exertaining swring bed and	204	7.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (includir through December 31 of the cost reporting period (see instructions)	ng private room days)	0	10. 00
11.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including	ng private room days) after	0	11.00
December 31 of the cost reporting period (if calendar year, enter 0 on thi	s line)		
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (incluthrough December 31 of the cost reporting period	ıding private room days)	0	12.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (inclu	uding private room days)	0	13.00
after December 31 of the cost reporting period (if calendar year, enter 0		_	
14.00 Medically necessary private room days applicable to the Program (excluding 15.00 Total nursery days (title V or XIX only)	g swing-bed days)	2.015	14. 00 15. 00
16.00 Nursery days (title V or XIX only)		2,015	ı
SWING BED ADJUSTMENT			
17.00 Medicare rate for swing-bed SNF services applicable to services through De reporting period	ecember 31 of the cost	0. 00	17. 00
18.00 Medicare rate for swing-bed SNF services applicable to services after Dece	ember 31 of the cost	0. 00	18. 00
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through Dec	cember 31 of the cost	0.00	19. 00
reporting period			
20.00 Medical drate for swing-bed NF services applicable to services after Decemendary reporting period	ber 31 of the cost	0.00	20.00
21.00 Total general inpatient routine service cost (see instructions)		7, 504, 854	1
22.00   Swing-bed cost applicable to SNF type services through December 31 of the 5 x line 17)	cost reporting period (line	0	22. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the co	ost reporting period (line 6	0	23. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the c	east reporting period (line	0	24. 00
7 x line 19)	, 31		
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost x line 20)	st reporting period (line 8	0	25. 00
26.00 Total swing-bed cost (see instructions)		0	
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minu	ıs line 26)	7, 504, 854	27. 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observa	ation bed charges)	0	28. 00
29.00 Pri vate room charges (excluding swing-bed charges)	iti di Bad dila gasi	0	
30.00 Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	1
32.00 Average private room per diem charge (line 29 ÷ line 3)		0. 00	32. 00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	1
34.00 Average per diem private room charge differential (line 32 minus line 33)	see instructions)	0. 00	1
35.00 Average per diem private room cost differential (line 34 x line 31)		0. 00	•
36.00 Private room cost differential adjustment (line 3 x line 35)		0	36. 00
37.00 General inpatient routine service cost net of swing-bed cost and private r	room cost differential (line	7, 504, 854	37. 00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			1
38.00 Adjusted general inpatient routine service cost per diem (see instructions	s)	785. 27	38. 00
39.00 Program general inpatient routine service cost (line 9 x line 38)		199, 459	39. 00
40.00 Medically necessary private room cost applicable to the Program (line 14)	(line 35)	0	1
41.00   Total Program general inpatient routine service cost (line 39 + line 40)		199, 459	41.00

Health Financial Systems REID COMPUTATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL		CES CN: 15-0048	In Lie	u of Form CMS-2 Worksheet D-1	
3			CCN: 15-S048	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Ti tl	e XIX	Subprovi der -	5/22/2019 7:5 Cost	9 am
Cost Center Description	Total	Total	Average Per	I PF	Program Cost	
·	Inpatient Cost	Inpatient Days	Diem (col. + col. 2)		(col. 3 x col. 4)	
42.00 NUDCEDV (+: +1 a V * VIV and v)	1. 00	2. 00	3.00	4. 00 00 0	5. 00	42.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0  s	C	0.	00  0	0	42.00
43. 00 INTENSIVE CARE UNIT 44. 00 CORONARY CARE UNIT	0	C	0.	00 0	0	43. 00 44. 00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
Cost Center Description					1. 00	47.00
48.00 Program inpatient ancillary service cost (W						48.00
49.00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructi	ons)		199, 459	49. 00
50.00 Pass through costs applicable to Program inp	oatient routine	services (fro	m Wkst. D, sı	um of Parts I and	0	50.00
51.00 Pass through costs applicable to Program in and IV)	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost exclu	,	elated non-nh	vsician anest	thetist and	0	
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		Tatou, Horr pri		The trist, and		00.00
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57.00 Difference between adjusted inpatient opera-	ting cost and ta	irget amount (	line 56 minus	s line 53)	0	57.00
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and o	compounded by the	0.00	58. 00 59. 00
market basket 60.00 Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket	t	0.00	60.00
61.00 If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
amount (line 56), otherwise enter zero (see		.5 (TTHES 54 A	. 00), 01 1/0 0	or the target	_	
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)	ment (see instru	ıcti ons)				62. 00 63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost report	ting period (See	0	64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	ng period (See	0	65.00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost i	reportina period	0	67.00
(line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routing	-				0	
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient				oor tring porrou		69.00
PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70.00 Skilled nursing facility/other nursing facil 71.00 Adjusted general inpatient routine service				<b>(</b> )		70.00
72.00 Program routine service cost (line 9 x line	71)					72.00
73.00 Medically necessary private room cost application 74.00 Total Program general inpatient routine serv		•				73. 00 74. 00
75.00 Capital -related cost allocated to inpatient 26, line 45)				Part II, column		75. 00
76.00 Per diem capital-related costs (line 75 ÷ li						76.00
77.00 Program capital-related costs (line 9 x line 78.00 Inpatient routine service cost (line 74 minu						77. 00 78. 00
79.00 Aggregate charges to beneficiaries for exces			*.	I i 70)		79.00
80.00 Total Program routine service costs for comp 81.00 Inpatient routine service cost per diem limi		ost iiilli tätlö	ıı (ııne /ö Mi	nus IIIle /9)		80. 00 81. 00
82.00 Inpatient routine service cost limitation (1		* .				82.00
83.00 Reasonable inpatient routine service costs 84.00 Program inpatient ancillary services (see in	•	15)				83. 00 84. 00
85.00 Utilization review - physician compensation	(see instruction					85.00
86.00 Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST	ır ougn 85)				86.00
87.00 Total observation bed days (see instructions 88.00 Adjusted general inpatient routine cost per	•	line 2)			0 0. 00	87. 00 88. 00
89.00 Observation bed cost (line 87 x line 88) (see	•	,				89. 00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	720, 106	7, 504, 854	0. 09595	2 0	0	90.00
91.00 Nursing School cost	0	7, 504, 854	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 504, 854	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 504, 854	0. 00000	0 0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T048		
	Title XIX	Subprovi der -	Cost
		IRF	

			I RF		
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days,			3, 725	1.00
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		ivata saam daya	3, 725 0	2. 00 3. 00
3. 00	do not complete this line.	i. IT you have only pr	ivate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		3, 725	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5.00
/ 00	reporting period		21 -6		/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room of	days) through December	31 of the cost	0	7.00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room or reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ento		days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX o	only (including privat	e room days)	0	12.00
12 00	through December 31 of the cost reporting period	anlı. (inaludina naiyat	a maam dayaa)	0	13.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			U	13.00
14.00	Medically necessary private room days applicable to the Program			0	14.00
	Total nursery days (title V or XIX only)			,	15.00
16. 00	Nursery days (title V or XIX only)			45	16.00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17.00
.,. 00	reporting period	tin dagii badambai di d		0.00	
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19.00
17.00	reporting period	in ough becomber 31 of	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			3, 513, 816	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ina period (line		22.00
	5 x line 17)	•			
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reportin	g period (line o	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 3	R1 of the cost reporti	na period (line	0	24.00
21.00	7 x line 19)	or the cost reporti	ing period (inite	G	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
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (Li	ne 21 minus line 26)		3, 513, 816	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
30.00	General inpatient routine service cost/charge ratio (line 27 ÷ 1	ine 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0. 000000	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 minus	s line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		- /	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	-	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			0.10.01	20.25
38.00	Adjusted general inpatient routine service cost per diem (see in	,		943. 31	•
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38 Medically necessary private room cost applicable to the Program	•		0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +	•		0	
		•	'	- 1	

Health Financial Systems REID HOSPITAL & HEALTH COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-0048 Period:		eu of Form CMS-2552-10 Worksheet D-1		
Same Same Same Same Same Same Same Same		Component	CCN: 15-T048	From 01/01/2018 To 12/31/2018	B    Date/Time Prepare		
			Ti tl	Title XIX Subprovider		5/22/2019 7:59 am Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4. 00 00 0	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	υį		η <u></u> υ.	00  0	0	42.00
44. 00 45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	C	0.	00 0	0	43. 00 44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)			48. 00 49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, sı	um of Parts I and	0	50.00
51. 00		atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	and IV) Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud	ding capital re	elated, non-ph	ysician anes	thetist, and	0	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00 55. 00	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and to	urgot omount (	lino E4 minus	s Lino E2)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	0					
60. 00 61. 00	market basket Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line Which operating costs (line 53) are less than	0. 00 0	60. 00 61. 00				
62. 00 63. 00	Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00							
65. 00							
66. 00	<pre>instructions)(title XVIII only)  Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For</pre>					0	66. 00
67. 00	ON Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67. 00
68. 00							68. 00
69. 00	00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						69.00
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	itine service	cost (line 3	7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)  Program routine service cost (line 9 x line 71)						71. 00 72. 00
73. 00 74. 00	edically necessary private room cost applicable to Program (line 14 x line 35)						73. 00 74. 00
75. 00							75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2)						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79. 00 80. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation						81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions)						83. 00 84. 00
84. 00 85. 00							
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					85. 00 86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87.00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			0.00	88. 00
89. UU	Observation bed cost (line 87 x line 88) (see	e instructions)				ı o	89.00

Health Financial Systems REID	HOSPITAL & HEALTH CARE SERVICES			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provider CCN: 15-0048		Worksheet D-1		
		Component (		From 01/01/2018 To 12/31/2018			
		Ti tl	e XIX	Subprovi der -	Cost		
				I RF			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1. 00	2. 00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	549, 147	3, 513, 816	0. 15628	2 0	0	90.00	
91.00 Nursing School cost	0	3, 513, 816	0.00000	0	0	91.00	
92.00 Allied health cost	0	3, 513, 816	0.00000	0	0	92.00	
93.00 All other Medical Education	0	3, 513, 816	0. 00000	0 0	0	93.00	

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVIO				Period:	u of Form CMS-2	
INPATI	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0048		Worksheet D-3	
				From 01/01/2018 To 12/31/2018		
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
	LAIDATI FAIT DOUTLAG CEDVI OF COCT OFFITEDO		1.00	2. 00	3. 00	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS			05 757 005		00.00
30.00	03000 ADULTS & PEDI ATRI CS			25, 757, 305		30.00
31.00	03100 INTENSIVE CARE UNIT			4, 866, 641		31.00
40. 00 41. 00	O4000  SUBPROVI DER - I PF   O4100  SUBPROVI DER - I RF			0		40. 00 41. 00
	04300 NURSERY			0		41.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 22195	31, 584, 295	7, 010, 355	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 30165	· · · · · · · · · · · · · · · · · · ·		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 18860			
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 12706	· · · · · · · · · · · · · · · · · · ·		•
60.00	06000 LABORATORY		0. 1907			
65. 00	06500 RESPI RATORY THERAPY		0. 13282	· · · · · · · · · · · · · · · · · · ·		
66. 00	06600 PHYSI CAL THERAPY		0. 73155	· · · · · · · · · · · · · · · · · · ·		1
69.00	06900 ELECTROCARDI OLOGY		0. 15128	· · · · · · · · · · · · · · · · · · ·		1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 25179	31, 150	7, 843	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 71550		11, 510	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 69775	10, 690, 092	7, 459, 044	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 32813	23, 459, 925	7, 697, 999	73.00
74.00	07400 RENAL DI ALYSI S		1. 04796	574, 330	601, 875	74.00
76.00	03950 ANCI LLARY - OTHER		0. 00000	00	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 55676	6, 362	3, 542	76. 97
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY		0. 19646	,		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 61680			
03 00	104040 EAMLLY DRACTICE		0 50110	12 175	I 7 100	02 00

0. 591190

2. 656318

12, 175

156, 089, 765

156, 089, 765

7, 198

0 96.00 39, 369, 789 200.00

93.00

201. 00 202. 00

MCRI F32 - 15. 5. 166. 1

93.00 04040 FAMILY PRACTICE

200.00

201.00 202.00

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0048	Peri od:	Worksheet D-3	
		Component	CCN: 15-S048	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
		Title	· XVIII	Subprovi der -	PPS	7 4
				I PF		
	Cost Center Description		Ratio of Cos	10.000	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00				0		30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER – I PF			5, 900, 590		40.00
41. 00				3, 700, 370		41.00
43.00	04300 NURSERY					43.00
10.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00			0. 2219!	57 104, 316	23, 154	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3016	·	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 18860	02 411, 160	77, 546	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1270	61 23, 713	3, 013	59.00
60.00	06000 LABORATORY		0. 1907		136, 058	
65.00	06500 RESPI RATORY THERAPY		0. 13282		56, 516	
66.00	06600 PHYSI CAL THERAPY		0. 7315		173, 370	
69. 00			0. 15128		2, 482	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 25179		651	
71.00			0. 71550		45	
72.00			0. 69775		0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS		0. 32813		375, 083	
76.00	07400   RENAL DI ALYSI S   03950   ANCI LLARY - OTHER		1. 04796 0. 00000		4, 448 0	1
76. 00	07697 CARDI AC REHABI LI TATI ON		0. 55676		0	
70. 97	OUTPATIENT SERVICE COST CENTERS		0. 55676	00	0	10.97
91 00	09100 EMERGENCY		0. 19640	558, 105	109, 650	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 61680		0 0	1
93.00			0. 59119		74	
. 0. 00	OTHER REIMBURSABLE COST CENTERS		3.3711		, ,	1 50
96.00			2. 6563	18 0	0	96.00
200.00		h 98)		3, 639, 472	962, 090	200.00
201.00				0		201.00
202.00		,		3, 639, 472		202.00

	Financial Systems REID HOSPITAL & HEALTH ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
INPAII	ENT ANGILLARY SERVICE COST APPORTIONWENT	Provider C	CN. 13-0046	From 01/01/2018	WOLKSHEEL D-3	)
		•	CCN: 15-T048	To 12/31/2018	Date/Time Pre 5/22/2019 7:5	epared: 59 am
		Titl∈	e XVIII	Subprovi der -	PPS	
			1	I RF		
	Cost Center Description		Ratio of Cos	•	Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x	
				criai ges	col. 1 x	
			1.00	2.00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31. 00	03100 I NTENSI VE CARE UNI T			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			2, 507, 052		41.00
	04300 NURSERY			, ,		43.00
	ANCILLARY SERVICE COST CENTERS		•			
50.00	05000 OPERATING ROOM		0. 2219	57 88, 398	19, 621	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3016	50 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1886	02 105, 813	19, 957	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1270		2, 257	
60.00	06000 LABORATORY		0. 1907		52, 416	
65.00	06500 RESPI RATORY THERAPY		0. 1328	· ·		
66. 00	06600 PHYSI CAL THERAPY		0. 7315		1, 351, 339	
69. 00	06900 ELECTROCARDI OLOGY		0. 1512		89	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 2517		169	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7155		97	
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0. 6977		101 212	
74.00	07400 RENAL DIALYSIS		0. 3281 1. 0479		181, 313 17, 520	
	03950 ANCI LLARY - OTHER		0.0000		17,520	
	07697 CARDI AC REHABI LI TATI ON		0. 5567		0	
70. 77	OUTPATIENT SERVICE COST CENTERS		0. 3307	55  0	0	70. 77
91.00	09100 EMERGENCY		0. 1964	69 2, 152	423	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6168	· ·	0	1
93. 00	04040 FAMILY PRACTICE		0. 5911		Ö	1
	OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		2. 6563	18 0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			3, 414, 634	1, 712, 668	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			3, 414, 634		202.00

Health Financial Systems	REID HOSPITA	L & HEALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERV	/ICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 7:5	pared: 9 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center	Description		Ratio of Cost		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE	SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEI	DI ATRI CS			1, 458, 707		30.00
31.00 03100 INTENSIVE CA	ARE UNIT			294, 607		31.00
40. 00   04000   SUBPROVI DER	- IPF			0		40.00
41. 00   04100   SUBPROVI DER	- IRF			0		41.00
43. 00   04300 NURSERY				174, 562		43.00
ANCILLARY SERVICE	COST CENTERS		•			
50. 00 05000 OPERATING RO	OOM		0. 22195	7 430, 720	95, 601	50.00
1 1			1			1

Heal th	Financial Systems REID HOSPITAL & HEALTH	I CARE SERVI	CES	In lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
		Component	CCN: 15-S048	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 7:5	pared:
		Ti tl	e XIX	Subprovi der -	Cost	
	Coot Contar Deceription		Ratio of Cos	I PF	I nnoti ont	
	Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
			l ro onal goo	Charges	(col . 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 I NTENSI VE CARE UNI T			4/2 707		31.00
40. 00 41. 00	04000   SUBPROVI DER     1 PF   04100   SUBPROVI DER     1 RF			462, 797		40. 00 41. 00
	04300 NURSERY			0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0. 2219!	57 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 3016		Ō	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 18860	02	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1270	51 0	0	59.00
60.00	06000 LABORATORY		0. 1907		0	
65.00	06500 RESPI RATORY THERAPY		0. 13282		0	65.00
66.00	06600 PHYSI CAL THERAPY		0. 7315		0	
	06900 ELECTROCARDI OLOGY		0. 15128		0	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 25179		0	
71.00	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   MPL. DEV. CHARGED TO PATIENT		0. 71550		0	
72. 00 73. 00	107300 DRUGS CHARGED TO PATIENTS		0. 6977! 0. 3281:		0	1
74.00	07400 RENAL DI ALYSI S		1. 0479		0	
	03950 ANCI LLARY - OTHER		0. 00000		0	1
	07697 CARDI AC REHABI LI TATI ON		0. 55676		o o	
	OUTPATIENT SERVICE COST CENTERS					1
91.00	09100 EMERGENCY		0. 1964	59 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 61680	01 0	0	92.00
93.00	04040 FAMILY PRACTICE		0. 59119	90 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS					
	09600 DURABLE MEDI CAL EQUI P-RENTED		2. 6563		l .	96.00
200.00		(11)		0	0	200.00
201.00		s (IIne 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		I	0		202. 00

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	rovi der C	CN: 15-0048	Peri od: From 01/01/2018	Worksheet D-3	
	C	component	CCN: 15-T048	To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
		Ti tl	e XIX	Subprovi der -	Cost	
	Cost Center Description		Ratio of Cos	IRF t Inpatient	I npati ent	
	cost center bescription		To Charges		Program Costs	
			l 10 onar ges	Charges	(col. 1 x	
				onal goo	col . 2)	
			1.00	2.00	3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
30. 00 0300	OO ADULTS & PEDIATRICS			0		30.00
31. 00   0310	OO INTENSIVE CARE UNIT			0		31.0
10. 00 0400	OO SUBPROVI DER - I PF			0		40.00
11.00 0410	OO SUBPROVI DER - I RF			81, 325		41.00
13.00 0430	NURSERY			0		43.0
	LLARY SERVICE COST CENTERS					
50.00 0500	OO OPERATING ROOM		0. 2219	57 0	0	50.0
	DO DELIVERY ROOM & LABOR ROOM		0. 3016	50 0	0	52.0
	OO RADI OLOGY-DI AGNOSTI C		0. 18860		0	
	OO CARDIAC CATHETERIZATION		0. 1270		0	
	OO LABORATORY		0. 1907	I I	0	
	OO RESPI RATORY THERAPY		0. 13282		0	65.0
	DO PHYSI CAL THERAPY		0. 7315		0	
	00 ELECTROCARDI OLOGY		0. 15128		0	
	DO ELECTROENCEPHALOGRAPHY		0. 25179	I I	0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 71550		0	
	00 IMPL. DEV. CHARGED TO PATIENT		0. 6977!		0	1
	DO DRUGS CHARGED TO PATIENTS		0. 32813		0	
	OO RENAL DIALYSIS		1. 04796		0	
	50 ANCI LLARY - OTHER		0.00000	I I	0	
	07 CARDI AC REHABI LI TATI ON		0. 55676	65 0	0	76. 9
	PATIENT SERVICE COST CENTERS		0.10(4)	(0)		01.0
	DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART)		0. 19646		0	
			0. 61680		0	
	IO FAMILY PRACTICE  R REIMBURSABLE COST CENTERS		0. 59119	<del>7</del> 0  0	0	93.0
	R REIMBURSABLE COST CENTERS  OO DURABLE MEDICAL EQUIP-RENTED		2. 6563	18l ol	0	96.0
200.00 096C	Total (sum of lines 50 through 94 and 96 through 98)		2.0003	18 0		200.0
200.00	Less PBP Clinic Laboratory Services-Program only charges	(lino 41)				200. 0
	THESS PRE CITIED LADOLATORY SERVICES-PRODUAID ONLY CHARGES	LINE OI)	I .	1 ()1		120 I . C

Health Financial Systems	REID HOSPITAL & HEALTH C	CARE SERVICES	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P		From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared:

			10 12/31/2016	5/22/2019 7:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	0 39, 532, 747	1.00
1. 02	DRG amounts other than outlier payments for discharges occurrinstructions)	ing on or after October	1 (see	11, 545, 677	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			893, 439 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
3.00	Managed Care Simulated Payments	,		5, 992, 445	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	orting period (see instru	uctions)	152. 82	4.00
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending or	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-o	on to the cap for	0.00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	,,,,,	, , , , ,	0. 00	
8. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slunder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospi tal	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir instructions)	nes (8, 8,01 and 8,02)	(see	0. 00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	rds	0. 00 0. 00	
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0. 00	13.00
14. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	0. 00	14.00
15.00	Sum of lines 12 through 14 divided by 3.				15. 00
16.00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital clo	sure		0. 00	
18.00	Adjusted rolling average FTE count				18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4	<b>ŀ</b> ).		0. 088208	
20.00	Prior year resident to bed ratio (see instructions)			0. 088942	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)			0. 088208 2, 401, 605	
22. 00	IME payment adjustment (see Instructions)			281, 753	
22.01	Indirect Medical Education Adjustment for the Add-on for § 42	22 of the MMA		201, 703	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$ .		CFR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0. 00	1
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	1
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions	3)		0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	• )		2, 401, 605	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	01)		281, 753	1
30.00	Percentage of SSI recipient patient days to Medicare Part A p	atient davs (see instru	ctions)	4. 78	30.00
31.00	Percentage of Medicaid patient days (see instructions)		,	21. 31	1
32.00	Sum of lines 30 and 31			26. 09	1
33. 00	Allowable disproportionate share percentage (see instructions	3)		10. 74	1
	Disproportionate share adjustment (see instructions)	,		1, 371, 456	
	, , , , , , , , , , , , , , , , , , ,		'	, , , , , , , , , , , ,	

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVICES	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A	epared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35.00
35.01	Factor 3 (see instructions)		0. 000381566	0. 000381928	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, enterinstructions)	er zero on this line) (se	e 2, 581, 942	3, 074, 238	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 931, 151	774, 877	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		2, 706, 028		36.00
30.00	Additional payment for high percentage of ESRD beneficiary di				1 55.50
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
10.00	652, 682, 683, 684 and 685 (see instructions)	ar seriar ges i er ins bros			10.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, (instructions)	683, 684 an 685. (see	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-DRGs 652, 682, 683, 684	0		41.01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68			l	43.00
43.00	instructions)	32, 003, 004 all 003. (See	0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. 00
46. 00			0.00		46. 00
47. 00	Subtotal (see instructions)	1.01)	58, 450, 952		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	67, 032, 792	l	48.00
40.00	only. (see instructions)	silari rurar nospitars	07,032,772		40.00
				Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instructions			67, 314, 545	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar	nd Pt. II, as applicable)		4, 380, 771	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		464, 600	52.00
53.00	Nursing and Allied Health Managed Care payment			57, 592	53.00
54.00	Special add-on payments for new technologies			0	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 6	59)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I	III, column 9, lines 30 t	hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		<b>,</b>	82, 930	58.00
	Total (sum of amounts on lines 49 through 58)	,		72, 300, 438	
	Primary payer payments			30, 698	
61. 00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		72, 269, 740	
62. 00	Deductibles billed to program beneficiaries	/		5, 386, 940	
	Coinsurance billed to program beneficiaries			85, 760	
64. 00	Allowable bad debts (see instructions)			547, 405	
65. 00	Adjusted reimbursable bad debts (see instructions)			355, 813	
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		269, 786	
47.00	10.10.00.00.00.00.00.00.00.00.00.00.00.0			1	1

68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)

67, 152, 853 67. 00

0

277, 007

-79, 066 70. 94

68.00

69.00

70.00

70.50

70.87

70.88

70.89

70.90

70. 91

0 70.92

70. 93

0 70.95

70.88

67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)

Demonstration payment adjustment amount before sequestration

Pioneer ACO demonstration payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

70.91 HSP bonus payment HRR adjustment amount (see instructions)

Bundled Model 1 discount amount (see instructions)

70.93 HVBP payment adjustment amount (see instructions)

70.94 | HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

Health Financial Systems	REID HOSPITAL & HEALTH			In Lieu of Form CMS-2552-10
CALCULATION OF DELMDUDCEMENT CETTLEMENT		D: -I CCN 1E 0040	D!!	W

	Financial Systems REID HOSPITAL & HEALTH					2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0048	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Ti tl c	e XVIII	Hospi tal	PPS	7 dili
		11110		(уууу)	Amount	
			FFT			
70.04	The second control of			0	1.00	70.04
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n corumn o		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)			_	_	
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			67, 350, 794	71.00
71.01	Sequestration adjustment (see instructions)				1, 347, 016	71.01
71.02	Demonstration payment adjustment amount after sequestration				0	71. 02
72.00	Interim payments				65, 849, 411	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2. 72. and			154, 367	74.00
	73)	_,,			,	
75.00	Protested amounts (nonallowable cost report items) in accorda	nce with			o	75.00
70.00	CMS Pub. 15-2, chapter 1, §115.2				Ĭ	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					İ
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	nf 2 03			0	90.00
70.00	plus 2.04 (see instructions)	01 2.00			Ĭ	70.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				o	91.00
92. 00	Operating outlier reconciliation adjustment amount (see instr	uctions)			Ö	
93.00	Capital outlier reconciliation adjustment amount (see instruc					93.00
	'	,				
94.00	The rate used to calculate the time value of money (see instructions)				0.00	95.00
95.00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruc	trons)		Dust aux de 10/1	0 / 16+ 10 / 1	96.00
				Pri or to 10/1		
	IICD Dawn Dawn America			1. 00	2. 00	
100 00	HSP Bonus Payment Amount				0	100.00
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	-)		0. 0000000000	0. 0000000000	101.00
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)			0. 0000000000	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000000000000000000000000000000000000	0. 0000000000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	)		0. 0000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	) ration) Adju	ustment	0.0000000000000000000000000000000000000	0. 0000000000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions RURA adjustment amount for HSP bonus payment (see instructions RURA Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	) ration) Adju	ustment the 21st	0.0000000000000000000000000000000000000	0. 0000000000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	) ration) Adju	ustment the 21st	0.0000000000000000000000000000000000000	0. 0000000000	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	) ration) Adji riod under	ustment the 21st	0.0000000000000000000000000000000000000	0. 0000000000	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	) ration) Adji riod under	ustment the 21st	0.0000000000000000000000000000000000000	0. 0000000000	101.00 102.00 103.00 104.00 200.00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)	) ration) Adji riod under	ustment the 21st	0.0000000000000000000000000000000000000	0. 0000000000	101.00 102.00 103.00 104.00 200.00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0.0000000000000000000000000000000000000	101.00 102.00 103.00 104.00 200.00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0.0000000000000000000000000000000000000	101.00 102.00 103.00 104.00 200.00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0.0000000000000000000000000000000000000	101.00 102.00 103.00 104.00 200.00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  RURA adjustment amount for HSP bonus payment (see instructions)  Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 ctration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HVBP adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)	) ration) Adju riod under e 49)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 ctration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adj riod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 o	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 206. 00 207. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adjuriod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see inst	) ration) Adjuriod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adjuriod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRBR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see inst  Medicare Part A inpatient service costs (from Wkst. E, Pt. A,  Adjustment to Medicare IPPS payments (see instructions)	) ration) Adjuriod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pecentury Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)	) ration) Adjuriod under e 49) first year	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 strati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions)  HVBP Adjustment for HSP Bonus Payment  HVBP adjustment factor (see instructions)  HVBP adjustment amount for HSP bonus payment (see instruction)  HRR Adjustment for HSP Bonus Payment  HRR adjustment factor (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  HRR adjustment amount for HSP bonus payment (see instructions)  Rural Community Hospital Demonstration Project (§410A Demonst  Is this the first year of the current 5-year demonstration pe  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin  Medicare discharges (see instructions)  Case-mix adjustment factor (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in  period)  Medicare target amount  Case-mix adjusted target amount (line 203 times line 204)  Medicare inpatient routine cost cap (line 202 times line 205)  Adjustment to Medicare Part A Inpatient Reimbursement  Program reimbursement under the §410A Demonstration (see inst  Medicare Part A inpatient service costs (from Wkst. E, Pt. A,  Adjustment to Medicare IPPS payments (see instructions)  Reserved for future use  Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under e 49) first year ructions) line 59)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjuriod under e 49) first year ructions) line 59)	the 21st	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0 0 0 0 0 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line Low-volume adjustment (see instructions)	ration) Adjuriod under e 49) first year ructions) line 59)	of the curre	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 c	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjuriod under e 49) first year ructions) line 59)	of the curre	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 c	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2018	Worksheet E Part B Date/Time Prepared:

			10 12/31/2018	5/22/2019 7:5	
-		Title XVIII	Hospi tal	PPS	77 alli
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00	Medical and other services (see instructions)			13, 896	
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		41, 905, 742	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			48, 288, 252 18, 342	
4. 00	Outlier reconciliation amount (see instructions)			10, 342	1
5. 00	Enter the hospital specific payment to cost ratio (see instru	ıctions)		0.000	1
6. 00	Line 2 times line 5	,		0	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		205, 054	
10.00	Organ acquisitions			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			13, 896	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			42, 347	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		42, 347	
14. 00	Total reasonable charges (sum of lines 12 and 13)	1110 07)		42, 347	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(	(e)			47.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	oly if line 19 exceeds li	ino 11) (coo	42, 347 28, 451	
17.00	instructions)	ily II IIIle 18 exceeds II	ile II) (see	20, 431	19.00
20. 00	Excess of reasonable cost over customary charges (complete on	nlvifline 11 exceeds Li	ne 18) (see	0	20.00
	instructions)	3	, (,,,		
21.00	Lesser of cost or charges (see instructions)			13, 896	21.00
22.00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			48, 511, 648	24.00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	25)		0	25. 00
26. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	8, 612, 240	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			39, 913, 304	
27.00	instructions)	p. 40 the 64m of 111166 21	20] (000	0,7,7.0,00.1	27.0
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		257, 924	28.00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			40, 171, 228	1
31.00	Primary payer payments			7, 564	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		40, 163, 664	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	CL3)		0	33.00
34. 00	Allowable bad debts (see instructions)			1, 925, 835	
35.00	Adjusted reimbursable bad debts (see instructions)			1, 251, 793	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 514, 362	36.00
37.00	· · · · · · · · · · · · · · · · · · ·			41, 415, 457	
	MSP-LCC reconciliation amount from PS&R			-318	
39. 00	OTHER ADJUSTMENTS			-411	1
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)			39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	acad davicas (saa instru	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	iced devices (see ilistido	, ti 0iis)		
40.00	Subtotal (see instructions)			41, 415, 364	
40. 01	Sequestration adjustment (see instructions)			828, 307	
40.02	Demonstration payment adjustment amount after sequestration			0	40.0
41.00	Interim payments			39, 823, 175	41.0
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)	Lucius Education		763, 882	
44. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	44.0
	§115.2   TO BE COMPLETED BY CONTRACTOR				-
					90.0
00.00					
	Original outlier amount (see instructions)			0	
91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.0
	Original outlier amount (see instructions)				91. 00 92. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE	SERVI CES	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-0048	Peri od:	Worksheet E
			From 01/01/2018	
	Compo	nent CCN: 15-S048	To 12/31/2018	Date/Time Prepared:
				5/22/2019 7:59 am
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
	· · · · · · · · · · · · · · · · · · ·		IPF		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			562	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		693	2.00
3.00	OPPS payments			1, 035	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5.00
6. 00	Line 2 times line 5	,		0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8. 00	Transitional corridor payment (see instructions)	11/ 1 12 1: 200		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, COI. 13, TINE 200		1 0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			562	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges			4 740	40.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 60)		1, /12	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	THE 04)		1, 712	
	Customary charges			.,	
15. 00	1 33 3		0	0	15. 00
16. 00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			1, 712	18.00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	1, 150	19. 00
20.00	instructions)	luifling 11 avagada li	no 10) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT TITLE IT exceeds IT	ne 18) (See	U	20. 00
21.00				562	21. 00
	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	0	23.00		
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			1, 036	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on lin			103	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	1, 495	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, I</pre>	ine 50)		0	28. 00
29. 00				0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 495	30. 00
31.00	1 3 1 3 1 3			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		1, 495	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	023)		0	33.00
34.00	Allowable bad debts (see instructions)			0	34.00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		1 405	36. 00 37. 00
	MSP-LCC reconciliation amount from PS&R			1, 479	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		_	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	and daylone (one imptru	ati ana)	0	39. 97 39. 98
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see flisting	Lti ons)	0	39. 90
40. 00				1, 495	
40. 01	Sequestration adjustment (see instructions)			30	40. 01
40. 02	' '			0	40. 02
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			1, 450 0	41. 00 42. 00
43. 00	` <i>3'</i>				
44.00	Protested amounts (nonallowable cost report items) in accorda	15 0	44.00		
	§115. 2				
90 00	TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0. 00	92.00
93.00	,			0	
94.00	Total (sum of lines 91 and 93)		ļ	0	94.00

Health Financial Systems	REID HOSPITAL & HEALTH	CARE SERVICES	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	1	Provider CCN: 15-0048	Peri od:	Worksheet E
			From 01/01/2018	
		Component CCN: 15-T048	To 12/31/2018	Date/Time Prepared:
		•		5/22/2019 7:59 am
		Title XVIII	Subprovi der -	PPS

			Title XVIII	Subprovi der – I RF	PPS	
Note   Note   National   Nation		· ·		IKF		
Medical and other services (see Instructions)		DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
Medical and other services reinbursed under OPPS (see instructions)   173   2.00	1. 00				448	1.00
0.00   0.00		1	tions)			
0.000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000						
Enter the hospital apacific payment to cost ratio (see Instructions)   0.000   5.00		, , , , , , , , , , , , , , , , , , , ,			-	
Line 2 times in 6		,	ctions)		-	
Transitional corridor payment (see instructions)   6 : 60			,			
Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200   0 9, 00   10.00   00   00   00   00   00   0						
10.00			11/ 1 12 1: 200		-	
11.00			IV, COI. 13, TINE 200		-	
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reason					-	
1,364   12,00						
13.00   Organ acquisition charges (From Wist. D-4, Pt. III., col. 4, Iiin. 69)   0   13.00	40.00	9			1 0/1	
1.0   10   10   10   10   10   10   10			ino 60)		1, 364	•
Customary charges			THE 04)		1, 364	
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   A					.,	
had such payment been made in accordance with 42 CFR §413.13(e)		1 33 3			-	
17.00   Ratio of line 15 to line 16 (not to exceed 1.000000)   17.00	16. 00			on a chargebasis	0	16. 00
1.364   18. 00   Total customary charges (see instructions)   1.364   18. 00   1.00	17. 00		e)		0. 000000	17. 00
Instructions						•
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19. 00		ly if line 18 exceeds li	ne 11) (see	916	19. 00
instructions	20.00		luifling 11 avagada li	no 10) (ccc	0	20.00
1. 00   Lesser of cost or charges (see instructions)   0. 22.00   Cost of physicians' services in a teaching hospital (see instructions)   0. 23.00   20.00   Cost of physicians' services in a teaching hospital (see instructions)   0. 23.00   20	20.00		Ty IT TITLE IT exceeds IT	ne 18) (See	U	20.00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   3.50   24. 00   COMPUTATION OF REIMBURSEMENT SETTLEMENT	21. 00	,			448	21.00
Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   24.00		Interns and residents (see instructions)	-			
COMPUTATION OF REIMBURSEMENT SETTLEMENT   25.00			-			
25.00   Deductible and coinsurance amounts (for CAH, see instructions)   0 25.00	24.00				359	24.00
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   27. 00	25. 00		s)		0	25. 00
Instructions	26. 00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see inst	ructions)	0	26. 00
28. 00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         28. 00           29. 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29. 00           30. 00         Subtotal (sum of lines 27 through 29)         807         30. 00           31. 00         Primary payer payments         0         31. 00           32. 00         Subtotal (line 30 minus line 31)         0         31. 00           ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33. 00           34. 00         Allowable bad debts (see instructions)         0         34. 00           35. 00         Adjusted reimbursable bad debts (see instructions)         0         34. 00           36. 00         Allowable bad debts (see instructions)         0         35. 00           37. 00         Subtotal (see instructions)         807         37. 00           38. 00         MSP-LCC reconcilitation amount from PS&R         0         38. 00           39. 01         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         39. 50           39. 97         Pomonstration payment adjustment amount before sequestration         0         39. 50           39. 97         Pomonstration payment adjustment amount before sequestration         0         39. 98	27. 00	,	plus the sum of lines 22	2 and 23] (see	807	27. 00
29.00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29.00           30.00         Subtotal (sum of lines 27 through 29)         807         30.00           31.00         Primary payer payments         0         31.00           32.00         Subtotal (line 30 minus line 31)         807         32.00           ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33.00           34.00         Allowable bad debts (see instructions)         0         34.00           35.00         Allowable bad debts (see instructions)         0         35.00           36.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         0         36.00           37.00         Subtotal (see instructions)         0         36.00           38.00         MSP-LCC reconciliation amount from PS&R         0         38.00           39.00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39.00           39.01         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39.50           39.07         Partial or full credits received from manufacturers for replaced devices (see instructions)         0         39.50           39.99         Partial or full credits received from manufacturers for replaced devices (see instructions)	28 00		ine 50)		0	28 00
30.00   Subtotal (sum of lines 27 through 29)   807   30.00   31.00   31.00   31.00   31.00   32.00					-	
Subtotal (line 30 minus line 31)					807	30. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00		1 3 1 3 1 3			-	
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)	32.00		CES)		807	32.00
34.00	33. 00	·	CL3)		0	33.00
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       36.00         37.00       Subtotal (see instructions)       807       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0       39.97         39.98       RECOVERY OF ACCELERATED DEPRECIATION       0       39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Sequestration adjustment (see instructions)       807       40.00         40.01       Sequestration adjustment (see instructions)       807       40.00         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       779       41.00         42.00       Tentative settlement (for contractors use only)       42.00         43.00       Bal ance due provider/program (see instructions)       0       42.00         44.00       Protested amounts (nonallowable cost report items) in accordance with C		· · · · · · · · · · · · · · · · · · ·				•
37.00   Subtotal (see instructions)   807   37.00   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   39.50   39.50   97   90   90   90   90   90   90   9		, , , , , , , , , , , , , , , , , , , ,			-	
38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Dioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Sequestration adjustment (see instructions)       807       40.00         40.01       Demonstration payment adjustment amount after sequestration       0       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.00         41.00       Interim payments       779       41.00         42.00       Interim payments       779       41.00         43.00       Balance due provider/program (see instructions)       0       42.00         44.00       Filis. 2       0       44.00         For BE COMPLETED BY CONTRACTOR       0       44.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       90.00			ructions)		-	
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   91.00   39.50   91.00   92.00   70.00   93.00		l				
39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 0 39. 99 40. 01 Sequestration adjustment (see instructions) 10 40. 02 1 Demonstration payment adjustment amount after sequestration 10 40. 02 1 Interim payments 10 40. 02 1 Interim payments 10 40. 02 1 Interim payments 10 40. 02 1 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 91. 00 1 Se COMPLETED BY CONTRACTOR 10 Outlier reconciliation adjustment amount (see instructions) 10 90. 00 11 Time Value of Money (see instructions) 12 0 39. 99 139. 98 140. 00 39. 99 140. 00 140. 01 140. 01 140. 01 140. 01 140. 01 140. 02 141. 00 141. 00 142. 00 143. 00 144.						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  50 Sequestration adjustment (see instructions)  61 Pomonstration payment adjustment amount after sequestration  62 Under impayments  63 Under impayments  64 Under impayments  65 Under impayments  66 Under impayments  67 Under impayments  67 Under impayments  68 Under impayments  69 Under impayments  60 Under impayments  61 Under impayments  61 Under impayments  61 Under impayments  62 Under impayments  63 Under impayments  64 Under impayments  64 Under impayments  65 Under impayments  67 Under impayments  60 Under i			s)			
39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   807   40.00   40.01   Sequestration adjustment (see instructions)   16   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   41.00   Interim payments   779   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   8al ance due provider/program (see instructions)   12   43.00   43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   \$115.2   TO BE COMPLETED BY CONTRACTOR   0   90.00   Original outlier amount (see instructions)   0   91.00   92.00   The rate used to calculate the Time Value of Money (see instructions)   0   93.00   93.00   Time Value of Money (see instructions)   0   93.00				-+:>		
40.00 Subtotal (see instructions)  807 40.00  40.01 Sequestration adjustment (see instructions)  16 40.01  40.02 Demonstration payment adjustment amount after sequestration  10 40.02  41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{1}{2}\$ 115.2  \$\frac{1}{2}\$ TO BE COMPLETED BY CONTRACTOR  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  10 93.00  11 Time Value of Money (see instructions)  12 90.00  13 93.00			ced devices (see instru	CTI ONS)		
40.01 Sequestration adjustment (see instructions)  40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{115.2}{10.00}\$  \$\frac{10.00}{10.00}\$  \$\frac{115.2}{10.00}\$  \$\frac{10.00}{10.00}\$  \$10.00					-	
41.00   Interim payments   779   41.00   42.00   43.00   Tentative settlement (for contractors use only)   0   42.00   43.00   Balance due provider/program (see instructions)   12   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Variable   15.2   Variable	40. 01					•
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 44.00 94.00 95.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00						•
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00    91.52    10 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 Utlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  12 43.00    44.00    45.00    90.00    90.00    91.00    92.00    10     11     12     13     14     15     15     16     17     18     18     19     19     10		1				
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{9115.2}}{\text{10 BE COMPLETED BY CONTRACTOR}}\$  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  73.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)						•
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)  98.00 Outlier reconciliation adjustment amount (see instructions)  99.00 Outlier reconciliation adjustment amount (see instructions)		, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	chapter 1,		
90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	00.00				0	00 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00		, ,				
93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,				
94.00   Total (sum of lines 91 and 93)   0   94.00	93. 00	Time Value of Money (see instructions)			0	93. 00
	94. 00	lotal (sum of lines 91 and 93)			0	94.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0048 Peri od: Worksheet E-1 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/22/2019 7:59 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 65, 863, 511 39, 849, 075 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/13/2018 40, 400 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 09/17/2018 54, 500 09/17/2018 25, 900 3.50 3.51 3.51 0 3.52 0 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines -14, 100 -25, 900 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 65, 849, 411 39, 823, 175 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 6.00 Determined net settlement amount (balance due) based on

763, 882

40, 587, 057

NPR Date

(Mo/Day/Yr)

2.00

154, 367

Contractor

Number

1.00

66, 003, 778

6.01

6.02

7.00

8 00

the cost report. (1)

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6.02

7.00

Health Financial Systems REID HOSPI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0048 Component CCN: 15-S048

		T: +1 o	. VVIIII	Cubanavi dan	5/22/2019 7: 50 PPS	9 am
		IIIIe	xVIII	Subprovi der -	PPS	
		I npati en	it Part A		t B	
		mm/dd/\aaaa	Amount	mm/dd/yyyy	Amount	
		mm/dd/yyyy 1.00	2.00	3. 00	4. 00	
00	Total interim payments paid to provider	1.00	4, 777, 763		1, 450	1.
	Interim payments payable on individual bills, either		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	1
	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					3
	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)					
Ì	Program to Provider					1
	ADJUSTMENTS TO PROVIDER				0	3
2				)	0	3
3			(		0	
)4			(		0	3
)5	Danid dan da Danaman			)	0	3
	Provider to Program ADJUSTMENTS TO PROGRAM				0	3
1	ADJUSTINIENTS TO FROGRAM					3
2					0	3
3					o	3
4					0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines			D	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 777, 763	3	1, 450	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		l .			l
	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none,					
Į.	write "NONE" or enter a zero. (1)					
	Program to Provider		1			١.
1	TENTATI VE TO PROVI DER				0	
3						
	Provider to Program			21		
0	TENTATI VE TO PROGRAM		(		0	5
1					0	5
2					0	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines			P	0	5
	5.50-5.98) Determined net settlement amount (balance due) based on					,
0	the cost report. (1)					6
1	SETTLEMENT TO PROVIDER		43, 42	1	15	6
	SETTLEMENT TO PROGRAM		10, 12		0	
	Total Medicare program liability (see instructions)		4, 821, 184	1	1, 465	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor		)	1. 00	2. 00	8

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

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		3, 706, 35		779	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			ol	1 0	3. 01
3. 02	NOSOSTIMENTS TO TROVIDER			Ö		3. 02
3. 03				0	0	3. 03
3.04				0	0	3.04
3. 05				0	0	3.05
0 50	Provi der to Program					0.50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 52				0		3. 52
3. 53				Ö	l o	3. 53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)		2 70/ 25		770	4 00
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		3, 706, 35	I	779	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5. 02	TERMINITE TO THOMPSEN			Ö	0	5. 02
5.03				0	0	5.03
	Provi der to Program			-1		
5. 50	TENTATIVE TO PROGRAM			0	0	5. 50
5. 51 5. 52				0	0	5. 51 5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		42, 87	3	12	6. 01 6. 02
7. 00	Total Medicare program liability (see instructions)		3, 749, 22	٧	791	7. 00
7.00	Total mode out o program i rability (see instructions)		5, 147, 22	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
0.05		(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor			1		8. 00

Heal th	Financial Systems REID HOSPITAL & HEALTH	L CARE SERVICES	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0048	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II	pared:
-		Title XVIII	Hospi tal	PPS	7 (1111
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			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	3-12			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 I	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					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32 00	Ralance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

32.00

Heal th	Financial Systems REID HOSPITAL & HEAL	_TH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	Worksheet E-3	
		Component CCN: 15-S048	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/22/2019 7:5	pared: 9 am
		Title XVIII	Subprovi der - I PF	PPS	
				1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and m	nedical education payments	)	5, 345, 956	
2.00	Net IPF PPS Outlier Payments			0	2.00
3.00	Net IPF PPS ECT Payments			0 0. 00	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)				4. 00
4. 01	Cap increases for the unweighted intern and resident FTE coprogram or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00	4. 01
5. 00	New Teaching program adjustment. (see instructions)			0.00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs i teaching program" (see instuctions)	n the new program growth	period of a "new	0. 00	
7. 00	Current year's unweighted I&R FTE count for residents withit teaching program" (see instuctions)	n the new program growth	period of a "new	0. 00	7. 00
8. 00	Intern and resident count for IPF PPS medical education adj	ustment (see instructions	)	0.00	8.00
9. 00	Average Daily Census (see instructions)	(	<i>'</i>	26. 183562	
10.00		o the power of .5150 -1}.		0. 000000	
11.00		,		0	
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11	)		5, 345, 956	12.00
	Nursing and Allied Health Managed Care payment (see instruc			0	
	Organ acquisition (DO NOT USE THIS LINE)	,			14.00
	Cost of physicians' services in a teaching hospital (see in	structions)		0	15.00
	Subtotal (see instructions)	•		5, 345, 956	16.00
17.00	Primary payer payments			0	17.00
	Subtotal (line 16 less line 17).			5, 345, 956	18.00
	Deducti bl es			341, 364	19.00
20.00	Subtotal (line 18 minus line 19)			5, 004, 592	
21 00				120 200	21 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048 Component CCN: 15-T048	Peri od: From 01/01/2018 To 12/31/2018		pared:
	Title XVIII	Subprovi der - I RF	PPS	
			1. 00	

Inpatient Rehabilitation LIP Payments (see instructions)	1137 889 833 0.00 0.00 0.00 0.00 0.00 0.409 0	11. 00 12. 00 13. 00 14. 00
1.00 Net Federal PPS Payment (see instructions) 2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 3.00 Inpatient Rehabilitation LIP Payments (see instructions) 5.00 Outlier Payments 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Dail y Census (see instructions) 11.00 Teaching Adjustment Factor (see instructions) 12.00 Teaching Adjustment factor (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (D0 NOT USE THIS LINE) 16.00 Organ acquisition (D0 NOT USE THIS LINE) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3.82	1137 889 833 0.00 0.00 0.00 0.00 0.00 0.409 0	2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 Medicare SSI ratio (IRF PPS only) (see instructions) 3.00 Inpatient Rehabilitation LIP Payments (see instructions) 5.01 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 11.00 Teaching Adjustment Factor (see instructions) 12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (DO NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	1137 889 833 0.00 0.00 0.00 0.00 0.00 0.409 0	2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
Inpatient Rehabilitation LIP Payments (see instructions)	889 833 0.00 0.00 0.00 0.00 0.00 0.479 000 0	3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4.00 Outlier Payments 5.00 Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.42(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 10.00 Average Daily Census (see instructions) 11.00 Teaching Adjustment factor (see instructions) 12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instructions) 15.00 Organ acquisition (D0 NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	833 0.00 0.00 0.00 0.00 0.00 0.479 0000 0.00 0.00	4. 00 5. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)  5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412 424(d)(1)(iii)(F)(1) or (2) (see instructions)  7.00 New Teaching program adjustment. (see instructions)  8.00 Current year's unweighted FTE count of L&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  8.00 Current year's unweighted L&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  9.00 Intern and resident count for L&R PPS medical education adjustment (see instructions)  10.00 Average Daily Census (see instructions)  11.00 Teaching Adjustment Factor (see instructions)  12.00 Teaching Adjustment (see instructions)  13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instructions)  15.00 Organ acquisition (DO NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  3.84  20.00 Deductibles  21.00 Subtotal (line 17 less line 18).  3.84  20.00 Ocinsurance  3.82  3.82  3.82  3.82  3.83	0. 00 0. 00 0. 00 0. 00 0. 00 0. 479 0000 0 0	5. 00 5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
to November 15, 2004 (see instructions)  Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  6.00 New Teaching program adjustment. (see instructions)  7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  10.00 Average Daily Census (see instructions)  11.00 Teaching Adjustment Factor (see instructions)  12.00 Teaching Adjustment (see instructions)  13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  15.00 Organ acquisition (D0 NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  3.84  8.00 Deductibles  20.00 Deductibles  21.00 Subtotal (line 17 less line 18).  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 20)  20.00 Coinsurance  3.82	0. 00 0. 00 0. 00 0. 00 0. 00 0. 479 0000 0 409 0	5. 01 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)  6.00 New Teaching program adjustment. (see instructions)  7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  8.00 Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions)  10.00 Average Daily Census (see instructions)  12.00 Teaching Adjustment Factor (see instructions)  13.00 Teaching Adjustment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  15.00 Organ acquisition (D0 NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  18.00 Primary payer payments  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	0. 00 0. 00 0. 00 0. 00 6479 0000 0 409 0	6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)  Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  10.00 Intern and resident count for IRF PPS medical education adjustment (see instructions)  10.01 Average Daily Census (see instructions)  10.02 Teaching Adjustment Factor (see instructions)  10.03 Total PPS Payment (see instructions)  10.04 Total PPS Payment (see instructions)  10.05 Nursing and Allied Health Managed Care payments (see instruction)  10.06 Ocst of physicians' services in a teaching hospital (see instructions)  10.07 Subtotal (see instructions)  10.08 Subtotal (line 17 less line 18).  10.09 Deductibles  10.00 Coinsurance  20.00 Subtotal (line 21 minus line 20)  20.00 Subtotal (line 21 minus line 22)  3,82	0. 00 0. 00 0. 00 6479 0000 0 409 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
teaching program" (see instructions)  Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)  Intern and resident count for IRF PPS medical education adjustment (see instructions)  10.00 Average Daily Census (see instructions)  11.00 Teaching Adjustment Factor (see instructions)  12.00 Teaching Adjustment (see instructions)  13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  Organ acquisition (D0 NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  18.00 Primary payer payments  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	0. 00 6479 0000 0 409 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
teaching program" (see instructions)  9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions)  10.00 Average Daily Census (see instructions)  11.00 Teaching Adjustment Factor (see instructions)  12.00 Teaching Adjustment (see instructions)  13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  15.00 Organ acquisition (D0 NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	0. 00 6479 0000 0 409 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 10.00 Average Daily Census (see instructions) 11.00 Teaching Adjustment Factor (see instructions) 12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (DO NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0479 0000 0 409 0	10. 00 11. 00 12. 00 13. 00 14. 00
11.00 Teaching Adjustment Factor (see instructions)  12.00 Teaching Adjustment (see instructions)  13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  15.00 Organ acquisition (D0 NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  18.00 Primary payer payments  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	0000 0 409 0	11. 00 12. 00 13. 00 14. 00
11.00 Teaching Adjustment Factor (see instructions) 12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (D0 NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0 409 0	12. 00 13. 00 14. 00
12.00 Teaching Adjustment (see instructions) 13.00 Total PPS Payment (see instructions) 14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (D0 NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0 409 0	12. 00 13. 00 14. 00
13.00 Total PPS Payment (see instructions)  14.00 Nursing and Allied Health Managed Care payments (see instruction)  15.00 Organ acquisition (DO NOT USE THIS LINE)  16.00 Cost of physicians' services in a teaching hospital (see instructions)  17.00 Subtotal (see instructions)  18.00 Primary payer payments  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	0	14.00
14.00 Nursing and Allied Health Managed Care payments (see instruction) 15.00 Organ acquisition (DO NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0	14.00
15.00 Organ acquisition (DO NOT USE THIS LINE) 16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0	
16.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Subtotal (see instructions) 18.00 Primary payer payments 19.00 Subtotal (line 17 less line 18). 20.00 Deductibles 21.00 Subtotal (line 19 minus line 20) 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	- 1	15.00
17. 00       Subtotal (see instructions)       3,84         18. 00       Primary payer payments       3,84         19. 00       Subtotal (line 17 less line 18).       3,84         20. 00       Deductibles       2         21. 00       Subtotal (line 19 minus line 20)       3,82         22. 00       Coinsurance         23. 00       Subtotal (line 21 minus line 22)       3,82	- 1	16.00
18.00 Primary payer payments  19.00 Subtotal (line 17 less line 18).  20.00 Deductibles  21.00 Subtotal (line 19 minus line 20)  22.00 Coinsurance  23.00 Subtotal (line 21 minus line 22)  3,82	4119	
19.00 Subtotal (line 17 less line 18). 3,84 20.00 Deductibles 2 21.00 Subtotal (line 19 minus line 20) 3,82 22.00 Coinsurance 23.00 Subtotal (line 21 minus line 22) 3,82	0	18.00
20. 00       Deductibles       2         21. 00       Subtotal (line 19 minus line 20)       3,82         22. 00       Coinsurance         23. 00       Subtotal (line 21 minus line 22)       3,82	~	
21. 00       Subtotal (line 19 minus line 20)       3,82         22. 00       Coinsurance         23. 00       Subtotal (line 21 minus line 22)       3,82	440	
22. 00       Coi nsurance         23. 00       Subtotal (Line 21 minus Line 22)         3, 82		
23.00 Subtotal (line 21 minus line 22) 3,82	020	
	010	
	307	
26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27. 00   Subtotal (sum of lines 23 and 25)		
		28.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 29.00 Other pass through costs (see instructions)	0 483	
	483	
30.00   Outlier payments reconciliation 31.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30. 00 31. 00
	- 1	
31.50 Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99 Demonstration payment adjustment amount before sequestration	720	31. 99
32.00 Total amount payable to the provider (see instructions)  3,82		
	515	
32.02 Demonstration payment adjustment amount after sequestration	0	32.02
33. 00 Interim payments 3, 70		
34.00 Tentative settlement (for contractor use only)	0	34.00
	873	
36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
TO BE COMPLETED BY CONTRACTOR		
	833	
51.00 Outlier reconciliation adjustment amount (see instructions)		51.00
52.00 The rate used to calculate the Time Value of Money	0	52.00
53.00 Time Value of Money (see instructions)	0. 00	

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od:	Worksheet E-3

From 01/01/2018 | Part VII To 12/31/2018 | Date/Time Prepared: 5/22/2019 7:59 am Hospi tal Title XIX Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 2, 289, 192 1.00 Medical and other services 2.00 1, 957, 378 2 00 3.00 Organ acquisition (certified transplant centers only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 2, 289, 192 1, 957, 378 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 2, 289, 192 1, 957, 378 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 Ancillary service charges 4, 513, 821 6, 956, 896 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 Incentive from target amount computation 11 00 11 00 Total reasonable charges (sum of lines 8 through 11) 12.00 4, 513, 821 6, 956, 896 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 Ratio of line 13 to line 14 (not to exceed 1.000000) 15.00 Total customary charges (see instructions) 6, 956, 896 4, 513, 821 16.00 16.00 4, 999, 518 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 2, 224, 629 17.00 line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 18.00 18.00 0 16) (see instructions) 19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 2, 289, 192 1, 957, 378 21.00 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 22.00 0 0 23.00 Outlier payments 0 23.00 Program capital payments 0 24.00 24.00 o 25.00 Capital exception payments (see instructions) 25.00 Routine and Ancillary service other pass through costs 0 26,00 Ω 26 00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 0 28.00 Titles V or XIX (sum of lines 21 and 27) 2, 289, 192 1, 957, 378 29.00 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 2, 289, 192 1, 957, 378 31.00 32.00 Deductibles 0 Λ 32.00 33.00 Coi nsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 2, 289, 192 1, 957, 378 36,00 36,00 37.00 TO ZERO OUT MEDICALD -2, 289, 192 -1, 957, 378 37.00 38.00 Subtotal (line 36  $\pm$  line 37) 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 39 00 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 0 0 41.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43.00 43 00 0 chapter 1, §115.2

Health Financial Systems	REID HOSPITAL & HEALTH	CARE SERVICES	In Lieu	ı of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2018	Worksheet E-3 Part VII	
		Component CCN: 15-S048			
		Title XIX	Subprovi der -	Cost	
			I PF		
			I npati ent	Outpati ent	

		. I PF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	199, 459		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	199, 459	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	199, 459	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8. 00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
	basis			
14.00	Amounts that would have been realized from patients liable for payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17.00
	line 4) (see instructions)			
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	199, 459	0	18.00
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21. 00		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			
	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00		0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26. 00	Routine and Ancillary service other pass through costs	0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	,	199, 459	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deducti bl es	0	0	32.00
33.00	Coi nsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2			

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICE	ES	In Lieu	ı of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCM			Worksheet E-3	
			rom 01/01/2018		
	Component CC	CN: 15-T048   T	To 12/31/2018		
				5/22/2019 7:59	9 am
	Title	XIX	Subprovi der -	Cost	
			I RF		
			I npati ent	Outpati ent	
			1. 00	2. 00	

		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	K SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1. 00	Inpatient hospital/SNF/NF services	0	_	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0	0	5.00
6. 00 7. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)	o	0	6. 00 7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES	l ol	0	7.00
	Reasonable Charges			
8. 00	Routi ne servi ce charges	ol		8.00
9. 00	Ancillary service charges	o	0	9.00
10.00	Organ acquisition charges, net of revenue	o	ŭ	10.00
11. 00	Incentive from target amount computation	ol		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	o	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
	basi s			
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	
16.00	Total customary charges (see instructions)	0	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18. 00
10.00	16) (see instructions)	o o	U	10.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	o	0	20.00
	Cost of covered services (enter the lesser of line 4 or line 16)	o	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	ers.		
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	ام	0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	30. 00 31. 00
32.00	Deductibles		0	31.00
33. 00	Coi nsurance		0	33.00
34. 00	Allowable bad debts (see instructions)		0	34.00
35. 00	Utilization review		O	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	o	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	o	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	o	Ü	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	o	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	o	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	o	0	43.00
	chapter 1, §115.2			

OL RECT	Financial Systems REID HOSPITAL & HEALTI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider Co		Period:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	110VIdel C		From 01/01/2018		
				To 12/31/2018	Date/Time Prep 5/22/2019 7:59	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic	programs for	r cost reporti	ng periods	0. 00	1.00
2. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	R 413 79(e)	(1) (see insti	ructions)	0. 00	2.00
3. 00	Amount of reduction to Direct GME cap under section 422 of MM		(1) (000 11.01.	401.01.0)	0. 00	3.00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFI	R §413.79 (m).	(see	0. 00	3. 01
1. 00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare	0. 00	4.00
	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	)	. 3			
1. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst	ructions fo	r cost reporti	ng periods	0. 00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	s (see ins	tructions for	cost reporting	0. 00	4. 02
	periods straddling 7/1/2011)	·				
5. 00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	0. 00	5.00
5. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	r the current	year from your	13. 48	6.00
	records (see instructions)					
7. 00	Enter the lesser of line 5 or line 6		Primary Care	Other	0. 00 Total	7.00
			1.00	2.00	3. 00	
3. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	13. 4	8 0.00	13. 48	8.00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	vi se	0. 0	0.00	0. 00	9.00
. 00	multiply line 8 times the result of line 5 divided by the amo		0.0	0.00	0.00	7.00
	6.					40.00
0.00	Weighted dental and podiatric resident FTE count for the curr Unweighted dental and podiatric resident FTE count for the cu			0. 00 0. 00		10.00
1. 00	Total weighted FTE count	arrent year	0.0			11.00
12.00	Total weighted resident FTE count for the prior cost reportir	ng year (see	0.0	0. 00		12.00
13. 00	instructions) Total weighted resident FTE count for the penultimate cost re	enorti na	0. 0	0.00		13.00
10.00	year (see instructions)	por triig	0.0	0.00		10.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	d by 3).	0.0			14.00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	orograms	13. 4 13. 4			15. 00 15. 01
16. 00	Adjustment for residents displaced by program or hospital clo		0.0			16.00
16. 01	Unweighted adjustment for residents displaced by program or h	nospi tal	0. 0	0.00		16. 01
17. 00	closure Adjusted rolling average FTE count		13. 4	8 0.00		17.00
18. 00	Per resident amount		85, 000. 0			18.00
19. 00	Approved amount for resident costs		1, 145, 80	0 0	1, 145, 800	19.00
					1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42		20.00
24 00	Sec. 413.79(c)(4)				10.40	04.00
21. 00 22. 00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr	,				21. 00 22. 00
	Enter the locality adjustment national average per resident a	,	instructions)			23.00
	Multiply line 22 time line 23				0	
25. 00	Total direct GME amount (sum of lines 19 and 24)		Inpati ent	Managed care	1, 145, 800	25.00
			Part A	Mariagea eare		
	COMPUTATION OF PROCESM DATIENT LOAD		1.00	2. 00	3. 00	
26. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		28, 92	6 3, 766		26. 00
	Total Inpatient Days (see instructions)		51, 00			27.00
27. 00	1		0 5/747	( 0 070040		28.00
28. 00	Ratio of inpatient days to total inpatient days		0. 56717			
27. 00 28. 00 29. 00 30. 00			649, 87			29. 00 30. 00

Heal th	Financial Systems REID HOSPITAL & HEALTH	I CARE SERVICES	In lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 15-0048	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	`		I CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	949, 063	33.00
34.00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0.000000	34.00
35. 00	7			0	35.00
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			75, 900, 102	
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00 40. 00
40.00	Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		30, 698 75, 869, 404	
41.00	Part B Reasonable Cost	is Title 40)		73, 609, 404	41.00
42.00				42, 126, 569	42.00
43. 00				7, 564	
	Total Part B reasonable cost (line 42 minus line 43)			42, 119, 005	
	Total reasonable cost (sum of lines 41 and 44)			117, 988, 409	
	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line 45)		0. 643024	
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin	e 44 ÷ line 45)		0. 356976	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			
	Total program GME payment (line 31)			722, 524	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)			464, 600	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		257, 924	50.00

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

Provider CCN: 15-0048

1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	CURRENT ASSETS  Cash on hand in banks  Temporary investments  Notes receivable  Accounts receivable  Other receivable  Allowances for uncollectible notes and accounts receivable Inventory  Prepaid expenses  Other current assets  Due from other funds  Total current assets (sum of lines 1-10)  FIXED ASSETS  Land  Land improvements  Accumulated depreciation  Buildings	6, 570, 398 5, 033, 520 0 -1 379, 929, 798	Speci fi c Purpose Fund 2.00	Endowment Fund 3.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91 ant Fund 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Cash on hand in banks Temporary investments Notes recei vable Accounts recei vable Other recei vable Allowances for uncollectible notes and accounts recei vable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	22, 742, 836 289, 971, 709 0 125, 459, 308 -923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	2.00 0 0 0 0 0 0 0 0	3. 00 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Cash on hand in banks Temporary investments Notes recei vable Accounts recei vable Other recei vable Allowances for uncollectible notes and accounts recei vable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	289, 971, 709 0 125, 459, 308 -923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00	Temporary investments Notes receivable Accounts receivable Other receivable Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	289, 971, 709 0 125, 459, 308 -923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Notes receivable Accounts receivable Other receivable Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	0 125, 459, 308 -923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Accounts receivable Other receivable Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	-923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Allowances for uncollectible notes and accounts receivable Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	-923, 225 -68, 924, 747 6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0	0 0 0 0 0 0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Inventory Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	6, 570, 398 5, 033, 520 0 -1 379, 929, 798	0 0 0 0	0 0 0 0 0 0	0 0 0	7. 00 8. 00 9. 00 10. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Prepaid expenses Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	5, 033, 520 0 -1 379, 929, 798	0 0	0 0 0 0	0 0	8. 00 9. 00 10. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Other current assets Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	0 -1 379, 929, 798	0	0 0 0 0	0	9. 00 10. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Due from other funds Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	14, 477, 094	0	0 0 0	0	10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total current assets (sum of lines 1-10) FIXED ASSETS Land Land improvements Accumulated depreciation	14, 477, 094	- 1	0		
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	FIXED ASSETS Land Land improvements Accumulated depreciation	14, 477, 094	<u> </u>	<u>~</u>	()	
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Land Land improvements Accumulated depreciation	l '				1 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Accumulated depreciation	14 000 010	0	0	0	12.00
15. 00 16. 00 17. 00 18. 00 19. 00		14, 989, 210	0	o	0	13.00
16. 00 17. 00 18. 00 19. 00	Bui I di nas	0	0	0	0	
17. 00 18. 00 19. 00		297, 210, 638	0	0	0	
18. 00 19. 00	Accumulated depreciation	-141, 966, 941	0	0	0	
19. 00	Leasehold improvements Accumulated depreciation	12, 458, 447 -7, 175, 092	0	U O	0	
	Fi xed equi pment	2, 182, 235	0	0	0	
20.00	Accumulated depreciation	-1, 505, 214	Ö	ő	0	
	Automobiles and trucks	0	0	o	0	
22. 00	Accumulated depreciation	0	0	o	0	22.00
	Major movable equipment	182, 552, 200	0	0	0	
	Accumulated depreciation	-150, 926, 554	0	0	0	
	Mi nor equi pment depreci abl e	0	0	0	0	
	Accumul ated depreciation	0	0	0	0	
	HIT designated Assets Accumulated depreciation	0	0	0	0	
	Mi nor equi pment-nondepreci abl e	0	0	0	0	
	Total fixed assets (sum of lines 12-29)	222, 296, 023	Ö	ol		
	OTHER ASSETS					
	Investments	0	0	0	0	
	Deposits on Leases	0	0	0	0	
1	Due from owners/officers	0	0	0	0	
	Other assets Total other assets (sum of lines 31-34)	69, 604, 154 69, 604, 154	0	0	0	
	Total assets (sum of lines 11, 30, and 35)	671, 829, 975	0	Ö	0	
	CURRENT LIABILITIES		- 1	-1		1
37.00	Accounts payable	19, 610, 621	0	0	0	37.00
	Salaries, wages, and fees payable	21, 532, 268	0	0	0	
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	7, 818, 388	0	0	0	
1	Deferred income Accelerated payments	-36, 621	U	٩	Ü	41.00
1	Due to other funds	-30, 021	0	0	0	1
	Other current liabilities	0	Ö	ő	0	
	Total current liabilities (sum of lines 37 thru 44)	48, 924, 656	0	o	0	
	LONG TERM LIABILITIES					
1	Mortgage payable	0	0	0	0	
	Notes payable	215, 389, 425	0	0	0	
1	Unsecured Loans	0 270 (40	0	0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	2, 279, 640 217, 669, 065	0	0	0	1
1	Total liabilities (sum of lines 45 and 50)	266, 593, 721	0	o	0	
H	CAPI TAL ACCOUNTS	200/070/721	<u> </u>	<u> </u>		000
	General fund balance	405, 236, 254				52.00
53. 00	Specific purpose fund		0			53.00
1	Donor created - endowment fund balance - restricted			0		54.00
	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance			o	0	56.00
1	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				U	30.00
	Total fund balances (sum of lines 52 thru 58)	405, 236, 254	0	О	0	59.00
	Total liabilities and fund balances (sum of lines 51 and	671, 829, 975	0	o	0	
	59)					1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					o 12/31/2018	Date/Time Pre 5/22/2019 7:5	
		General	Fund	Special Pu	irpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	44	432, 860, 072 -27, 623, 862 405, 236, 210		0	0 0	5. 00
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	44 405, 236, 254	0 0	0	000000000000000000000000000000000000000	7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 Endowment	0 405, 236, 254 PI ant			0	16. 00
		Fund	7. 00	0.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	6.00	7.00 0 0 0 0				1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0	C			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		d			19.00

 
 Heal th Financial
 Systems
 REID HO

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0048

		'	0 12/31/2016	5/22/2019 7:5	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	55, 068, 173	i i	55, 068, 173	1.00
2.00	SUBPROVIDER - I PF	10, 503, 695		10, 503, 695	2.00
3.00	SUBPROVI DER - I RF	4, 109, 657		4, 109, 657	3. 00
4.00	SUBPROVIDER			,	4.00
5. 00	Swing bed - SNF			0	5. 00
6. 00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY			ŭ,	7. 00
8. 00	NURSING FACILITY				8.00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	69, 681, 525		69, 681, 525	10.00
10.00	Intensive Care Type Inpatient Hospital Services	07,001,020		07,001,020	10.00
11. 00	INTENSIVE CARE UNIT	11, 327, 309		11, 327, 309	11. 00
12. 00	CORONARY CARE UNIT	11, 027, 007		11,027,007	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 I	i nes 11, 327, 309		11, 327, 309	16. 00
10.00	111-15)	11, 327, 309		11, 327, 307	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	81, 008, 834		81, 008, 834	17. 00
18. 00	Ancillary services	262, 232, 756		686, 435, 180	18.00
19. 00	Outpatient services	14, 936, 003		74, 457, 700	19.00
20. 00	RURAL HEALTH CLINIC	14, 936, 003		74, 437, 700	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
			· O	U	
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES				23.00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P. )	07.100	F 004 700	E 404 047	25.00
26.00	HOSPICE	97, 189			26.00
27. 00	OTHER	78, 369, 187			27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 436,643,969	589, 571, 309	1, 026, 215, 278	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		475 040 474		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		475, 249, 474		29. 00
30.00	ADD (SPECIFY)	C	1		30.00
31.00		C			31.00
32.00					32.00
33.00		C			33.00
34.00					34.00
35.00	T	C			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00					38.00
39. 00					39. 00
40.00			1		40.00
41.00		C			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	475, 249, 474		43.00
	to Wkst. G-3, line 4)	I	1		

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0048	Peri od:	Worksheet G-3

Hear th	dealth Financial Systems Reid Hospital & Health Care Services In Lieu of Form CMS-250				
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0048	Peri od:	Worksheet G-3	
			From 01/01/2018		narad.
			To 12/31/2018	Date/Time Prep 5/22/2019 7:59	
				0,22,201, 1.0	, diii
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1, 026, 215, 278	1.00
2.00	Less contractual allowances and discounts on patients' accou	nts		594, 059, 301	2.00
3.00	Net patient revenues (line 1 minus line 2)			432, 155, 977	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		475, 249, 474	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-43, 093, 497	5. 00
	OTHER INCOME				l
6.00	Contributions, donations, bequests, etc			2, 760, 000	6. 00
7.00	Income from investments			-5, 972, 027	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
	Purchase di scounts			9, 364	
	Rebates and refunds of expenses			0	11.00
	Parking Lot receipts			0	12.00
	Revenue from laundry and linen service			357, 518	
	Revenue from meals sold to employees and guests			3, 712, 515	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patrents		0	16.00
	Revenue from sale of drugs to other than patients			18, 000	
	Revenue from sale of medical records and abstracts			52, 949	
	Tuition (fees, sale of textbooks, uniforms, etc.)			44, 230	
	Revenue from gifts, flowers, coffee shops, and canteen			15 220	20. 00 21. 00
	Rental of vending machines			15, 339	
	Rental of hospital space			6, 392, 370	22.00
	Governmental appropriations OTHER INCOME			0 8, 079, 377	
				15, 469, 635	
	Total other income (sum of lines 6-24) Total (line 5 plus line 25)			-27, 623, 862	
	OTHER EXPENSES (SPECIFY)			-27, 023, 802	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			-27, 623, 862	
27.00	inct theome (or 1033) for the period (title 20 illinus title 20)			21,023,002	27.00

						5/22/2019 7:5	9 am
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col. 1 plus	CATI ONS		
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		1, 650	1, 650	-1, 650	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	1	5, 127	5, 127	ol	5, 127	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	o	69, 231	69, 231	26, 058	95, 289	3.00
4.00	ADMINISTRATIVE & GENERAL*	585, 611	33, 664		18, 452	637, 727	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	-29		0	-29	5.00
6. 00	LAUNDRY & LINEN SERVICE*			0	ő	0	6.00
7. 00	HOUSEKEEPI NG*		0		ő	0	7. 00
8. 00	DI ETARY*		4, 418	4, 418	0	4, 418	8.00
9. 00	NURSING ADMINISTRATION*		4, 410	4, 410		4, 410	9.00
	ROUTINE MEDICAL SUPPLIES*		0		o o	0	
10.00	MEDICAL SUPPLIES*		0		U	0	10.00
11.00		0	104 004	104 004	O O	104 004	11.00
12. 00	STAFF TRANSPORTATION*	0	104, 826	104, 826	O	104, 826	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	143, 578	143, 578	0	143, 578	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15. 00
16. 00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSI CI AN SERVI CES**	O	187, 321	187, 321	ol	187, 321	26. 00
27.00	NURSE PRACTITIONER**	o	. 0	o	ol	0	27. 00
28. 00	REGISTERED NURSE**	211, 977	0	211, 977	202, 394	414, 371	28. 00
29. 00	LPN/LVN**	33, 010	0	33, 010	80, 315	113, 325	29. 00
30.00	PHYSI CAL THERAPY**	0	0	00,010	00,010	0	30.00
31. 00	OCCUPATIONAL THERAPY**		0		ol Ol	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**		0		0	0	32.00
33. 00	MEDICAL SOCIAL SERVICES**		0			0	33.00
34. 00	SPIRITUAL COUNSELING**		0		ol ol	0	34.00
			0		o o	0	
35. 00	DI ETARY COUNSELI NG**		0		U	-	35.00
36.00	COUNSELING - OTHER**	00 505	0	00 505	50,000	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	99, 585	0	99, 585	58, 898	158, 483	37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	0	0	O	0	38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	0	0	0	0	39. 00
40. 00	I MAGING SERVICES**	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	137, 881	137, 881	23, 751	161, 632	42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY**	0	0	0	o	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	O	800, 507	800, 507	ol	800, 507	46.00
	NONREI MBURSABLE COST CENTERS	'	·		<u> </u>	•	
60.00	BEREAVEMENT PROGRAM *	0	0	O	o	0	60.00
61. 00	VOLUNTEER PROGRAM *		0	0	ő	0	61.00
62. 00	FUNDRAI SI NG*		0		ol Ol	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*		0		0	0	63.00
			0			0	
64. 00 65. 00	PALLIATIVE CARE PROGRAM*		0		ν Q	0	64.00
	OTHER PHYSICIAN SERVICES*		0		Š	-	65.00
66.00	RESI DENTI AL CARE*		0		O	0	66.00
67.00	ADVERTI SI NG*	0	982	982	0	982	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	] 0	0	0	68.00
69. 00	THRI FT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
100.00	TOTAL	930, 183	1, 489, 156	2, 419, 339	408, 218	2, 827, 557	100.00

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

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/22/2019 7:59 am Provider CCN: 15-0048 Hospi ce CCN: 15-1524

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				4
1.00	CAP REL COSTS-BLDG & FIXT*	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	, -, · <u>-</u> ·		2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-316	94, 973		3. 00
4.00	ADMINISTRATIVE & GENERAL*	0	637, 727		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	-29	l control of the cont	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	0		7. 00
8.00	DI ETARY*	0	4, 418		8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDI CAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	104, 826		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	143, 578		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25. 00
26.00	PHYSICIAN SERVICES**	0	187, 321		26.00
27.00	NURSE PRACTITIONER**	0	0		27. 00
28.00	REGI STERED NURSE**	0	414, 371		28. 00
29.00	LPN/LVN**	0	113, 325		29. 00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33. 00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35. 00	DI ETARY COUNSELI NG**	0	Ö	•	35.00
36. 00	COUNSELING - OTHER**	0	Ö		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	158, 483	•	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39. 00	PATI ENT TRANSPORTATI ON**	0	Ö	·	39.00
40. 00	I MAGING SERVICES**	0	Ö		40.00
41. 00	LABS & DI AGNOSTI CS**	0	Ö	i e	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	161, 632	i e	42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0	1	42. 50
43. 00	OUTPATIENT SERVICES**	0	Ö		43.00
44. 00	PALLIATIVE RADIATION THERAPY**	0	Ö		44.00
45. 00	PALLIATIVE CHEMOTHERAPY**	0	Ö		45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	ŀ	·	46.00
10.00	NONREI MBURSABLE COST CENTERS		000,007		1 .0.00
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	· -		61.00
62. 00	FUNDRAI SI NG*	0	ĺ		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	ĺ	l .	63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	ĺ		64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66. 00	RESI DENTI AL CARE*	0			66.00
67. 00	ADVERTI SI NG*	-982		•	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	-902			68.00
69. 00	THRIFT STORE*	0		•	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0		l control of the cont	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)*	0		•	71.00
100.00		-1, 298		•	100.00
	efor the amounts in column 7 to Wkst. O.E. co			1	1100.00

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME Provi der CCN: 15-0048 Peri od: Worksheet 0-2 From 01/01/2018 CARE Hospi ce CCN: 15-1524 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Hospi ce I SALARI ES OTHER SUBTOTAL RECLASSI FI -SUBTOTAL (col . 1 + CATI ONS col. 2) 4.00 1.00 2.00 3.00 5.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 187, 321 26.00 0 187, 321 187, 321 26.00 o 27.00 NURSE PRACTITIONER 0 27.00 28.00 REGISTERED NURSE 211, 977 211, 977 211, 977 28.00 33, 010 29.00 LPN/LVN 33, 010 0 0 0 33, 010 29.00 PHYSI CAL THERAPY 30.00 0 C 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 32.00 MEDICAL SOCIAL SERVICES 0 33.00 0 33.00 0 0 SPIRITUAL COUNSELING 0 34.00 0 34.00 35.00 DIETARY COUNSELING 0 0 0 35.00 36.00 COUNSELING - OTHER 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 99, 585 37.00 0 99, 585 99, 585 37.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 38.00 PATIENT TRANSPORTATION 0 39.00 39.00 0 0 IMAGING SERVICES 0 0 40.00 0 0 40.00 LABS & DIAGNOSTICS 0 O 41.00 Λ 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 137, 881 137, 881 137, 881 42.00 DRUGS CHARGED TO PATIENTS 42.50 0 0 0 0 42.50 OUTPATIENT SERVICES 43.00 C 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 800, 507 800, 507 800, 507 46. 00 100. 00 TOTAL 572 1, 125, 709 1, 470, 281 1, 470, 281 100. 00

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATI ENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	187, 321	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	211, 977	28. 00
29. 00	LPN/LVN	0	33, 010	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	99, 585	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	137, 881	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	800, 507	46.00
100.00	TOTAL *	0	1, 470, 281	100.00

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

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/22/2019 7:59 am Provider CCN: 15-0048 RESPITE CARE Hospi ce CCN: 15-1524

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE C	OST CENTERS					
25. 00   I NPATI ENT CARE-CONTRACTED		0	0	0	0	25. 00
26.00 PHYSICIAN SERVICES	0	0	0	0	0	26.00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	0	0	22, 506	22, 506	28. 00
29. 00 LPN/LVN	0	0	0	8, 931	8, 931	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35. 00 DIETARY COUNSELING	0	0	0	0	0	35.00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERV	TI CES 0	0	0	6, 549	6, 549	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXY	GEN O	0	0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 I MAGING SERVICES	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	0	0	2, 641	2, 641	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42. 50
43.00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (	SPECIFY) 0	0	0	0	0	46. 00
100. 00 TOTAL *	0	0	0	40, 627	40, 627	100.00
* T	. Wi. + O F I 1 1: F2					

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

	· · · · · · · · · · · · · · · · · · ·			
		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	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	22, 506	28.00
29.00	LPN/LVN	0	8, 931	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	6, 549	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	2, 641	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	40, 627	100.00

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

			nospi ce cei	15 1524	10 12/31/2010	5/22/2019 7:5	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED		0		0	0	
	PHYSI CI AN SERVI CES	0	0		0	0	0.00
	NURSE PRACTITIONER	0	0		0	0	
28. 00	REGI STERED NURSE	0	0		0 179, 888	179, 888	
	LPN/LVN	0	0		0 71, 384	71, 384	1
	PHYSI CAL THERAPY	0	0		0	0	
	OCCUPATI ONAL THERAPY	0	0		0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
	MEDICAL SOCIAL SERVICES	0	0		0	0	33.00
	SPI RI TUAL COUNSELI NG	0	0		0	0	01.00
	DI ETARY COUNSELI NG	0	0		0	0	35.00
	COUNSELING - OTHER	0	0		0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 52, 349	52, 349	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0		0	0	39.00
40.00	I MAGING SERVICES	0	0		0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0		0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 21, 110	21, 110	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0		0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0	0	46.00
100.00	TOTAL *	0	0		0 324, 731	324, 731	100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED		0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	Ö	26.00
27. 00	NURSE PRACTITIONER		0	27.00
28. 00	REGI STERED NURSE	0	179, 888	28.00
29. 00	LPN/LVN		71, 384	29.00
30.00	PHYSI CAL THERAPY		0	30.00
31.00	OCCUPATI ONAL THERAPY	C	o	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	C	o	32.00
33.00	MEDICAL SOCIAL SERVICES	C	o	33.00
34.00	SPIRITUAL COUNSELING	C	o	34.00
35.00	DI ETARY COUNSELING	C	o	35.00
36.00	COUNSELING - OTHER	C	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	C	52, 349	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	C	0	38.00
39.00	PATIENT TRANSPORTATION	C	0	39.00
40.00	I MAGING SERVICES	C	0	40.00
41.00	LABS & DIAGNOSTICS	C	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	C	21, 110	42.00
42.50	DRUGS CHARGED TO PATIENTS	C	0	42. 50
43.00	OUTPATIENT SERVICES	C	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	C	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	C	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	C	0	46. 00
100.00	TOTAL *	C	324, 731	100.00

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

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	of Form CMS-2552-10
COST ALLOCATION - DETERMINATION O	F HOSPITAL-BASED HOSPICE NET	Provider CCN: 15-0048		Worksheet 0-5
EVERYORS FOR ALLOCATION			Erom 01/01/2010	

EXPENSES FOR ALLOCATION 15-1524 To 12/31/2018 Date/Time Prepared: Hospi ce CCN: 5/22/2019 7:59 am Hospi ce I HOSPI CE GENERAL TOTAL Descriptions EXPENSES (sum DI RECT SERVI CE EXPENSES (see EXPENSES FROM of cols. 1 + instructions) WKST B PART I 2) (see instructions) 1.00 2. 00 3. 00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 7,069 7,069 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 5, 127 5, 127 2.00 EMPLOYEE BENEFITS DEPARTMENT 94, 973 229, 264 324, 237 3.00 3.00 ADMINISTRATIVE & GENERAL 637, 727 508, 234 4.00 1, 145, 961 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 6.00 0 7.00 HOUSEKEEPI NG 31, 816 31,816 7.00  $\cap$ 8.00 DI ETARY 4, 418 4, 418 8.00 9.00 NURSING ADMINISTRATION 0 9.00 ROUTINE MEDICAL SUPPLIES 10.00 0 38 38 10.00 MEDICAL RECORDS 51, 794 11.00 0 51, 794 11.00 12.00 STAFF TRANSPORTATION 104,826 104,826 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 PHARMACY 321, 801 14 00 143, 578 178, 223 14 00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 C 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 40, 6<u>63</u> 17.00 40, 663 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 0 50.00 51.00 HOSPICE ROUTINE HOME CARE 1, 470, 281 1, 470, 281 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 40, 627 40,627 52.00 HOSPICE GENERAL INPATIENT CARE 324, 731 53.00 324, 731 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 60.00 VOLUNTEER PROGRAM 61.00 0 61.00 0 0 **FUNDRALSING** 62.00 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 OTHER PHYSICIAN SERVICES 0 65.00 0 65.00 66.00 RESIDENTIAL CARE 0 66.00 ADVERTI SI NG 67.00 67.00 0 68.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 0 THRIFT STORE 69.00 69.00 0 0 70.00 NURSING FACILITY ROOM & BOARD 0 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00

99.00

-29

3, 873, 360 100. 00

29

1, 047, 101

2, 826, 259

99.00 NEGATIVE COST CENTER

100.00 TOTAL

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

From 01/01/2018 Part I Hospi ce CCN: 15-1524 12/31/2018 Date/Time Prepared: To 5/22/2019 7:59 am Hospi ce I TOTAL CAP REL BLDG CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions **EXPENSES** & FIX EQUI P **BENEFITS DEPARTMENT** 0 1.00 2.00 3.00 ЗА GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 7,069 7, 069 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 5, 127 2 00 5, 127 3.00 EMPLOYEE BENEFITS DEPARTMENT 324, 237 0 324, 237 3.00 ADMINISTRATIVE & GENERAL 1, 145, 961 7,069 0 151, 385 1, 304, 415 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 5.00 LAUNDRY & LINEN SERVICE 0 6.00 0 C 0 0 6.00 7.00 HOUSEKEEPI NG 31, 816 0 0 31, 816 7.00 8.00 DI ETARY 4, 418 0 0 0 4, 418 8.00 0 NURSING ADMINISTRATION 0 9.00 0 9.00 0 0 ROUTINE MEDICAL SUPPLIES 0 0 10.00 38 38 10.00 11.00 MEDICAL RECORDS 51, 794 0 0 0 51, 794 11.00 12.00 STAFF TRANSPORTATION 104, 826 104, 826 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 0 13.00 0 0 14.00 PHARMACY 321, 801 0 0 0 321, 801 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 0 0 0 OTHER GENERAL SERVICE 0 0 16.00 16.00 0 0 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 40, 663 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 1, 470, 281 86, 799 1,557,080 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 40, 627 C 565 9, 569 50, 761 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 324, 731 0 4,562 76, 484 405, 777 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 0 0 0 61.00 FUNDRAI SI NG 0 o 62.00 0000000 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 0 63.00 0 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 0 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG 0 0 0 67 00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 0 0 68.00 0 69.00 THRIFT STORE C 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 0 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 O 71.00 C 0 0 99.00 NEGATIVE COST CENTER -29 C 0 99.00 100.00 TOTAL 3, 873, 360 7, 069 5, 127 324, 237 3, 873, 360 100. 00

Provi der CCN: 15-0048

Peri od:

Heal th FinancialSystemsREID HOSPITAL & HEALTH CARE SERVICESCOST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTSProvider CCN: 1 In Lieu of Form CMS-2552-10 Worksheet 0-6 Part I Date/Time Prepared: 5/22/2019 7:59 am Provider CCN: 15-0048 Peri od: From 01/01/2018 To 12/31/2018 Hospi ce CCN: 15-1524 Hospi ce I

	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	263611 p 11 0113	E & GENERAL	OPERATION &	LINEN SERVICE	HOUSEREEFFING	DI EITAKI	
		E a centente	MAI NTENANCE	LINEN SERVICE			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	1, 304, 415					4.00
5.00	PLANT OPERATION & MAINTENANCE	0	C				5.00
6.00	LAUNDRY & LINEN SERVICE	0	C	0			6.00
7.00	HOUSEKEEPI NG	16, 155	C		47, 971		7.00
8.00	DI ETARY	2, 243	C		0	6, 661	8.00
9.00	NURSING ADMINISTRATION	0	C		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	19	C		0		10.00
11.00	MEDI CAL RECORDS	26, 299	C	)	0		11.00
12.00	STAFF TRANSPORTATION	53, 226	C		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C		0		13.00
14.00	PHARMACY	163, 397	C		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C		0		15.00
16.00	OTHER GENERAL SERVICE	0	C		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	20, 647	C	)	0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	790, 619					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	25, 774	C		5, 282	741	
53. 00	HOSPICE GENERAL INPATIENT CARE	206, 036	C	0	42, 689	5, 920	53.00
	NONREI MBURSABLE COST CENTERS	т		1			
60.00	BEREAVEMENT PROGRAM	0	C	)	0		60.00
61.00	VOLUNTEER PROGRAM	0		)	0		61.00
62.00	FUNDRAL SI NG	0		<u>'</u>	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM	0		(	0		63.00
64.00	OTHER PHYSICIAN SERVICES	0			O O		64.00
65. 00 66. 00	RESIDENTIAL CARE	0			0	0	65. 00 66. 00
67. 00	ADVERTI SI NG	0		,	0	U	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0		68.00
69. 00	THRIFT STORE				0		69.00
70. 00	NURSING FACILITY ROOM & BOARD				o o		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	٠		n	0	1
99. 00	NEGATI VE COST CENTER					0	
	TOTAL	1, 304, 415	Ċ	o o	47, 971	_	100.00
	· · · · · · <del>· ·</del>	., 55., 116	·	1		2,001	1.30.00

0

158, 052

0 99.00

0 100.00

In Lieu of Form CMS-2552-10 Health Financial Systems COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2018 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2018 5/22/2019 7:59 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 9.00 10.00 11.00 12.00 13.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 000000 ROUTINE MEDICAL SUPPLIES 57 10.00 10.00 11.00 MEDICAL RECORDS 78,093 11.00 12.00 STAFF TRANSPORTATION 158, 052 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 158, 052 0 50.00 0 HOSPICE ROUTINE HOME CARE 74,098 51.00 51.00 54 0 0 52.00 HOSPICE INPATIENT RESPITE CARE C 444 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 3, 551 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 0 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 62.00 FUNDRAI SI NG 62.00 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 Ω 71.00 0 0 0

57

78, 093

99.00 NEGATIVE COST CENTER

100.00 TOTAL

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2018 Part I Hospi ce CCN: 15-1524 12/31/2018 Date/Time Prepared: 5/22/2019 7:59 am Hospi ce I PHARMACY PHYSI CI AN OTHER GENERAL PATI ENT/ TOTAL Descriptions ADMI NI STRATI V SERVI CE RESI DENTI AL E SERVICES CARE SERVICES 14.00 15.00 16.00 17.00 18.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 14.00 PHARMACY 485, 198 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 0 15.00 OTHER GENERAL SERVICE 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 61, 310 17.00

LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 158, 052 50.00 0 HOSPICE ROUTINE HOME CARE 460, 377 2, 882, 228 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 2, 761 0 6, 819 92, 582 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 22,060 0 54, 491 740, 527 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 0000000 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 66.00 0 67 00 ADVERTI SI NG 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 71.00 0 0 99. 00 NEGATI VE COST CENTER 0 0 -29 99.00 100.00 TOTAL 485, 198 61, 310 3, 873, 360 100. 00

Health Financial	Systems	REID HOSPITAL & HEALTH	H CARE SERVICES		In Lieu of Form CMS-2552-10
MOLTADOLATION	LIOCOL TAL DA	ACED HOSDICE CENEDAL CEDVICE COSTS	Dravi dan CCN, 1E 0040	Dorsi od.	Warkshoot O (

Peri od: From 01/01/2018 To 12/31/2018 OST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0048 Worksheet 0-6 Part II STATISTICAL BASIS Date/Time Prepared: Hospi ce CCN: 15-1524 5/22/2019 7:59 am Hospi ce I Cost Center Descriptions CAP REL BLDG CAP REL MVBLE **EMPLOYEE** RECONCILIATIO ADMINISTRATIV & FIX EQUI P **BENEFITS** E & GENERAL Ν (SQUARE FEET) (DOLLAR DEPARTMENT (ACCUMULATED VALUE) (GROSS COSTS) SALARI ES) 1. 00 2.00 4.00 3.00 4A GENERAL SERVICE COST CENTERS 1 00 445 1 00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 445 2.00 EMPLOYEE BENEFITS DEPARTMENT 1, 287, 139 3.00 0 0 3.00 ADMINISTRATIVE & GENERAL 4.00 445 0 600, 960 -1, 304, 415 2, 568, 974 4.00 PLANT OPERATION & MAINTENANCE 5.00 0 0 0 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 31, 816 7.00 0 8.00 DI FTARY 0 0 0 4, 418 8.00 NURSING ADMINISTRATION 0 9.00 0000 0 0 O 9.00 10.00 ROUTINE MEDICAL SUPPLIES 38 10.00 0 11.00 MEDICAL RECORDS 0 0 51, 794 11.00 STAFF TRANSPORTATION 0 0 12.00 104, 826 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 0 0 14.00 **PHARMACY** 0 0 321, 801 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 C 0 15.00 16.00 OTHER GENERAL SERVICE 0 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 40, 663 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 Λ 50.00 51.00 HOSPICE ROUTINE HOME CARE 344, 572 0 1,557,080 51.00 HOSPICE INPATIENT RESPITE CARE 49 37, 986 0 52.00 0 50, 761 52.00 405, 777 53 00 HOSPICE GENERAL INPATIENT CARE 0 396 303, 621 0 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 0 60.00 VOLUNTEER PROGRAM 0 0 61.00 0 0 0 0 61.00 0 0 62 00 FUNDRAI SI NG 0 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0000 0 0 64.00 0 0 0 0 OTHER PHYSICIAN SERVICES 65.00 0 0 0 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 0 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 0 C 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 1, 304, 415 100. 00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 5, 127 7.069 324, 237

15.885393

11. 521348

0.251905

0. 507757 101. 00

101.00 UNIT COST MULTIPLIER

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

STATISTICAL BASIS

Provider CCN: 15-0048
Hospice CCN: 15-1524

Hospice I

Cost Center Descriptions

PLANT
OPERATION &
MAINTENANCE
(SOUARE FEET)

SOUARE FEET)

DAYS)

In Lieu of Form CMS-2552-10

Worksheet 0-6
Part II
Date/Time Prepared: 5/22/2019 7:59 am

Hospice I

NURSING
ADMINISTRATIO
N
(IN-FACILITY
DAYS)

N (DIRECT NURS.
HRS.)

FROM 01/01/2018
BY
OPERATION &
MAINTENANCE
(SOUARE FEET)
DAYS)

FROM 01/01/2018
BY
OPERATION &
MORSHOET 0-6
Part II
Date/Time Prepared: 5/22/2019 7:59 am

HOUSEKEEPING
(IN-FACILITY
DAYS)

N (DIRECT NURS.
HRS.)

9-00

	Cost Center Descriptions	OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	(SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	ADMI NI STRATI O  N (DI RECT NURS.	
						HRS. )	
	CENEDAL CEDALCE COCT CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1 (	GENERAL SERVICE COST CENTERS O CAP REL COSTS-BLDG & FIXT		T	I			1.00
1. 0							
2. 0							2.00
3.0							3.00
4. 0 5. 0							4. 00 5. 00
		0					
6.0		0					6.00
7.0		0	<u>'</u>	445	052		7.00
8.0		0	<u>'</u>	0	953		8.00
9. 0		0	<u>'</u>	0		0	9.00
10.		0	(	0		-	10.00
11.		0	(	0		0	11.00
12.		0	(	0		0	12.00
13.		0	<u>'</u>	0		0	13.00
14.		0	<u>'</u>	0		0	14.00
15.		0	<u>'</u>	0		0	15.00
16.		0	<u>'</u>	0		0	16.00
17.	00 PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE	0	)	] 0			17. 00
50.						0	50.00
50. 51.							51.00
52.		0		49	106		52.00
52. 53.		0		1	847		53.00
55.	NONREI MBURSABLE COST CENTERS		,	370	047	0	33.00
60.		1 0	<b>\</b>	1 0		0	60.00
61.		0	l .	1 0		0	61.00
62.		0		1 0		l o	62.00
63.		0		0		o o	63.00
64.		0		0		0	64.00
65.		0		0		o o	65.00
66.		0		l ő	0	o o	66.00
67.		0		0	· ·	0	67.00
68.		0		0		o o	68. 00
69.		0		0		0	69. 00
70.	OO NURSING FACILITY ROOM & BOARD						70.00
71.		0	0	0	0	0	71.00
99.	· · · · · · · · · · · · · · · · · · ·				_		99.00
	0.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I	) 0	0	47, 971	6, 661	o	100.00
	. OO UNIT COST MULTIPLIER	0. 000000	0. 000000			0.000000	101.00
	•	1	•	•		'	•

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

Hear th	Financial Systems REID	HUSPITAL & HEALT	H CARE SERVI	CES	in Lie	u of form CMS-	<u> 2552-10</u>
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der C	CN: 15-0048	Peri od:	Worksheet 0-6	)
STATIS	STICAL BASIS			N 45 4504	From 01/01/2018		
			Hospi ce CC	N: 15-1524	To 12/31/2018	Date/Time Pre 5/22/2019 7:5	epared:
					Hospi so I	3/22/2019 7. 3	9 4111
	Cook Cooker Decordations	DOUTLNE	MEDICAL	CTAFF	Hospi ce I	DUADMACY	
	Cost Center Descriptions	ROUTI NE	MEDI CAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER	PHARMACY	
		MEDI CAL				(CHARGES)	
		SUPPLI ES	(PATI ENT	N (MILEAGE)	COORDI NATI ON		
		(PATIENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)	11 00	10.00	SERVICE)	14.00	
	CENEDAL CEDIUCE COCT CENTEDO	10. 00	11. 00	12. 00	13.00	14. 00	
1 00	GENERAL SERVICE COST CENTERS	T T		I			1 00
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8. 00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES	18, 629					10.00
11. 00	MEDI CAL RECORDS		18, 629				11.00
12.00	STAFF TRANSPORTATION			1, 00	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0		13.00
14.00	PHARMACY				0	18, 629	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16.00	OTHER GENERAL SERVICE				0 0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE	<b>'</b>					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1, 00	0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	17, 676	17, 676		0 0	17, 676	
52.00	HOSPICE INPATIENT RESPITE CARE	106	106	•	o o	106	1
53.00	HOSPICE GENERAL INPATIENT CARE	847	847		o o	847	
00.00	NONREI MBURSABLE COST CENTERS	017	017	ļ.	<u> </u>	017	00.00
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM				o o	0	61.00
62.00	FUNDRAI SI NG				0 0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	Ö	
64. 00	PALLIATIVE CARE PROGRAM				0 0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65.00
66.00	RESI DENTI AL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0	0	1
					0 0	_	
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	
69.00	THRIFT STORE				U U	0	07.00
70.00	NURSING FACILITY ROOM & BOARD					_	70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)				0 0	0	
99.00	NEGATI VE COST CENTER		70.000	150.05		405 400	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		78, 093			485, 198	
101.00	UNIT COST MULTIPLIER	0. 003060	4. 192012	158. 05200	0. 000000	26. 045306	1101.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 1

STATISTICAL BASIS Provi der CCN: 15-0048 | Peri od: | Worksheet 0-6 | Part II | Hospi ce CCN: 15-1524 | To 12/31/2018 | Date/Ti me Prepared: | 5/2/2019 | 7:50 am

						5/22/2019 7:5	59 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICES			
		(PATI ENT	BASIS)	(IN-FACILITY			
		DAYS)	,	DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS			•			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP	•					2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE	4					6.00
7. 00	HOUSEKEEPI NG	4					7.00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION	•					9.00
10.00	ROUTINE MEDICAL SUPPLIES	1					10.00
11. 00	MEDICAL RECORDS						11.00
							1
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	40.400					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	18, 629	1				15.00
	OTHER GENERAL SERVICE		C				16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			953			17. 00
	LEVEL OF CARE		1		1		
50. 00	HOSPICE CONTINUOUS HOME CARE	C		1			50.00
51. 00	HOSPICE ROUTINE HOME CARE	17, 676		1			51.00
	HOSPICE INPATIENT RESPITE CARE	106	1				52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	847	'  C	847			53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		(	1			60.00
61. 00	VOLUNTEER PROGRAM			1			61.00
62. 00	FUNDRAI SI NG		(	)			62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		(	)			63.00
64.00	PALLIATIVE CARE PROGRAM		C				64.00
65.00	OTHER PHYSICIAN SERVICES		C				65.00
66.00	RESI DENTI AL CARE	C	0	0			66.00
67.00	ADVERTI SI NG		C				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		C				68.00
69.00	THRI FT STORE						69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	C					71.00
	NEGATI VE COST CENTER	1					99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0		61, 310			100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000				101.00
	ı		1		1		

LEVEL OF CARE

LLVLL OF CARE		Hospi ce CCI	N: 15-1524 1	o 12/31/2018	Date/Time Prepared: 5/22/2019 7:59 am		
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
		Part I, Col. 9 line	Charge Ratio				
		0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00		(	0	0	
2.00	OCCUPATIONAL THERAPY	67.00					2. 00
3.00	SPEECH PATHOLOGY	68. 00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00			0	0	
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00	l e	1	0	0	
6. 00	LABORATORY	60.00			,	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			-	0	
8. 00	FAMILY PRACTICE	93. 00		(	0	0	0.00
9. 00	RADI OLOGY-THERAPEUTI C	55. 00					9. 00
10.00	ANCI LLARY - OTHER	76. 00			,	0	
	CARDI AC REHABI LI TATI ON	76. 97	0. 556765	(	0	0	
11. 00	Totals (sum of lines 1-11)	01			0 1 1 100		11.00
		Charges by		Shared Service	e Costs by LOC		
		LOC (from					
		Provi der Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
	cost center bescriptions	IIIIF	x col. 2)	x col. 3)	x col. 4)	x col. 5)	
		5. 00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
1.00	PHYSI CAL THERAPY	0	0		0	0	1.00
2.00	OCCUPATI ONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	5.00
6.00	LABORATORY	0	0		0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	7.00
8.00	FAMILY PRACTICE	0	0	(	0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C						9.00
10.00	ANCI LLARY - OTHER	0	0	(	0	0	10.00
10. 97	CARDIAC REHABILITATION	0	0	(	0	0	10. 97
11. 00	Totals (sum of lines 1-11)		0		0	0	11.00

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

Heal th	Financial Systems REID HOSPITAL & HEALTH	H CARE SERVIC	ES	In Lieu	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der CCI		Peri od:	Worksheet 0-8	
		Hanni an CON		From 01/01/2018	D-+- /T: D	
		Hospi ce CCN:	15-1524	To 12/31/2018	Date/Time Pre 5/22/2019 7:5	
				Hospi ce I	0, 22, 201, 110	, <u>u</u>
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			158, 052	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0. 00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	ie 10)		0		4.00
5.00	Program cost (line 3 times line 4)			0 0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			2, 882, 228	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 676	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				163. 06	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	14, 36			9. 00
10.00	Program cost (line 8 times line 9)		2, 342, 03	158, 657		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			92, 582	11.00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.00
13. 00	Total average cost per diem (line 11 divided by line 12)				873. 42	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		97 9		14.00
15. 00	Program cost (line 13 times line 14)		84, 72	7, 861		15.00
	HOSPICE GENERAL INPATIENT CARE					
16. 00		7, col. 9,			740, 527	16.00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				847	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				874. 29	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	83			19.00
20. 00	Program cost (line 18 times line 19)		730, 03	10, 491		20.00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 873, 389	
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				18, 629	
23. 00	Average cost per diem (line 21 divided by line 22)				207. 92	23.00

	Financial Systems REID HOSPITAL & HEA			u of Form CMS-2	2552-10	
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0048	Peri od:	Worksheet L		
			From 01/01/2018 To 12/31/2018		nared:	
	10 12/31/2010					
	Title XVIII Hospital					
	DART I FILLY PROCRECTIVE METHOD			1. 00		
	PART I - FULLY PROSPECTIVE METHOD  CAPITAL FEDERAL AMOUNT				-	
1. 00	Capital DRG other than outlier			4, 137, 979	1.00	
1. 01	Model 4 BPCI Capital DRG other than outlier			4, 137, 777	1.00	
2. 00	Capital DRG outlier payments			90, 514		
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01	
3.00	Total inpatient days divided by number of days in the cost	reporting period (see ins	tructions)	105. 29	3.00	
4.00	Number of interns & residents (see instructions)		ŕ	13. 48	4.00	
5.00					5.00	
6.00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1.0 $$	1, columns 1 and	152, 278	6. 00	
7.00	1.01) (see instructions)				7.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)				7.00	
8. 00					8.00	
9.00					9. 00	
10.00					10.00	
11. 00					11.00	
12.00	O Total prospective capital payments (see instructions)			4, 380, 771	12.00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST			1.00		
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00	
2. 00	Program inpatient ancillary capital cost (see instructions)			Ō		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00	
4.00	Capital cost payment factor (see instructions)			0	4.00	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00		
1. 00	Program inpatient capital costs (see instructions)			0	1.00	
2. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)				2.00	
3. 00	Net program inpatient capital costs (line 1 minus line 2)				3.00	
4.00					4.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)				5.00	

	PART I - FULLY PROSPECTIVE WETHOD		ļ
	CAPITAL FEDERAL AMOUNT		
1. 00	Capital DRG other than outlier	4, 137, 979	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier	0	1. 01
2.00	Capital DRG outlier payments	90, 514	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	105. 29	3.00
4.00	Number of interns & residents (see instructions)	13. 48	4.00
5.00	Indirect medical education percentage (see instructions)	3. 68	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)	152, 278	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instructions)	0. 00	8.00
9. 00	Sum of lines 7 and 8	0.00	
10. 00	Allowable disproportionate share percentage (see instructions)	0.00	1
11. 00	Disproportionate share adjustment (see instructions)	0.00	11.00
		-	
12. 00	Total prospective capital payments (see instructions)	4, 380, 771	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)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1. 00	Program inpatient capital costs (see instructions)	0	
2. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3. 00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0. 00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0. 00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7. 00
8. 00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9. 00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11. 00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	
14. 00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	
15. 00	Current year allowable operating and capital payment (see instructions)	0	15.00
	Current year operating and capital payment (see instructions)	0	
		-	1
	(irrent year exception offeet amount (eee instructions)	(1)	1 1 / ()()
	Current year exception offset amount (see instructions)	0	17. 00