	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa			
payments made	since the beginning of the cost reporting period bein	g deemed overpayment	s (42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-00		Worksheet S
AND SETTLEMENT	「 SUMMARY		From 01/01/2020	
			To 12/31/2020	
				7/8/2021 10:37 am
PART I - COST	REPORT STATUS			
Provi der	<ol> <li>[ X ] Electronically prepared cost report</li> </ol>		Date: 7/8/202	1 Time: 10:37 am
use only	2. [ ] Manually prepared cost report			
	3. [ 0 ] If this is an amended report enter the number	of times the provid	ler resubmitted this o	cost report
	4. [ F ] Medicare Utilization. Enter "F" for full or "	L" for low. '		•
Contractor	5. [ 1 ]Cost Report Status 6. Date Received:		10. NPR Date:	
use only	(1) As Submitted 7. Contractor No.		11. Contractor's Vendo	or Code: 4
)	(2) Settled without Audit 8. [ N ] Initial Report for	or this Provider CCN	12. [ 0 ]If line 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN	number of tin	nes reopened = 0-9.
	(4) Reopened			·
	(5) Amended			
	I .			

## PART II - CERTIFICATION

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 01/01/2020 and ending 12/31/2020 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	

	·		Ti tle XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-1, 197	116, 219	0	0	1.00
2.00	Subprovider - IPF	0	-6, 037	37		0	2.00
3.00	Subprovider - IRF	0	92, 684	6		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	85, 450	116, 262	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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 Р 0 3.00 1 CARE SERVICES SUBPROVI DER Subprovi der - IPF 99915 4.00 15S048 01/01/2001 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) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 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 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for 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 24. 00 1. 343 4, 519 474 118 7.804 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.

ealth Financial Systems REID OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	HOSPITAL & HEALTH	CARE SERVIO Provider CO		Peri od:	In Lie		m CMS-2 eet S-2	552-
				From 01/0 To 12/3	31/2020	Part I Date/Ti 7/8/202	me Prep 21 10:37	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ays Med	ther di cai d days	
200 100 110 110 110 110 110 110 110 110	1.00	2.00	3. 00	4. 00	5. 00		5. 00	0.5
5.00 If this provider is an IRF, enter the in-sta 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- Medicaid eligible unpaid days in column 4, M HMO paid and eligible but unpaid days in col	of-state edi cai d	22	0	Urban/F		737 Date of	Geogr	25.
				1.	00	2. (		
6.00 Enter your standard geographic classificatio cost reporting period. Enter "1" for urban o Enter your standard geographic classificatio reporting period. Enter in column 1, "1" for enter the effective date of the geographic r 5.00   If this is a sole community hospital (SCH),	r "2" for rural. n (not wage) statu: urban or "2" for i eclassification in	s at the en rural. If a column 2.	d of the co pplicable,	st	2 2			<ul><li>26.</li><li>27.</li><li>35.</li></ul>
effect in the cost reporting period.		por 1 0 d o 0						
				Begi n 1.	00	Endi 2. (	00	
o.00 Enter applicable beginning and ending dates of periods in excess of one and enter subseq	uent dates.	·			/2020	12/31	/2020	36.
.00 If this is a Medicare dependent hospital (MD is in effect in the cost reporting period.	H), enter the number	er of perio	ds MDH stat	us	0			37
.01 Is this hospital a former MDH that is eligible accordance with FY 2016 OPPS final rule? Entirestructions)								37
.00 If line 37 is 1, enter the beginning and end greater than 1, subscript this line for the enter subsequent dates.	ing dates of MDH s number of periods i	tatus. If I n excess o	ine 37 is f one and					38
					<u>′N</u> 00	Y/ 2. (		
Does this facility qualify for the inpatient hospitals in accordance with 42 CFR §412.101 1 "Y" for yes or "N" for no. Does the facili accordance with 42 CFR 412.101(b)(2)(i), (ii or "N" for no. (see instructions) 1.00 Is this hospital subject to the HAC program	(b)(2)(i), (ii), ou ty meet the mileag ), or (iii)? Enter reduction adjustme	r (iii)? En e requireme in column nt? Enter "	ter in colu nts in 2 "Y" for y Y" for yes	nn es or N	ı I	N		39. 40.
"N" for no in column 1, for discharges prior no in column 2, for discharges on or after 0	to October 1. Ento ctober 1. (see ins	er "Y" for tructions)	yes or "N"	for	V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
.00 Does this facility qualify and receive Capit with 42 CFR Section §412.320? (see instruction).00 Is this facility eligible for additional pay	ons)	•			e N N	N N	N N	45 46
pursuant to 42 CFR §412.348(f)? If yes, comp Pt. III.	•		,			l IV		40
<ul> <li>1.00 Is this a new hospital under 42 CFR §412.300</li> <li>1.00 Is the facility electing full federal capital</li> <li>Teaching Hospitals</li> </ul>	` '		,		N N	N N	N N	47 48
.00 Is this a hospital involved in training resi "N" for no in column 1. If column 1 is "Y", GME payment reduction? Enter "Y" for yes or	are you impacted by	y CR 11642				Y		56
.00 If line 56 is yes, is this the first cost re GME programs trained at this facility? Ente is "Y" did residents start training in the f for yes or "N" for no in column 2. If colum "N", complete Wkst. D, Parts III & IV and D-	r "Y" for yes or "I irst month of this n 2 is "Y", comple 2, Pt. II, if appli	N" for no i cost repor te Workshee cable.	n column 1. ting period t E-4. If c	If column ? Enter "' olumn 2 is	/"			57
B.OO   If line 56 is yes, did this facility elect c defined in CMS Pub. 15–1, chapter 21, §2148?			ans' servic	es as	N			58
.00 Are costs claimed on line 100 of Worksheet A			, Pt. I. NAHE 413.8	85 Worket	N neet A	Pass-TI	arough	59
			Y/N	Li n	e #	Qualifi Crite Coo	cation rion de	
	ducation (NAHE) cos	sts for	1. 00 Y		00 ′	3. (	00	60
.00 Are you claiming nursing and allied health e			· '					20
.00 Are you claiming nursing and allied health e any programs that meet the criteria under 42 instructions) Enter "Y" for yes or "N" for is "Y", are you impacted by CR 11642 (or sub adjustement? Enter "Y" for yes or "N" for n	no in column 1. In sequent CR) NAHE M							

Provider CCN: 15-0048

Peri od:

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 Ν 0 76.00 no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 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. Υ 91.00 is this hospital reimbursed for title V and/or XIX through the cost report either in Ν 91.00 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 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 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 Ν Ν 96.00 applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 97 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 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Ν 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) 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. Ν 108.00

Health Financial Systems REID HOSPITAL & HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	_	CN: 15-0048 F	In Lieu Period: From 01/01/2020 To 12/31/2020		-2 repared:
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2. 00 N	3. 00 N	4.00 N	109. 00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes or	"N" for no. I	f yes,	1.00 N	110.00
			1.00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dlumn 1 is Y, Ticipating in	period? Enter enter the n column 2.	N	2. 00	111.00
		1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	peri od? s "Y", enter ne	N	2.33	5. 55	112.00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3, or E only) 3" percent (includes	N			0115.00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	Y			116. 00
"N" for no.  117.00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	ance? Enter	N			117. 00
118.00 is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.			1		118. 00
		Premi ums	Losses	Insurance	
110 01 list amounts of malaprostics are minute and paid lesses.		1.00	2. 00	3. 00	0110 01
118.01 List amounts of malpractice premiums and paid losses:			0		0118.01
			1. 00	2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N		118. 02
119.00D0 NOT USE THIS LINE 120.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1, "' ualifies for	/" for yes or the Outpatient	Y	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost impla	ntable devic	es charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5. 06	122. 00
Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, en	nter the certi				126. 00
in column 1 and termination date, if applicable, in column 2 127.00 of this is a Medicare certified heart transplant center, ent		fication date			127. 00
in column 1 and termination date, if applicable, in column 2 128.00 of this is a Medicare certified liver transplant center, ent	2. Ter the certin				128. 00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		cation date in	ור		129. 00
130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col	umn 2.				130.00
131.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col		certi fi cati on			131.00

ealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		ALTH CARE SERVI		Perion From To		worksheet S Part I Date/Time P 7/8/2021 10	-2 repared:
					1. 00	2. 00	
32.00 If this is a Medicare certified is in column 1 and termination date,			ication date	9			132.00
33.00 Removed and reserved	тт арргтсавге, тт согиш	2.					133. 00
34.00 If this is an organ procurement or and termination date, if applicable All Providers		the OPO number	in column 1				134. 00
40.00 Are there any related organization	n or home office costs as	defined in CMS	Pub. 15-1.		Υ		140.00
chapter 10? Enter "Y" for yes or '	"N" for no in column 1. I	f yes, and home	office cost	ts			
are claimed, enter in column 2 the		<u>r. (see instruc</u> 00	tions)		3. 00		
If this facility is part of a cha			ouah 143 the	name		of the home	
office and enter the home office							
41. 00 Name: REID HOME OFFICE 42. 00 Street: 1100 REID PARKWAY	Contractor's Name: W PO Box:	PS	Contrac	tor's	Number: 0810	1	141. 00 142. 00
43.00 City: RICHMOND	•	N	Zi p Code	a:	4737	4	143. 0
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		c				
44.00	ala la la la la Maria la la cart	40				1. 00	111
44.00 Are provider based physicians' cos	sts included in worksheet	A?				Y	144. 00
					1. 00	2. 00	
45.00 If costs for renal services are cl inpatient services only? Enter "Y'					Υ		145. 0
no, does the dialysis facility ind period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in	clude Medicare utilization for no in column 2. gy changed from the previ n column 1. (See CMS Pub.	n for this cost ously filed cos	reporting t report?	f	N		146. 0
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog	clude Medicare utilization for no in column 2. gy changed from the previ n column 1. (See CMS Pub.	n for this cost ously filed cos	reporting t report?	f	N		146. 0
no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	clude Medicare utilization for no in column 2. gy changed from the preving column 1. (See CMS Pub. dd/yyyy) in column 2.	n for this cost ously filed cos 15-2, chapter	reporting t report? 40, §4020) I	f	N	1.00	
no, does the dialysis facility incorperiod? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no incorporate yes, enter the approval date (mm/d) 47.00Was there a change in the statistic	clude Medicare utilization for no in column 2. gy changed from the previnculumn 1. (See CMS Pub. dd/yyyy) in column 2.	ously filed cos 15-2, chapter yes or "N" for	reporting t report? 40, §4020) I	f	N .	N	147. 0
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no, does the dialysis facility incorperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/of 47.00 Was there a change in the statistic 48.00 Was there a change in the order of 49.00 Was there a change to the simplification of the statistic facility contain a provious charges? Enter "Y" for yes or "N"	clude Medicare utilization for no in column 2. gy changed from the previncolumn 1. (See CMS Pub. dd/yyyy) in column 2. dcal basis? Enter "Y" for allocation? Enter "Y" for ited cost finding method?	ously filed cos 15-2, chapter  yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 In exemption fro	reporting t report? 40, §4020) I  no. for no. for no. fees or "N" for Part B  2.00  m the applic and Part B	or no.	Title V 3.00 of the low 42 CFR §41:	N N N Title XIX 4.00 er of costs 3.13)	146. 00 147. 00 148. 00 149. 00
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no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"  46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/or section)  47.00 Was there a change in the statistical states and the statistical states and the statistical states are changed in the order of the statistical states and the statistical states are changed in the statistical statistical states are changed in the statistical statistical states are changed in the statistical states are changed in the statistical states are changed in the statistical statistical states are changed in the statistical	clude Medicare utilization for no in column 2. gy changed from the previncolumn 1. (See CMS Pub. dd/yyyy) in column 2. dcal basis? Enter "Y" for allocation? Enter "Y" for ited cost finding method?	yes or "N" for N N N N	reporting t report? 40, §4020) I  no. for no. for no. fes or "N" for Part B 2.00  m the applic and Part B N N N N	or no.	Title V 3.00 of the lowe 42 CFR §41: N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N	147. 0 148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"  46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/or section of the section of the statistical section of the section	clude Medicare utilization for no in column 2. gy changed from the previncolumn 1. (See CMS Pub. dd/yyyy) in column 2. dcal basis? Enter "Y" for allocation? Enter "Y" for ited cost finding method?	ously filed cos 15-2, chapter  yes or "N" for for yes or "N" f Enter "Y" for y Part A 1.00 In exemption from the content for Part A N N N N	reporting t report? 40, §4020) I  no. for no. for no. fees or "N" for Part B 2.00 om the applia and Part B N N N	or no.	Title V 3.00 of the low 42 CFR §41: N N N	N N N Title XIX 4.00 er of costs 3.13) N N N	147. 0 148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0
no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"  46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/or section of the section of the statistical section of the section	clude Medicare utilization for no in column 2. gy changed from the previncolumn 1. (See CMS Pub. dd/yyyy) in column 2. dical basis? Enter "Y" for allocation? Enter "Y" fied cost finding method? der that qualifies for a "N" for no for each compo	ously filed cos 15-2, chapter  yes or "N" for for yes or "N" fe Enter "Y" for y Part A 1.00 In exemption from the form the form of the for	reporting t report? 40, §4020) I  no. for no. for no. fees or "N" for Part B 2.00 om the applia and Part B N N N N N N	or no.	Title V 3.00 of the low 42 CFR §41: N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N	147. 0 148. 0 149. 0
no, does the dialysis facility incomperiod? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/or section of the statistical section of the simplification of the statistical section of the simplification of the statistical section of the statistic	clude Medicare utilization for no in column 2. gy changed from the previous clumn 1. (See CMS Publical basis? Enter "Y" for f allocation? Enter "Y" for f allocation? Enter "Y" fied cost finding method? "N" for no for each composition of the	ously filed cos 15-2, chapter  yes or "N" for for yes or "N" fenter "Y" for y Part A 1.00 In exemption from the part A N N N N N N N N N N N N N N N N N N N	reporting t report? 40, §4020) I  no. for no. for no. fees or "N" for Part B 2.00  m the applic A and Part B N N N N N N N N N N N N N N N N N N N	or no.	Title V 3.00 of the low 42 CFR §41: N N N N N CBSAs?	N N N Title XIX 4.00 er of costs 3.13) N N N N N	147. 0 148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 160. 0 161. 0
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167. 00 168. 00

168. 01 9. 99169. 00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)

169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)

reasonable cost incurred for the HIT assets (see instructions)

Health Financial Systems	REID HOSPITAL & HEALTH	1 CARE SERVICES	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	NTIFICATION DATA	Provider CCN: 15-0048	Peri od:	Worksheet S-2	
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre	
				7/8/2021 10: 3	<u>/ am</u>
	Begi nni ng	Endi ng			
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170. 00		
			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? Enter	N on	0	171.00

N

N

19.00

Report data for corrections of other PS&R Report

information? If yes, see instructions.

nith Financial Systems REID HOSPITAL SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI	. & HEALTH CARE SE RE Provi de	r CCN: 15-0048	Peri od:	eu of Form CM Worksheet S	
			From 01/01/2020 To 12/31/2020	Part II	Prepar
	Des	scription	Y/N	Y/N	J. 07 G
		0	1. 00	3. 00	
.00 If line 16 or 17 is yes, were adjustments made to PS Report data for Other? Describe the other adjustment:	S:		N	N	20
	Y/N 1.00		Y/N	Date 4.00	
.00 Was the cost report prepared only using the provider		2.00	3. 00 N	4.00	21
records? If yes, see instructions.	3 11		14		
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY	Y (EXCEPT CHILDRE	NS HOSPLTALS)		1. 00	
Capital Related Cost	· (EXOLIT OILEBILE	10 11001 1 17120)			
00 Have assets been relifed for Medicare purposes? If ye				N	22
00 Have changes occurred in the Medicare depreciation experience reporting period? If yes, see instructions.	xpense due to app	raisals made du	uring the cost	N	23
.00 Were new leases and/or amendments to existing leases lf yes, see instructions.	entered into dur	ing this cost m	reporting period?	N	24
00 Have there been new capitalized leases entered into	during the cost r	eporting period	d? If yes, see	N	25
instructions.			16		
.00 Were assets subject to Sec. 2314 of DEFRA acquired du instructions.	ring the cost rep	orting period?	ir yes, see	N	20
OO Has the provider's capitalization policy changed dur copy.	ing the cost repo	rting period? I	f yes, submit	N	2
Interest Expense  00 Were new Loans, mortgage agreements or Letters of cr	edit entered into	during the cos	st reporting	l N	
period? If yes, see instructions.		Ü	. 0	Y	2
00 Did the provider have a funded depreciation account a treated as a funded depreciation account? If yes, see		(Debt Service	Reserve Fullu)	,	2
00 Has existing debt been replaced prior to its schedul instructions.	ed maturity with	new debt? If ye	es, see	Y	30
00 Has debt been recalled before scheduled maturity with instructions.	hout issuance of	new debt? If ye	es, see	N	3
Purchased Services  OD Have changes or new agreements occurred in patient compared to the patient of the patient of the patient of the patient of the purchased Services	are services furn	ished through (	contractual	Υ	3
arrangements with suppliers of services? If yes, see	instructions.	_			
00 If line 32 is yes, were the requirements of Sec. 213 no, see instructions.	5.2 appried perta	Thi ng to compe	titive brading? i	I Y	3:
Provider-Based Physicians  On Are services furnished at the provider facility unde	r an arrangomont	with provider b	asod physicians?	T N	3
If yes, see instructions.	r an arrangement	with brovider-r	based physicians?	IN IN	3
00 If line 34 is yes, were there new agreements or amen- physicians during the cost reporting period? If yes,			e provi der-based	N	3
			Y/N	Date	
Homo Offico Costs			1. 00	2. 00	
Home Office Costs  O Were home office costs claimed on the cost report?			Y		3
00 If line 36 is yes, has a home office cost statement	been prepared by	the home office			3
If yes, see instructions.					
00 If line 36 is yes, was the fiscal year end of the house the provider? If yes, enter in column 2 the fiscal year.			of N		38
00 If line 36 is yes, did the provider render services see instructions.			es, N		30
00 If line 36 is yes, did the provider render services instructions.	to the home offic	e? If yes, see	Э		4
		1.00	2	. 00	
Cost Report Preparer Contact Information					
On Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and			BEJARANO		4
respectively.  On Enter the employer/company name of the cost report	BKD				4.
	1				ll l
preparer.  Oo Enter the telephone number and email address of the	cost 3173834000		KBEJARANO@BKD.	COM	43

Heal th	Financial Systems	REID HOSPITAL & HE	ALTH	CARE SERVI	CES		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEME	NT QUESTI ONNAI RE		Provi der C	CCN: 15-0048	Peri		Worksheet S-2	2
							01/01/2020		
						То	12/31/2020	Date/Time Pre 7/8/2021 10:3	epared: 17 am
								177072021 10.0	77 4111
				3.	. 00				
	Cost Report Preparer Contact Informati	on							
41.00	Enter the first name, last name and th	e title/position	DI R	ECTOR					41.00
	held by the cost report preparer in co	lumns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the	cost report							42.00
	preparer.								
43.00	Enter the telephone number and email a								43.00
	report preparer in columns 1 and 2, re	specti vel y.							

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 1 | Peri od: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0048

				'	0 12/31/2020	7/8/2021 10: 3	
						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	193	70, 638		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 IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		193	70, 638	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	30	10, 980	0. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		223	81, 618	0.00	0	14.00
15.00	CAH vi si ts					0	15.00
16.00	SUBPROVI DER - I PF	40.00	28	10, 248	1	0	16.00
17.00	SUBPROVI DER - I RF	41.00	20	7, 320		0	17. 00
18.00	SUBPROVI DER						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	C		ı		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	1
27. 00	Total (sum of lines 14-26)		271				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance 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		ı		32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33. 01
	, , , , , , , , , , , , , , , , , , , ,	'	ı	•	1	•	•

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 15-0048

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

7/8/2021 10:37 am 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 Hospital Adults & Peds. (columns 5, 6, 7 and 44, 133 1. 00 19, 417 1, 135 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) 4, 915 12, 915 2.00 3.00 HMO IPF Subprovider 1,037 1, 529 3.00 HMO IRF Subprovider 4.00 4 00 758 769 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 1, 135 7.00 Total Adults and Peds. (exclude observation 19, 417 7.00 44.133 beds) (see instructions) INTENSIVE CARE UNIT 8 00 2.778 164 6.349 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 1,700 13.00 44 1, 559. 11 14.00 Total (see instructions) 22, 195 1, 343 52, 182 16. 75 14.00 CAH visits 15.00 15.00 55. 79 16.00 SUBPROVIDER - IPF 4, 421 366 8, 484 0.00 16.00 17.00 SUBPROVIDER - IRF 2, 934 5, 384 0.00 26.90 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 1, 118 20 1, 290 0.00 23.42 24.00 24. 10 HOSPICE (non-distinct part) 24.10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 0 C 0 0.00 0.00 26.25 Total (sum of lines 14-26) 1,665.22 27 00 16 75 27 00 Observation Bed Days 28.00 296 5, 186 28.00 29.00 Ambul ance Trips 0 29.00 Employee discount days (see instruction) 30.00 451 30.00 31 00 Employee discount days - IRF 31.00 56 Labor & delivery days (see instructions) 32.00 0 99 99 32.00 32.01 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 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am

						7/8/2021 10: 3	7 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		(	5, 574	298	11, 568	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			4 400	0.040		
2.00	HMO and other (see instructions)			1, 139	2, 863		2.00
3.00	HMO I PF Subprovi der				96		3.00
4.00	HMO I RF Subprovi der				47		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
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00							11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00 13.00
14. 00		0. 00	,	5, 574	298	11, 568	
15. 00	Total (see instructions) CAH visits	0.00	,	3, 374	290	11, 300	15.00
16. 00	SUBPROVIDER - IPF	0.00	,	277	0	533	1
17. 00	SUBPROVIDER - I RF	0.00		217	0	325	1
	SUBPROVI DER	0.00	`	213	U	323	18.00
19. 00							19.00
	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	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	Observation Bed Days	0.00					28.00
29. 00	Ambul ance Trips						29.00
30.00	•						30.00
31. 00	Employee discount days - IRF						31.00
	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						• • •
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared:

Name						T	o 12/31/2020	Date/Time Pre 7/8/2021 10:3	
Salaries   Cross Wist   Cool 2 a col.   Salaries   Cool 2 a col.   Solaries   Cool 5   Cool 6   Cool								Average	, <u>G</u> ,
PART II - 906E DATA   1.00			Number	Reported					
NAME   11 - #NGE   LANIA						7		l ,	
SALABLE   SALA		<del> </del>	1. 00	2.00		4.00	5. 00	6. 00	
Total sailaries (sue   200.00   103,340,784   0   103,340,784   3,502,987,90   29,50   1   1   1   1   1   1   1   1   1									
Instructions   Instructions	1 00		200.00	103 340 784	0	103 340 784	3 502 987 90	29 50	1.00
A	1.00	instructions)	200.00	103, 340, 704		103, 340, 704	3, 302, 707. 70	27.30	1.00
### Admin is trative ### A - Teaching ##	2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	2. 00
Admin Instrative 4.01 Physicians - Part A - Teaching 5.00 Physicians and Non Physicians Part 8 for Physicians And Non Physicians Part 8 for Physicians Part 8 for Non-physicians Part 8 for Non-physician P	3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	3.00
Admin Instrative 4.01 Physicians - Part A - Teaching 5.00 Physicians and Non Physicians Part 8 for Physicians And Non Physicians Part 8 for Physicians Part 8 for Non-physicians Part 8 for Non-physician P	4 00	B Physician Part A		0	0	0	0.00	0.00	4.00
Physician Part B for	4.00	Administrative		O			0.00	0.00	4.00
Physicilan-Part B				0	0	0		l e	
hospital -based RRC and FORC   services	5.00			U	0	0	0.00	0.00	3.00
Services	6. 00			0	0	0	0. 00	0.00	6. 00
approved program   Company   Compa									
Contracted interns and residents (in an approved programs)   Solution   Contracted interns and programs   Solution   Contracted programs   Solution   Contract programs   Contract programs   Contract programs   Contract programs   Contract program	7. 00		21. 00	0	1, 859, 564	1, 859, 564	39, 338. 91	47. 27	7.00
residents (in an approved programs)	7. 01			0	0	0	0. 00	0. 00	7. 01
Nome office and/or related organization personnel   44.00		residents (in an approved							
Organization personnel	8. 00			0	0	0	0. 00	0.00	8.00
10.00   Excluded area salaries (see   7,021,477   695,332   7,716,809   241,746.58   31.92   10   11.00   11		organization personnel		_	_				
Instructions    Care			44.00	0 7. 021. 477	0 695. 332	0 7. 716. 809		l	
11.00   Contract labor: Direct Patient		instructions)		.,, 02.1, 1.7	070,002	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	211,710100	511.72	
Care   Contract   abor: Top   evel   management and other   management and administrative   services	11 00			8 202 333	0	8 202 333	133 910 36	61 25	11.00
management and other   management and administrative   services		Care							
management and administrative   services   services	12. 00			0	0	0	0. 00	0.00	12.00
13. 00   Contract labor: Physician-Part   660,655   0   660,655   4,173.00   158.32   13   13   14. 00   14. 00   14. 00   15.		management and administrative							
A - Administrative	13 00			660 655	0	660 655	<i>4</i> 173 ∩∩	158 32	13 00
organization salaries and wage-related costs  14. 01 Home office salaries  18. 094, 545  0 18. 094, 545  634, 860. 96  28. 50 14  14. 02 Related organization salaries  0 0 0 0 0.00  0.00  0.00  0.00  16. 00  16. 00  16. 00  16. 00  16. 00  17. over a contract  18. 094, 545  18. 094, 545  0 0 0 0 0.00  18. 094, 545  0 0 0 0.00  0		A - Administrative				000,000			
Wage-related costs   18,094,545   0   18,094,545   634,860.96   28.50   14   14.02   Related organization salaries   0   0   0   0   0   0   0   0   0	14. 00			0	0	0	0. 00	0.00	14.00
14.02   Related organization salaries   0   0   0   0   0   0   0   0   0		wage-related costs							
15.00   Home office: Physician Part A   0   0   0   0   0   0   0   0   0				18, 094, 545	0	18, 094, 545			
16.00   Home office and Contract				0	0	o o		l .	1
Physicians Part A - Teaching   Home office Physicians Part A   Teaching   Home office Physicians Part A   Teaching   Home office contract   Description	16 00			0	0	_	0.00	0.00	16.00
Teaching		Physicians Part A - Teaching		O			0.00	0.00	10.00
16. 02   Home office contract	16. 01	_		0	0	0	0. 00	0.00	16. 01
WAGE-RELATED COSTS	16. 02			0	0	0	0. 00	0.00	16. 02
17. 00   Wage-rel ated costs (core) (see instructions)   17									
18.00   Wage-related costs (other) (see instructions)   18	17. 00			34, 145, 309	0	34, 145, 309			17. 00
(see instructions) 19.00 Excluded areas 20.00 Non-physician anesthetist Part A 21.00 Non-physician anesthetist Part B 22.00 Physician Part A - Administrative 22.01 Physician Part B 24.00 Wage-related costs (RHC/FOHC) 25.00 Interns & residents (in an approved program) 25.50 Home office wage-related (core) 25.52 Home office: Physician Part A  2,564,278 0 2,564,278 0 0 2,564,278 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18 00								18. 00
20. 00 Non-physician anesthetist Part A  21. 00 Non-physician anesthetist Part B  22. 00 Physician Part A - Administrative  22. 01 Physician Part B  23. 00 Physician Part B  24. 00 Wage-related costs (RHC/FQHC)  25. 00 Interns & residents (in an approved program)  25. 50 Home office wage-related (core)  25. 52 Home office: Physician Part A  0 0 0 0 0  20 0 0 0  21 0 0 0 0  22 0 0 0 0 0  23 0 0 0 0 0  24 0 0 0 0 0  25 0 0 0 0 0  26 0 0 0 0  27 0 0 0 0  28 0 0 0 0  29 0 0 0 0  20 0 0 0  20 0 0 0  21 0 0 0  22 0 0 0 0  23 0 0 0 0  24 0 0 0 0  25 0 0 0 0  26 0 0 0 0  27 0 0 0 0  28 0 0 0 0  29 0 0 0 0  20 0 0 0  20 0 0 0  21 0 0 0  22 0 0 0  23 0 0 0 0  24 0 0 0 0  25 0 0 0 0  26 0 0 0 0  27 0 0 0 0  28 0 0 0 0  29 0 0 0 0  20 0 0 0 0  20 0 0 0 0  20 0 0 0	10.00	(see instructions)							
A Non-physician anesthetist Part B				2, 564, 278	0	2, 564, 278			19.00 20.00
B 22. 00 Physician Part A - Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B 0 0 0 0 22. 00 Wage-related costs (RHC/FOHC) 25. 00 Interns & residents (in an approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A 0 0 0 0 0 22 0	20.00	A anesthetist Part		U	0	0			20.00
Administrative  22.01 Physician Part A - Teaching	21. 00	Non-physician anesthetist Part		0	0	0			21.00
22. 01       Physician Part A - Teaching       0       0       0       0       22         23. 00       Physician Part B       0       0       0       0       0       23         24. 00       Wage-related costs (RHC/F0HC)       0       0       0       0       24         25. 00       Interns & residents (in an approved program)       416, 935       0       416, 935       25         40       Home office wage-related (core)       3, 907, 571       0       3, 907, 571       25         25. 51       Related organization wage-related (core)       0       0       0       0       25         25. 52       Home office: Physician Part A       0       0       0       0       25	22. 00	Physician Part A -		0	0	0			22.00
23. 00 Physician Part B	22 01	•		^	_	_			22.01
24. 00       Wage-related costs (RHC/FQHC)       0       0       0       0       24         25. 00       Interns & residents (in an approved program)       416, 935       0       416, 935       25         25. 50       Home office wage-related (core)       3, 907, 571       0       3, 907, 571       25         25. 51       Related organization wage-related (core)       0       0       0       0       25         25. 52       Home office: Physician Part A       0       0       0       0       25				0	0	0			22. 01 23. 00
approved program) 25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A  approved program) 3, 907, 571 0 3, 907, 571 25 0 0 0 0 0 25	24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 40. 40. 40. 40. 40. 40. 40. 40. 40. 40.	25.00	,		416, 935	0	416, 935			25. 00
25. 51 Related organization	25. 50	Home office wage-related		3, 907, 571	0	3, 907, 571			25. 50
wage-related (core) 25.52 Home office: Physician Part A 0 0 0 25	25. 51			0	n	n			25. 51
		wage-related (core)							
- Administrative -	25. 52	Home office: Physician Part A  - Administrative -		0	0	0			25. 52
wage-related (core)									

Laundry & Linen Service

(see instructions)

Housekeeping under contract

Dietary under contract (see

Central Services and Supply

Medical Records & Medical Records Library

Maintenance of Personnel

Nursing Administration

Housekeepi ng

instructions)

Social Service

43.00 Other General Service

Dietary

Cafeteri a

Pharmacy

31.00

32.00

33.00

34.00

35.00

36.00

37.00

38.00

39.00

40.00

41.00

42.00

Health Financial Systems In Lieu of Form CMS-2552-10 REID HOSPITAL & HEALTH CARE SERVICES HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/8/2021 10:37 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 229, 453 229, 453 8, 841. 28 25. 95 26.00 27.00 Administrative & General 5.00 7, 886, 293 105, 905 7, 992, 198 363, 003. 96 22. 02 27.00 28.00 3, 373, 666 3, 373, 666 71, 398. 46 47. 25 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 686, 763 686, 763 29, 076. 03 23. 62 30.00

631, 336

2, 618, 845

3, 680, 869

129, 498

755, 306

4, 439, 147

4, 324, 114

0

0

-200, 403

-2, 489, 172

2, 489, 172

280, 277

0

0

0

430, 933

2, 618, 845

1, 191, 697

2, 489, 172

280, 277

755, 306

0

4, 439, 147

4, 324, 114

129, 498

24, 584. 89

56, 504. 62

148, 376. 87

2, 180. 00

2, 080. 00

43, 615. 67

130, 994. 60

127, 303. 83

0.00

0.00

0 00

0.00

162, 058. 97

17. 53

16. 16

0.00

21.09

59. 40

16. 78

0.00

134. 75

17. 32

33. 89

0.00

33. 97 42. 00

0.00 43.00

31.00

32.00

33.00

34.00

35.00

36.00

37.00

38.00

39.00

40.00

41.00

8.00

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

Total overhead cost (see

instructions)

7.00

24. 74

7.00

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2020 To 12/31/2020 Part III Date/Time Prepared: 7/8/2021 10:37 am Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to (col.2 ± col. Salaries in Sal ari es 3) (from col. 4 Worksheet A-6) 1. 00 2.00 3.00 4.00 5.00 6.00 PART III - HOSPITAL WAGE INDEX SUMMARY Net salaries (see -1, 859, 564 1.00 106, 843, 948 104, 984, 384 3, 537, 227. 45 29. 68 1.00 instructions) 2.00 Excluded area salaries (see 7, 021, 477 695, 332 7, 716, 809 241, 746. 58 31. 92 2.00 instructions) 3.00 Subtotal salaries (line 1 99, 822, 471 -2, 554, 896 97, 267, 575 3, 295, 480. 87 29. 52 3.00 minus line 2) 4.00 26, 957, 533 26, 957, 533 772, 944. 32 4.00 Subtotal other wages & related 34.88 costs (see inst.) 5.00 Subtotal wage-related costs 38, 052, 880 38, 052, 880 0.00 39. 12 5.00 (see inst.) 162, 277, 988 6.00 Total (sum of lines 3 thru 5) 164, 832, 884 4, 068, 425. 19 39. 89 6.00 -2, 554, 896

28, 755, 290

185, 779

28, 941, 069

1, 170, 019. 18

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Provider CCN: 15-0048

Period:
From 01/01/2020
To 12/31/2020
Part IV
Date/Time Prepared:
7/8/2021 10: 37 am

PART IV - WAGE RELATED COSTS

Part A - Core List
RETIREMENT COST

1. 00 401K Employer Contributions
2. 00 Tax Sheltered Annuity (TSA) Employer Contribution
3. 548, 162 2. 00

2.00			Reported	
Part A - Core List			1. 00	
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00		Part A - Core List		
2.00		RETI REMENT COST		
2.00	1.00	401K Employer Contributions	0	1.00
3. 00   Nonqualified Defined Benefit Plan Cost (see instructions)   0. 3. 00   0. 0	2.00		3, 548, 162	2.00
4.00	3. 00			3. 00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)   401K/TSA PI an Administration fees   0   5.00   401K/TSA PI an Administration fees   0   0   6.00   1			0	4.00
5.00				
6. 00   Legal / Accounting / Management Fees-Pensi on Plan   Employee Managed Care Program Administration Fees   O   Took   Employee Managed Care Program Administration Fees   O   Took   Health Insurance (Purchased or Self Funded)   O   8. 00     Round Health Insurance (Purchased or Self Funded)   Health Insurance (Self Funded without a Third Party Administrator)   O   8. 00     Round Health Insurance (Self Funded without a Third Party Administrator)   O   8. 00     Round Health Insurance (Purchased)   O   0   12. 00     Round Health Insurance (Purchased)   O   0   12. 00     Round Health Insurance (If employee is owner or beneficiary)   O   0   12. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00     Round Health Insurance (If employee is owner or beneficiary)   O   14. 00	5.00		0	5.00
Employee Managed Care Program Administration Fees   0   7.00		Legal /Accounting/Management Fees-Pension Plan	0	6.00
HEALTH AND INSURANCE COST			0	7. 00
Heal th Insurance (Purchased or Self Funded)   Heal th Insurance (Self Funded without a Third Party Administrator)   0 8.00			_	
Heal th Insurance (Self Funded without a Third Party Administrator)   0 8.01	8. 00		0	8. 00
8. 02   Heal th Insurance (Self Funded with a Third Party Administrator)   23, 705, 061   8. 02     8. 03   Heal th Insurance (Purchased)   0   8. 03     9. 00   Prescription Drug Plan   77, 858   9. 00     10. 00   Dental , Hearing and Vision Plan   591, 646     11. 00   Life Insurance (If employee is owner or beneficiary)   127, 061     12. 00   Accident Insurance (If employee is owner or beneficiary)   127, 061     13. 00   Disability Insurance (If employee is owner or beneficiary)   394, 490     15. 00   Workers' Compensation Insurance   550, 729     16. 00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   16. 00     17. 00   Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.   16. 00     17. 00   TaxES   7, 668, 646   17. 00     18. 00   Medicare Taxes - Employers Portion Only   0   18. 00     19. 00   Unemployment Insurance   216, 550   19. 00     20. 00   Other Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see   0   21. 00     21. 00   Tuition Reimbursement   246, 319   23. 00     22. 00   Other than Core Related Cost   23. 00     24. 00   Part B - Other than Core Related Cost   24. 00     25. 00   Part B - Other than Core Related Cost   24. 00     26. 00   Part B - Other than Core Related Cost   24. 00     27. 00   Part B - Other than Core Related Cost   24. 00     28. 00   Part B - Other than Core Related Cost   24. 00     28. 00   Part B - Other than Core Related Cost   24. 00     29. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Part B - Other than Core Related Cost   24. 00     20. 00   Par			0	8. 01
8. 03   Heal th Insurance (Purchased)   9. 00   9. 00   Prescription Drug Plan   77,858   9. 00   10. 00   Dental, Hearing and Vision Plan   591,646   10. 00   11. 00   Life Insurance (If employee is owner or beneficiary)   127,061   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)   394,490   13. 00   Disability Insurance (If employee is owner or beneficiary)   0   14. 00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14. 00   Long-Term Care Insurance (If employee is owner or beneficiary)   0   14. 00   15. 00   Workers' Compensation Insurance   550,729   15. 00   16. 00   Retirement Health 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   18. 00   Non cumulative portion   18. 00   Non cu			23. 705. 061	8. 02
9.00   Prescription Drug Plan   77,858   9.00   10.00				8. 03
10.00   Dental, Hearing and Vision Plan   591,646   10.00   11.00   127,061   11.00   127,061   11.00   127,061   11.00   127,061   11.00   12.00				9. 00
11.00   Life Insurance (If employee is owner or beneficiary)   127,061   11.00   12.00   Accident Insurance (If employee is owner or beneficiary)   0   12.00   13.00   10.00   13.00   14.00   14.00   15.00   15.00   15.00   15.00   16.0				
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 cumul ative portion)  TAXES  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  246, 319  27, 105 Age 13.00  28, 00 Part B - Other than Core Related Cost				12.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)  'Workers' Compensation Insurance 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  Medicare Taxes - Employers Portion Only  Unemployment Insurance 20.00 State or Federal Unemployment Taxes  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 Tuition Reimbursement  Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			- 1	
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 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 246, 319 23.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost				
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  OTHER  21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))  Day Care Cost and Allowances  Tuition Reimbursement  246, 319 23. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			- 1	15. 00
Non cumulative portion) TAXES  17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes  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				
TAXES			ŭ	
17. 00				
18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 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) 24.00 Part B - Other than Core Related Cost	17. 00		7, 668, 646	17.00
19.00 Unempl oyment Insurance 216,550 19.00 20.00 State or Federal Unempl oyment 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 246,319 23.00  Total Wage Related cost (Sum of Lines 1 -23) 37,126,522 24.00  Part B - Other than Core Related Cost				18.00
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 246, 319 23.00 Total Wage Related cost (Sum of Lines 1 -23) 37, 126, 522 Part B - Other than Core Related Cost	19. 00		216, 550	19.00
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  33.00 Tuition Reimbursement  246, 319  25.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost				20.00
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 246,319 24.00 Part B - Other than Core Related Cost	20.00		Ŭ.	20.00
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    Instructions (Sum of lines 1 -23)	21 00		0	21 00
22. 00       Day Care Cost and Allowances       0       22. 00         23. 00       Tuition Reimbursement       246, 319       23. 00         24. 00       Total Wage Related cost (Sum of lines 1 -23)       37, 126, 522       24. 00         Part B - Other than Core Related Cost       24. 00	200		ŭ	200
23.00 Tuition Reimbursement 246,319 23.00 Total Wage Related cost (Sum of lines 1 -23) 24.00 Part B - Other than Core Related Cost 240.00	22.00		n	22.00
24.00 Total Wage Related cost (Sum of lines 1 -23)  Part B - Other than Core Related Cost  24.00			- 1	23.00
Part B - Other than Core Related Cost				
	2 00		3., 120, 022	00
7 726.00	25 00			25 00
	20.00	1		20.00

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

Worksheet S-3 Part V HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0048 Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am 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 8, 202, 333 37, 126, 522 1.00 8, 202, 333 34, 562, 244 2.00 Hospi tal 2.00 Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) 1, 071, 868 3.00 0 3.00 4.00 0 608, 760 4.00 5.00 0 5.00 0 Swing Beds - SNF Swing Beds - NF 6.00 0 Ω 6.00 7.00 0 0 7.00 8.00 Hospital -Based SNF 8.00 Hospi tal -Based NF Hospi tal -Based OLTC 9.00 9.00 10.00 10.00 Hospi tal -Based HHA 11.00 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospi tal -Based Hospi ce 0 456, 441 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

0 17.00

427, 209 18. 00

17.00 Renal Dialysis

18.00 Other

Heal th	n Financial Systems	REI D	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
HOSPI 1	TAL-BASED HOSPICE IDENTIFICATION	N DATA		Provi der C	CN: 15-0048	Peri od:	Worksheet S-9	
				Hospi ce CC	N: 15-1524	From 01/01/2020 To 12/31/2020	PARTS I THROU Date/Time Pre 7/8/2021 10:3	pared:
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursing	Facility		5)	
		1 00	2.00	Facility 3.00	4.00	F 00	4 00	
	PART I - ENROLLMENT DAYS FOR C	1.00			4.00	5. 00	6. 00	
1. 00	Hospice Continuous Home Care	I REPORTING	PERIODS BEGINN	TING BEFORE OCT	JDER 1, 2013			1.00
2. 00	Hospice Routine Home Care							2.00
3. 00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5. 00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1. 2015			
6.00	Number of patients receiving							6.00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9 00	Undunticated census count	I		l .	I			9 00

9.00 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 BEGII	NNING ON OR AFT	ER OCTOBER 1,	2015		
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	15, 687	524	1, 553	17, 764	11.00
12.00	Hospice Inpatient Respite Care	154	0	6	160	12.00
13.00	Hospice General Inpatient Care	964	20	146	1, 130	13.00
14.00	Total Hospice Days	16, 805	544	1, 705	19, 054	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PI	ERIODS BEGINNIN	IG ON OR AFTER	OCTOBER 1, 201	5	
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospi ce General Inpatient Care	0	0	0	0	16.00

	Financial Systems REID HOSPITAL & HEALTH C TAL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet S-10			
			From 01/01/2020 To 12/31/2020				
				1. 00			
	Uncompensated and indigent care cost computation			1.00			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 col	umn 8)	0. 299459	1.00		
	Medicaid (see instructions for each line)		,		1		
2.00	Net revenue from Medicaid			66, 509, 930	2.0		
3. 00	Did you receive DSH or supplemental payments from Medicaid?			N	3.0		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplement		i cai d?		4.0		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid		0	5.0		
6. 00	Medi cai d charges			197, 037, 208			
7. 00	Medicaid cost (line 1 times line 6)			59, 004, 565			
8. 00	Difference between net revenue and costs for Medicaid program (	line 7 minus sum of	lines 2 and 5; if	0	8.0		
	<pre>&lt; zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions fo</pre>	r coch line)			-		
9. 00	Net revenue from stand-alone CHIP	r each file)		0	9.0		
10.00				0	10.0		
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11.0		
	Difference between net revenue and costs for stand-alone CHIP (	line 11 minus line 9	if < zero then	Ö			
2.00	enter zero)		, 20.0 (	, and the second se			
	Other state or local government indigent care program (see inst	ructions for each li	ne)		İ		
13.00	Net revenue from state or local indigent care program (Not incl	uded on lines 2, 5 o	r 9)	0	13.0		
14. 00	Charges for patients covered under state or local indigent care	program (Not includ	ed in lines 6 or	0	14.0		
15. 00	State or local indigent care program cost (line 1 times line 14	)		o	15.0		
16. 00	Difference between net revenue and costs for state or local ind		line 15 minus line				
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/local in	digent care progra	ms (see			
17. 00		nding charity care		0	17.0		
	Government grants, appropriations or transfers for support of h			Ö			
19. 00			ams (sum of lines	0	1		
	8, 12 and 16)	3 . 3					
		Uni nsure	d Insured	Total (col. 1			
		pati ents		+ col . 2)			
		1.00	2. 00	3. 00			
00.00	Uncompensated Care (see instructions for each line)		(4( 0.554.710	4 440 004			
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility 1,855,	646 2, 554, 740	4, 410, 386	20.0		
1. 00	Cost of patients approved for charity care and uninsured discouinstructions)	nts (see 555,	690 2, 554, 740	3, 110, 430	21.0		
2. 00	Payments received from patients for amounts previously written	off as	0 0	0	22.0		
2 00	charity care						
23.00	Cost of charity care (line 21 minus line 22)	] 555,	690 2, 554, 740	3, 110, 430	∠3.0		
				1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patien	t davs beyond a Leng	th of stav limit	N N	24.0		
	imposed on patients covered by Medicaid or other indigent care				\		

0 25.00

26. 00 27. 00

27.01

28.00

29.00

12, 994, 210 1, 805, 358

2, 777, 473

10, 216, 737 4, 031, 609

7, 142, 039 30. 00 7, 142, 039 31. 00

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

26.00 Total bad debt expense for the entire hospital complex (see instructions)
27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)

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

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

28.00 Non-Medicare bad debt expense (see instructions)

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

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

stay limit

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	HUSPITAL & HEAL	Provi der Co			Worksheet A	2332-10
RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JF EXPENSES	Provider CC	JN. 13-0046   F	Period: From 01/01/2020	WOI KSHEEL A	
					o 12/31/2020		
	Occidence Description	6.1	011	Total Cost 4	D I	7/8/2021 10: 3	7 am
	Cost Center Description	Sal ari es	Other	,	Reclassificat	Reclassified Trial Balance	
				+ col. 2)	i ons (See A-6)	(col. 3 +-	
					A-0)	col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		0	(	19, 932, 360	19, 932, 360	1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE		0	ď		6, 707, 864	1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	C	0	0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	229, 453	29, 363	258, 816	-3, 113	255, 703	4.00
5. 01	00540 NONPATIENT TELEPHONES	0	0	C	0	0	5. 01
5. 02	00550 DATA PROCESSING	298, 997	3, 458, 577	3, 757, 574		3, 757, 574	
5. 03	00560 PURCHASING RECEIVING AND STORES	71, 472	23, 125	94, 597		94, 597	5. 03
5. 04	00570 ADMI TTI NG	4, 550, 289	2, 184, 460				
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	272, 437	272, 437			
5.06	00590 OTHER A&G	2, 965, 535	17, 002, 542				
7.00	00700 OPERATION OF PLANT	686, 763	177, 912			864, 675	
8. 00	00800 LAUNDRY & LI NEN SERVI CE	631, 336	674, 320				1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 618, 845 3, 680, 869	930, 571 3, 515, 400	3, 549, 416 7, 196, 269		3, 549, 416 1, 961, 995	
11. 00	01100 CAFETERI A	3, 000, 009	3, 313, 400	7, 190, 209			1
13. 00	01300 NURSING ADMINISTRATION		0		280, 277	280, 277	
14. 00	01400 CENTRAL SERVI CES & SUPPLY	755, 306	5, 384, 936	6, 140, 242		6, 140, 242	
15. 00	01500 PHARMACY	4, 439, 147	36, 056, 420			40, 493, 481	
	01600 MEDICAL RECORDS & LIBRARY	0	0	(0)	0	0	16.00
17. 00	01700 SOCI AL SERVI CE	3, 065, 023	563, 296	3, 628, 319	o	3, 628, 319	1
	01701 I NSERVI CE EDUCATION	1, 259, 091	1, 797, 815			3, 056, 906	
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	O	0	C	1, 957, 778	1, 957, 778	21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	1, 967, 984	1, 130, 578	3, 098, 562	-1, 957, 778	1, 140, 784	22.00
23.00	02300 PARAMED ED PRGM	278, 072	34, 047	312, 119	0	312, 119	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	26, 574, 395	13, 718, 252			39, 647, 763	•
31.00	03100 INTENSIVE CARE UNIT	4, 099, 953	2, 693, 207	6, 793, 160		6, 793, 160	
40.00	04000 SUBPROVI DER - I PF	3, 405, 363	510, 025			3, 915, 388	1
41.00	04100 SUBPROVI DER - I RF	1, 933, 943	455, 181	2, 389, 124		2, 389, 124	
43. 00	04300 NURSERY	813, 211	121, 743	934, 954	-15	934, 939	43.00
EO 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	1 (22 207	4E 242 000	44 004 104	12 200 072	22 507 222	50.00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 632, 297 849, 531	45, 263, 809 289, 529				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 717, 253	7, 795, 798				
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 921, 873	8, 057, 299				
60.00	06000 LABORATORY	4, 558, 196	10, 383, 916			14, 899, 871	
65. 00	06500 RESPIRATORY THERAPY	1, 868, 623	664, 416				
66.00	06600 PHYSI CAL THERAPY	7, 151, 580	1, 469, 411				1
69.00	06900 ELECTROCARDI OLOGY	1, 100, 621	900, 992	2, 001, 613			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	316, 892	88, 386	405, 278	0		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(	16, 634, 850		
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
	07400 RENAL DI ALYSI S	1, 074	878, 851	879, 925	0	879, 925	
76.00	03950 ANCI LLARY - OTHER	422 000	02 524	[ [1/ [2]	0	470.075	
76. 97	07697 CARDI AC REHABI LI TATI ON	422, 999	93, 536	516, 535	-37, 560	478, 975	76.97
91. 00	OUTPATIENT SERVICE COST CENTERS  O9100 EMERGENCY	7, 839, 190	7, 080, 649	14, 919, 839	-1, 200, 282	13, 719, 557	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 639, 190	7,000,049	14, 919, 035	-1, 200, 202	13, 719, 337	92.00
93. 00	04040 FAMILY PRACTICE	2, 028, 802	478, 485	2, 507, 287	-151, 644	2, 355, 643	•
75. 00	OTHER REIMBURSABLE COST CENTERS	2,020,002	470, 403	2,307,207	131, 044	2, 333, 043	/3.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	202, 707	450, 290	652, 997	-125	652, 872	96.00
70.00	SPECIAL PURPOSE COST CENTERS	2027.07	100/ 270	002/ ///	120	332/372	70.00
113.00	11300   NTEREST EXPENSE		8, 366, 523	8, 366, 523	-8, 366, 523	0	113.00
	11600 H0SPI CE	1, 054, 622	1, 253, 890				
118.00		102, 991, 307	184, 249, 987	287, 241, 294			118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	9, 548, 133			3, 518, 569	
	07950 RENTAL SPACE	32, 660	14, 737, 687				1
	07951 FOUNDATI ON	167, 657	302, 611	470, 268		470, 268	1
	07952 RETAIL SERVICES	149, 160	18, 469			167, 629	1
	07953 REID CONTRACTED SERVICES	0	0	C	382, 879		
	07954 REID PHYSICIAN ASSOC.	0	1 700 000	4 700 000	0 0		194.04
	07955 CONNERSVILLE LOCATION	0	1, 782, 899				
	07956 VACANT SPACE	0	411, 817	411, 817		135, 202	194.06
	07957 HOME OFFICE 07958 CAMBRIDGE RHC		0		0		194.07
200.00		103, 340, 784	211, 051, 603	314, 392, 387			
200.00	1 10 ME (35m of Elikes 110 till bugil 177)	100, 040, 704	211,001,000	1 517, 572, 507	١	017, 072, 007	<sub>1</sub> =00.00

	HOSPITAL & HEA				of Form CMS-2552-1
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CC	N: 15-0048	Peri od: From 01/01/2020	Worksheet A
				To 12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
Cost Center Description	Adjustments (See A-8)	Net Expenses For			
	(3ee A-0)	Allocation			
	6. 00	7. 00			
GENERAL SERVICE COST CENTERS  1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	1, 877, 048	21, 809, 408			1.00
1. 01   00100   NEW CAP BLDG & FIXT - OFFSITE	1,077,040	1			1. 00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	15, 897, 183	16, 152, 886			4.00
5. 01   00540   NONPATI ENT TELEPHONES 5. 02   00550   DATA   PROCESSI NG	10, 566, 849	14, 324, 423			5. 01 5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	-6, 684				5. 03
5. 04   00570   ADMI TTI NG	-10				5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-230, 850				5. 05
5. 06   00590   0THER A&G 7. 00   00700   0PERATI ON OF PLANT	13, 396, 962				5. 0 <i>6</i> 7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	-364, 499				8.00
9. 00   00900   HOUSEKEEPI NG	0				9.00
10. 00 01000 DI ETARY	-8, 172				10.00
11. 00   01100   CAFETERI A	-3, 392, 654				11.00
13. 00   01300   NURSI NG ADMINI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	-9, 324	280, 277 6, 130, 918			13. 00 14. 00
15. 00 01500 PHARMACY	-392, 303				15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1			16.00
17. 00   01700   SOCIAL SERVICE	0	-,,			17.00
17. 01   01701   I NSERVI CE EDUCATION 21. 00   02100   I &R SERVI CES-SALARY & FRI NGES APPRVD	-580, 688 0				17. 01 21. 00
22. 00   02200   1 &R SERVICES-OTHER PRGM. COSTS APPRVD	-668, 833				22.00
23. 00 02300 PARAMED ED PRGM	-305	1			23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	-6, 692, 031 0	1			30. 00 31. 00
40. 00   04000   SUBPROVI DER -   PF	-1, 508				40.00
41. 00   04100   SUBPROVI DER -   RF	-171, 422				41.00
43. 00   04300   NURSERY	0	934, 939			43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	-10, 862, 238	22, 644, 995			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	-140	1			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-278, 368				54.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	-1, 822				59.00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	-890, 356 -1, 425				60.00
66. 00   06600   PHYSI CAL THERAPY	-88, 332				66.00
69. 00 06900 ELECTROCARDI OLOGY	-63, 533				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-73	I I			70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00   07200   IMPL. DEV. CHARGED TO PATIENT	0				71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0			73.00
74. 00   07400   RENAL DI ALYSI S	0	879, 925			74.00
76. 00   03950   ANCI LLARY - OTHER 76. 97   07697   CARDI AC REHABI LI TATI ON	0	474 242			76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	-2, 733	476, 242			76. 97
91. 00 09100 EMERGENCY	-4, 728, 082	8, 991, 475			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.407	0.047.00/			92.00
93. 00 O4040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	-8, 437	2, 347, 206			93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	-412, 418	240, 454			96.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE	0	0			113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-2, 370 11, 878, 432				116. 00 118. 00
NONREI MBURSABLE COST CENTERS	11,070,432	313, 471, 003			110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	- 1			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0				192.00
194. 00 07950  RENTAL SPACE 194. 01 07951  FOUNDATI ON		4, 699, 687 470, 268			194. 00 194. 01
194. 02 07952 RETAIL SERVICES		167, 629			194. 02
194. 03 07953 REID CONTRACTED SERVICES	0	382, 879			194. 03
194. 04 07954 REID PHYSICIAN ASSOC.	0	0			194. 04
194. 05 07955 CONNERSVILLE LOCATION 194. 06 07956 VACANT SPACE	0	1, 404, 702 135, 202			194. 05 194. 06
194. 07 07957 HOME OFFICE	0	1			194. 08
194. 08 07958 CAMBRI DGE RHC	Ö	1 -1			194. 08
200.00   TOTAL (SUM OF LINES 118 through 199)	11, 878, 432	326, 270, 819			200. 00

Health Financial Systems RECLASSIFICATIONS REID HOSPITAL & HEALTH CARE SERVICES
Provider CCN: 15-0048 In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am

		Increases		<u> </u>	77 07 2021 10. 07 4111
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
	A - CAPITAL EXPENSE RECLASS				
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	11, 330, 937	1.0
2. 00	NEW CAP BLDG & FIXT - OFFSITE	1. 01	0	6, 415, 767	2.0
3.00	NEW CAP REL COSTS-BLDG &	1.00	0	20, 280	3.0
4. 00	NEW CAP BLDG & FIXT -	1. 01	0	285, 121	4.0
5. 00	NEW CAP REL COSTS-BLDG &	1.00	0	214, 620	5.0
6. 00	FIXT NEW CAP BLDG & FIXT -	1. 01	0	6, 976	6.0
7 00	OFFSI TE	0.00		0	
7. 00 8. 00		0. 00 0. 00	0	0	
9. 00		0.00	U	0	I
			0	- 1	
10.00		0.00	U	0	
11.00		0.00	0	0	
12.00		0.00	0	0	
13.00		0. 00	0	0	
14.00		0.00	0	0	14.0
15.00		0.00	0	0	· · · · · · · · · · · · · · · · · · ·
16.00		0.00	0	0	16.0
17.00		0.00	0	0	17. (
18.00		0.00	0_	0	18.0
	0		0	18, 273, 701	
	B - CAFETERIA RECLASS				
1.00	CAFETERI A	11. 00	2, 489, 172	2, 745, 102	1. (
			2, 489, 172	2, 745, 102	
	C - LAUNDRY RECLASS		•		
1.00	REID CONTRACTED SERVICES	194. 03	200, 403	182, 476	1. (
		+	200, 403	182, 476	
	D - NURSING VP RECLASS				
1.00	NURSING ADMINISTRATION	13. 00	280, 277	0	1. (
	0		280, 277	$\frac{0}{0}$	···
	E - OCCUPATIONAL MEDICINE RE	L ΔSS	200, 211	<u> </u>	
1. 00	OTHER A&G	5. 06	386, 182	814, 100	1.0
1.00	0		386, 182	814, 100	
	F - IMPLANTABLE DEVICES RECLA	A S S	300, 102	814, 100	
1 00	IMPL. DEV. CHARGED TO	72.00	O	14 424 050	1.0
1. 00		/2.00	Ч	16, 634, 850	1.0
2 00	PATI ENT	0.00			
2.00		0.00	0	0	2.0
3.00		0.00	0	0	l
4.00		0.00	0	0	4. (
5. 00		0.00		0	5.0
	0		0	16, 634, 850	
	G - INTEREST RECLASS				
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	8, 366, 523	1.0
	FIXT		+		
	0		0	8, 366, 523	
	J - INTERN AND RESIDENT				
1.00	I&R SERVICES-SALARY &	21.00	1, 859, 564	98, 214	1.0
	FRI_NGES_ APPRVD	L			
	0 — — — — — —		1, 859, 564	98, 214	
	N - HOSPI CE				
1.00	HOSPI CE	116. 00	494, 929	63, 220	1. (
		<u> </u>	494, 929	63, 220	
500 00	Grand Total: Increases		5, 710, 527	47, 178, 186	
500.00	Joi and Total . The eases	1 1	5, 110, 527	77, 170, 100	1 300. (

Peri od: From 01/01/2020 To 12/31/2020

Date/Time Prepared: 7/8/2021 10:37 am

					1	1/8/2021 10: 3/	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CAPITAL EXPENSE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	3, 113	9		1.00
2.00	ADMI TTI NG	5. 04	o	15, 176	9		2.00
3. 00	CASHI ERI NG/ACCOUNTS	5. 05	o	164, 229			3. 00
3. 00	RECEI VABLE	3.03	٩	104, 227	13		3.00
4. 00	OTHER A&G	5. 06	o	636, 726	13		4. 00
5.00	PHARMACY	15. 00	0	2, 086			5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	86, 735			6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	129, 096	l .		7.00
8.00	LABORATORY	60.00	0	42, 241	0		8.00
9.00	RESPI RATORY THERAPY	65. 00	0	922	0		9.00
10.00	PHYSI CAL THERAPY	66.00	ol	247, 212	ol		10.00
11. 00	CARDIAC REHABILITATION	76. 97	0	37, 560		A second	11.00
12. 00	FAMILY PRACTICE	93. 00	0	151, 644		A second	12.00
13. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	125	- 1	A CONTRACTOR OF THE CONTRACTOR	13.00
14. 00	HOSPI CE		0	1, 800			14. 00
		116.00	-1				
15. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	6, 029, 564			15.00
16.00	RENTAL SPACE	194. 00	0	10, 070, 660		· ·	16.00
17.00	CONNERSVILLE LOCATION	194. 05	0	378, 197	0		17.00
18.00	VACANT SPACE	194. 06	0	276, 615	0		18.00
	0 — — — — —	- $  -$		18, 273, 701			
	B - CAFETERIA RECLASS	<u>'</u>			<u>'</u>		
1.00	DI ETARY	10.00	2, 489, 172	2, 745, 102	0		1.00
00		— — <del></del> °†	2, 489, 172	2, 745, 102			00
	C - LAUNDRY RECLASS		2, 407, 172	2, 740, 102			
1 00		0.00	200, 403	100 474			1 00
1. 00	LAUNDRY & LINEN SERVICE	8.00		182, 476			1. 00
	0		200, 403	182, 476			
	D - NURSING VP RECLASS						
1. 00	OTHER A&G		28 <u>0, 2</u> 77	0			1.00
	0		280, 277	0			
	E - OCCUPATIONAL MEDICINE RE	CLASS					
1.00	EMERGENCY	91.00	386, 182	814, 100	0		1.00
			386, 182	814, 100			
	F - IMPLANTABLE DEVICES RECLA	ASS	222,		II.		
1.00	NURSERY	43. 00	0	15	0		1.00
2. 00	OPERATING ROOM	50.00	ő	13, 388, 873			2.00
3. 00	DELIVERY ROOM & LABOR ROOM	52. 00	o		l .		3. 00
				3, 760			
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 422			4.00
5. 00	CARDI AC CATHETERI ZATI ON	<u>59.</u> 00	0_	<u>3, 219, 7</u> 80			5.00
	0		0	16, 634, 850			
	G - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113. 00	0	<u>8, 366, 5</u> 23	11		1.00
	0		0	8, 366, 523			
	J - INTERN AND RESIDENT						
1.00	I &R SERVI CES-OTHER PRGM.	22. 00	1, 859, 564	98, 214	0		1.00
	COSTS APPRVD	22.30	., 20,, 00 1	,0,211			55
	0	$oldsymbol{\vdash} oldsymbol{\vdash} oldsymbol{\vdash} oldsymbol{\vdash}$	1, 859, 564	98, 214	<del>                                     </del>		
	N - HOSPI CE		1, 007, 004	70, 214			
1 00		20.00	404 000	(2.220			1 00
1. 00	ADULTS & PEDI ATRI CS	30.00	494, 929	63, 220			1. 00
	U		494, 929	63, 220		_	
500.00	Grand Total: Decreases		5, 710, 527	47, 178, 186		5	500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0048

				''	0 12/31/2020	7/8/2021 10: 3	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	16, 281, 439	945, 728	0	945, 728		1.00
2.00	Land Improvements	13, 517, 691	0	0	0	913, 620	2.00
3.00	Buildings and Fixtures	311, 331, 989	9, 786, 916		9, 786, 916	0	3.00
4.00	Building Improvements	12, 979, 130	655, 930		655, 930	0	4.00
5.00	Fixed Equipment	2, 180, 808	15, 392	0	15, 392	0	5.00
6.00	Movable Equipment	172, 254, 105	16, 590, 448	0	16, 590, 448	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	528, 545, 162	27, 994, 414	0	27, 994, 414	913, 620	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	528, 545, 162	27, 994, 414	0	27, 994, 414	913, 620	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	17, 227, 167	0				1. 00
2.00	Land Improvements	12, 604, 071	0				2.00
3.00	Buildings and Fixtures	321, 118, 905	0				3.00
4.00	Building Improvements	13, 635, 060	0				4.00
5.00	Fixed Equipment	2, 196, 200	0				5.00
6.00	Movable Equipment	188, 844, 553	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	555, 625, 956	0				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	555, 625, 956	0				10.00

3.00

Total (sum of lines 1-2)

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0048 Peri od: Worksheet A-7 From 01/01/2020 Part II Date/Time Prepared: То 12/31/2020 7/8/2021 10:37 am SUMMARY OF CAPITAL Interest Taxes (see Cost Center Description Depreciation Lease Insurance instructions) (see instructions) 9. 00 10.00 13.00 11.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 1.00 0 0 0 NEW CAP BLDG & FIXT - OFFSITE 1.01 0 0 1.01 NEW CAP REL COSTS-MVBLE EQUIP 2.00 0 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 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 0 0 NEW CAP REL COSTS-MVBLE EQUIP 2.00 0 2.00

0

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

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	eriod: rom 01/01/2020 o 12/31/2020	Date/Time Prep 7/8/2021 10:37	
	COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1, 00	2.00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	366, 781, 403	0	366, 781, 403	0. 660123	0	1. 00
1. 01 NEW CAP BLDG & FIXT - OFFSITE	188, 844, 553		188, 844, 553			1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0			2. 00
3.00 Total (sum of lines 1-2)	555, 625, 956	Ö	555, 625, 956		l	3. 00
		TION OF OTHER (			F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Relat	Total (sum of cols. 5	Depreciation	Lease	
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL	COSTS CENTERS			T		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2.707.7000		1.00
1. 01 NEW CAP BLDG & FIXT - OFFSITE	0	0	0	6, 415, 767		1.01
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 27 000 275	ı	2.00
3.00 Total (sum of lines 1-2)	0	<u> </u>	JMMARY OF CAPIT	27, 990, 275	221, 596	3.00
		30	JIVIIVIARY OF CAPIT	AL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	10.00	instructions)	15.00	
DADT III DECONOLITATION OF CARLTAI	11. 00	12. 00	13.00	14. 00	15.00	
1.00 PART III - RECONCILIATION OF CAPITAL NEW CAP REL COSTS-BLDG & FIXT			20, 280		21 000 400	1. 00
1.00   NEW CAP REL COSTS-BLDG & FIXT 1.01   NEW CAP BLDG & FIXT - OFFSITE	0	_			,	1.00
2.00 NEW CAP BLDG & FIXT - OFFSITE  2.00 NEW CAP REL COSTS-MVBLE EQUIP			285, 121 0			2. 00
3.00 Total (sum of lines 1-2)	0				ı "I	3.00
3.00   Total (Sum of Titles 1-2)	1	٥	303, 401	1	20, 317, 272	5.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES Provi der CCN: 15-0048 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 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 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FLXT (chapter lfi xt ONEW CAP BLDG & FIXT -Investment income - NEW CAP 1.01 1.01 1.01 BLDG & FIXT - OFFSITE (chapter OFFSI TE 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter FOUL P 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time В OPURCHASING RECEIVING AND 5.03 4.00 discounts (chapter 8) STORES 5.00 5.00 Refunds and rebates of 0.00expenses (chapter 8) 6.00 Rental of provider space by 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 7.00 0.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 9.00 10.00 -17, 358, 378 Provi der-based physici an A-8-2 0 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 0 (chapter 23) Related organization A-8-1 76, 269, 074 12.00 12.00 transactions (chapter 10) 13.00 Laundry and linen service 0 00 13 00 Cafeteria-employees and guests -2, 857, 422 CAFETERI A 11.00 14.00 14.00 В 15.00 Rental of quarters to employee 0.00 15.00 and others OPURCHASING RECEIVING AND 16.00 Sale of medical and surgical 16.00 В 5.03 supplies to other than STORES pati ents 17.00 Sale of drugs to other than -60, 971 PHARMACY 17.00 В 15.00 0 pati ents 18.00 Sale of medical records and B OMEDICAL RECORDS & LIBRARY 16.00 18.00 abstracts Nursing and allied health 0.00 19.00 education (tuition, fees, books. etc.) 20 00 -6, 187 DI ETARY Vending machines В 10 00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 22.00 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366,00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 \*\*\* Cost Center Deleted \*\*\* 114.00 25.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FLXT Depreciation - NEW CAP BLDG & ONEW CAP BLDG & FIXT -26.01 1.01 26.01 FIXT - OFFSITE OFFSI TE Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 27 00 27 00 2 00 COSTS-MVBLE EQUIP FOUL P Non-physician Anesthetist 0 \*\*\* Cost Center Deleted \*\*\* 19.00 28.00

0.00

29.00

29.00 Physicians' assistant

Provider CCN: 15-0048

Peri od:

From 01/01/2020 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Cost Center Description Amount Line # Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 30.00 Adjustment for occupational A-8-3 0 \*\*\* Cost Center Deleted \*\*\* 67.00 30.00 therapy costs in excess of limitation (chapter 14) OADULTS & PEDIATRICS 30.99 Hospice (non-distinct) (see 30.00 30.99 instructions) Adjustment for speech 0 \*\*\* Cost Center Deleted \*\*\* 31.00 A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 32.00 0 0.00 Depreciation and Interest MISCELLANEOUS INCOME -142, 662 EMPLOYEE BENEFITS DEPARTMENT В 4.00 33.00 33. 01 MISCELLANEOUS INCOME -495, 797 DATA PROCESSING 33.01 В 5.02 MISCELLANEOUS INCOME -6, 684 PURCHASING RECEIVING AND 33.02 В 5.03 33.02 STORES 33.03 MISCELLANEOUS INCOME В -10 ADMITTING 5.04 33.03 33.04 MISCELLANEOUS INCOME В -230, 850 CASHI ERI NG/ACCOUNTS 5.05 33.04 RECEI VABLE MISCELLANEOUS INCOME -7. 608 OTHER A&G В 33.05 33.05 5.06 0 MISCELLANEOUS INCOME -364, 499 LAUNDRY & LINEN SERVICE 8.00 0 33.06 33.06 В 33.07 MISCELLANEOUS INCOME В -535, 232 CAFETERI A 11.00 33.07 MISCELLANEOUS INCOME -9, 324 CENTRAL SERVICES & SUPPLY 33.08 33.08 В 14.00 MISCELLANEOUS INCOME -44, 105 | I NSERVI CE EDUCATI ON 33.09 В 17.01 33.09 33. 10 MISCELLANEOUS INCOME В 765 I &R SERVI CES-OTHER PRGM. 22.00 33.10 COSTS APPRVD 33.11 MISCELLANEOUS INCOME В -4, 805 ADULTS & PEDIATRICS 30.00 33.11 -6, 223 OPERATING ROOM MISCELLANEOUS INCOME 33. 12 В 50.00 33.12 33. 13 MISCELLANEOUS INCOME В -269, 204 RADI OLOGY-DI AGNOSTI C 54.00 33.13 MISCELLANEOUS INCOME -55, 295 LABORATORY 33.14 В 60.00 33.14 MISCELLANEOUS INCOME -1. 425 RESPIRATORY THERAPY 33.15 В 65.00 33.15 MISCELLANEOUS INCOME 33.16 В -77, 270 PHYSI CAL THERAPY 66.00 0 33.16 33. 17 MISCELLANEOUS INCOME В -500 EMERGENCY 91.00 33.17 MISCELLANEOUS INCOME В -409, 955 DURABLE MEDICAL EQUIP-RENTED 33.18 33.18 96.00 -3, 643, 621 NEW CAP REL COSTS-BLDG & INTEREST INCOME 11 33.19 B 1.00 33.19 FI XT UNNECESSARY BORROWING -4, 722, 902 NEW CAP REL COSTS-BLDG & 33. 20 1.00 11 33.20 Α IFI XT -16, 908, 465 EMPLOYEE BENEFITS DEPARTMENT 33. 21 SELF INSURANCE ADJUSTMENT 4.00 0 33. 21 Α MARKETI NG/ADVERTI SI NG -54 EMPLOYEE BENEFITS DEPARTMENT 33, 22 Α 4.00 O 33.22 33.23 MARKETI NG/ADVERTI SI NG Α -28.842 OTHER A&G 5.06 33.23 33. 24 MARKETI NG/ADVERTI SI NG Α -1, 970 DI ETARY 10.00 33.24 -4, 515 I NSERVI CE EDUCATION 33. 25 MARKETI NG/ADVERTI SI NG Α 17.01 0 33. 25 -98 & SERVICES-OTHER PRGM. MARKETI NG/ADVERTI SI NG 33.26 Α 22.00 33.26 COSTS APPRVD 33. 27 MARKETI NG/ADVERTI SI NG -6, 074 ADULTS & PEDIATRICS 30.00 33.27 Α 33.28 MARKETI NG/ADVERTI SI NG -1, 508 SUBPROVI DER - I PF 40.00 0 33.28 Α MARKETI NG/ADVERTI SI NG -3, 927 SUBPROVI DER - I RF 33 29 41.00 0 33 29 Α 33.30 MARKETI NG/ADVERTI SI NG Α -1, 611 OPERATING ROOM 50.00 33.30 33.31 MARKETI NG/ADVERTI SI NG Α -1, 021 RADI OLOGY-DI AGNOSTI C 54.00 33.31 33. 32 MARKETI NG/ADVERTI SI NG Α -1, 822 CARDI AC CATHETERI ZATI ON 59.00 ol 33, 32 MARKETI NG/ADVERTI SI NG -9, 817 PHYSI CAL THERAPY 33.33 Α 66.00 33.33 33.34 MARKETI NG/ADVERTI SI NG -73 ELECTROENCEPHALOGRAPHY 70.00 33.34 33. 35 MARKETI NG/ADVERTI SI NG -2, 690 CARDIAC REHABILITATION 76.97 33.35 Α 0 -7, 786 EMERGENCY MARKETI NG/ADVERTI SI NG 91 00 33 36 33.36 Α 33.37 MARKETI NG/ADVERTI SI NG Α -8, 387 FAMILY PRACTICE 93.00 33.37 MARKETI NG/ADVERTI SI NG -2, 463 DURABLE MEDICAL EQUIP-RENTED 33.38 33.38 Α 96.00 MARKETI NG/ADVERTI SI NG -1, 525 HOSPI CE 33.39 116.00 33.39 Α 33.40 NON-ALLOWABLE EXPENSES -900, 029 OTHER A&G Α 5.06 ol 33.40 33.41 NON-ALLOWABLE EXPENSES -15 DI ETARY 10.00 33.41 Α NON-ALLOWABLE EXPENSES -3 PHARMACY 33.42 Α 15.00 33.42 NON-ALLOWABLE EXPENSES -344, 571 NSERVICE EDUCATION 17.01 33.43 33.43 Α O 33 44 NON-ALLOWABLE EXPENSES Α -305 PARAMED ED PRGM 23.00 33.44 33. 45 NON-ALLOWABLE EXPENSES -800 ADULTS & PEDIATRICS 30.00 33.45 Α 33. 46 NON-ALLOWABLE EXPENSES Α -20 SUBPROVI DER - I RF 41.00 33.46 NON-ALLOWABLE EXPENSES -140 DELIVERY ROOM & LABOR ROOM 33.47 0 33.47 Α 52.00 NON-ALLOWABLE EXPENSES -1, 370 RADI OLOGY-DI AGNOSTI C 33.48 Α 54.00 33.48 33. 49 NON-ALLOWABLE EXPENSES -1, 245 PHYSI CAL THERAPY 0 66.00 33.49

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0048 Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5.00 33.50 NON-ALLOWABLE EXPENSES Α -43 CARDIAC REHABILITATION 76. 97 33.50 33. 51 NON-ALLOWABLE EXPENSES Α -4, 602 EMERGENCY 91.00 o 33.51 -50 FAMILY PRACTICE NON-ALLOWABLE EXPENSES 93.00 33. 52 33.52 Α 33.53 NON-ALLOWABLE EXPENSES Α -845 HOSPI CE 116.00 33.53 33.54 HAF EXPENSE Α -14, 052, 483 OTHER A&G 5.06 33.54 33. 55 BOND REFUNDING - 2015 BONDS 33. 56 BOND REFUNDING - 2016 BONDS -401, 531 OTHER A&G 5.06 33.55 Α Α -7, 737 OTHER A&G 5.06 33.56 33. 57 OCC MED - EMPLOYEE COST Α -35, 939 OTHER A&G 5.06 33.57 -331, 329 PHARMACY 33.58 OCC MED - EMPLOYEE COST 15.00 33. 58 Α OCC MED - EMPLOYEE COST -4, 773 RADI OLOGY-DI AGNOSTI C 33. 59 33.59 Α 54.00 50.00 TOTAL (sum of lines 1 thru 49) 11, 878, 432 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.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> 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 01/01/2020 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Li ne No. Cost Center Expense Items Amount of Amount Allowable Cost Included in Wks. A, column 1.00 2.00 3.00 4 00 5.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: REID OUTPATIENT SURGERY 1.00 50.00 OPERATING ROOM 21, 242, 819 28, 059, 457 1.00 1. OO NEW CAP REL COSTS-BLDG & FIX NEW CAPITAL 2.00 10, 243, 571 C 2.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT BENEFITS & HR 3.00 32, 948, 364 0 3.00 4.00 5. 02 DATA PROCESSING INFORMATION SYSTEMS 11, 062, 646 0 4.00 5. 06 OTHER A&G 4.01 A&G 28, 831, 131 0 4.01 4.02 0.00 0 4.02 5.00 104, 328, 531 5.00

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

			Related Organization(s) and.	or Home Office				
Symbol (1)	Name	Percentage of	Name	Percentage of				
, , ,		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	A	REID O/P SURGER	55. 00		0. 00	6.00
7.00	В		0.00	REID HOME OFFIC	100.00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Sys	tems	REID	HOSPITAL & F	HEALTH	CARE SER	VI CES			In Li	eu	of Form	n CMS-	2552-1
STATEMENT OF COSTS O	F SERVICES FROM	RELATED ORGANI	ZATIONS AND I	HOME	Provi der	CCN: 1	15-0048	Perio			Workshe	et A-	8-1
OFFICE COSTS									01/01/202		D . (T)	_	
								lo	12/31/202	20	Date/II	me Pr	epared:
								<u> </u>			7/8/202	<u>1 10:</u>	37 am
Net	Wkst. A-7 Ref.												
Adjustments													
(col. 4 minus	5												
col. 5)*													
6. 00	7. 00												
A. COSTS INCU	RRED AND ADJUST	MENTS REQUIRED	AS A RESULT	OF TRA	NSACTI ONS	WI TH	RELATED	ORGANI	ZATI ONS (	OR C	CLAI MED	HOME	
DEFLICE COSTS.													

5.00 | 76,269,074 | | 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.

1.00

2.00

3.00

4.00

4.01

4.02

1100 110 0	boon pootou to morniore m	cordinate a draw of 2, the discourt difference should be that cated in cordinate for this part	:
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00		6.00
7.00	HOME OFFICE	7.00
8.00		8.00 9.00
9.00		9.00
10.00		10.00
8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

1.00

2.00

3.00

4.00

4.01

4.02

-6, 816, 638

10, 243, 571

32, 948, 364

11, 062, 646

28, 831, 131

9

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0048

					'	12/31/2020	7/8/2021 10:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	17. 01	I NSERVI CE EDUCATI ON	325, 706	69, 230		179, 000	1, 606	1.00
2.00	22. 00	I&R SERVICES-OTHER PRGM.	669, 500	669, 500	0	197, 500	0	2.00
		COSTS APPRVD				·		
3.00	30.00	ADULTS & PEDIATRICS	6, 766, 238	6, 607, 360	158, 878	179, 000	998	3.00
4.00	41. 00	SUBPROVIDER - IRF	167, 475			179, 000	0	4.00
5.00	50.00	OPERATING ROOM	4, 037, 766	4, 037, 766	0	246, 400	0	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	2,000	2,000	0	260, 300	0	6.00
7. 00	60.00	LABORATORY	835, 061	835, 061	0	260, 300	0	7.00
8. 00	69. 00	ELECTROCARDI OLOGY	63, 533		0	179, 000	0	1
9. 00		EMERGENCY	4, 715, 194			179, 000	0	9. 00
10.00	0.00		0	0		0	0	10.00
200.00			17, 582, 473	17, 167, 119	415, 354	· -	2, 604	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	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	17. 01	INSERVICE EDUCATION	138, 209	6, 910	0	0	0	1.00
2.00	22. 00	I&R SERVICES-OTHER PRGM.	0	0	0	0	0	2.00
		COSTS APPRVD						
3.00	30.00	ADULTS & PEDIATRICS	85, 886	4, 294	0	0	0	3. 00
4.00	41. 00	SUBPROVIDER - IRF	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	6. 00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	8. 00
9.00	91.00	EMERGENCY	0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			224, 095	11, 204	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		INSERVICE EDUCATION	0		118, 267	187, 497		1.00
2.00	22. 00	I&R SERVICES-OTHER PRGM.	0	0	0	669, 500		2.00
		COSTS APPRVD						
3.00		ADULTS & PEDIATRICS	0	,	·	6, 680, 352		3.00
4.00		SUBPROVI DER - I RF	0	0	0	167, 475		4.00
5.00		OPERATING ROOM	0	0	0	4, 037, 766		5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0	0	2, 000		6. 00
7.00		LABORATORY	0	0	0	835, 061		7. 00
8.00	69. 00	ELECTROCARDI OLOGY	0	0	0	63, 533		8. 00
9. 00	91. 00	EMERGENCY	0	0	0	4, 715, 194		9. 00
10.00	0. 00		0		0	0		10.00
200.00			0	224, 095	191, 259	17, 358, 378		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				Ic	12/31/2020	Date/lime Pre   7/8/2021 10:3	
			CAP	TAL RELATED CO	STS		
		l	NEW BLBG &	LUEW OAR RURO	115111 111/01 5	ENDLOVEE	
	Cost Center Description	Net Expenses	NEW BLDG &	NEW CAP BLDG	NEW MVBLE	EMPLOYEE	
		for Cost Allocation	FLXT	& FLXT - OFFSLTE	EQUI P	BENEFITS DEPARTMENT	
		(from Wkst A		UFFSLIE		DEPARTMENT	
		col. 7)					
		0	1.00	1. 01	2. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	21, 809, 408	21, 809, 408				1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE	6, 707, 864	0	6, 707, 864	_		1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1/ 152 00/	0	0.741	0	1/ 1/0 /07	2.00
4. 00 5. 01	OO4OO	16, 152, 886	0	9, 741	0	16, 162, 627 0	4. 00 5. 01
5. 02	00550 DATA PROCESSING	14, 324, 423	82, 741	26, 665	0	46, 867	5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	87, 913	221, 549		0	11, 203	5. 03
5.04	00570 ADMITTING	6, 719, 563	11, 538		0	713, 253	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-122, 642	0	190, 431	0	0	5. 05
5.06	00590 OTHER A&G	33, 648, 318	95, 702		0	481, 445	5.06
7.00	00700 OPERATION OF PLANT	864, 675	274, 820		0	107, 649	7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	558, 278	308, 061	0	0	67, 548	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 549, 416 1, 953, 823	203, 742 457, 284		0	410, 501 186, 797	9. 00 10. 00
11. 00	01100 CAFETERI A	1, 933, 623	240, 105		0	390, 175	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	280, 277	48, 825		0	43, 933	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 130, 918	210, 061	0	0	118, 393	14.00
15.00	01500 PHARMACY	40, 101, 178	246, 524	0	0	695, 832	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	114, 965	0	0	16. 00
	01700 SOCI AL SERVI CE	3, 628, 319	30, 993		0	480, 439	1
17. 01	01701 I NSERVI CE EDUCATI ON	2, 476, 218	259, 960	0	0	197, 361	17. 01
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	1, 957, 778	0	0	0	291, 485	
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM	471, 951 311, 814	26, 498	65, 263	0	16, 995 43, 588	•
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	311, 014	20, 470	05, 203	U	43, 300	23.00
30. 00	03000 ADULTS & PEDIATRICS	32, 955, 732	2, 918, 623	0	0	4, 087, 959	30.00
31.00	03100 INTENSIVE CARE UNIT	6, 793, 160	613, 175		0	642, 664	31.00
40.00	04000 SUBPROVI DER - I PF	3, 913, 880	557, 931	0	0	533, 787	40.00
41.00	04100 SUBPROVI DER - I RF	2, 217, 702	446, 994		0	303, 144	1
43. 00		934, 939	66, 957	0	0	127, 470	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	22, 644, 995	1, 140, 387	318, 789	0	255, 861	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 135, 160	207, 688		0	133, 163	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	15, 083, 165	1, 746, 769		0	1, 209, 672	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	6, 757, 570	339, 129		0	301, 252	59. 00
60.00	06000 LABORATORY	14, 009, 515	726, 634	0	0	714, 493	60.00
65.00	06500 RESPI RATORY THERAPY	2, 530, 692	41, 133		0	292, 905	65.00
66.00	06600 PHYSI CAL THERAPY	8, 285, 447	201, 894		0	1, 121, 003	1
69.00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	1, 938, 080	195, 026 0	94, 777	0	172, 521	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	405, 205 0	0		0	49, 673 0	1
	07200 I MPL. DEV. CHARGED TO PATIENT	16, 634, 850	0		0	0	•
	07300 DRUGS CHARGED TO PATIENTS	0	0	Ö	0	0	1
74.00	07400 RENAL DIALYSIS	879, 925	37, 212	0	0	168	
76.00	03950 ANCI LLARY - OTHER	0	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	476, 242	204, 417	0	0	66, 305	76. 97
01 00	OUTPATIENT SERVICE COST CENTERS	0.001.475	772 2/1		0	1 1/0 252	01 00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 991, 475	773, 261	0	0	1, 168, 252	91. 00 92. 00
	04040 FAMILY PRACTICE	2, 347, 206	0	20, 626	0	318, 013	•
73.00	OTHER REIMBURSABLE COST CENTERS	2,347,200		20,020	<u> </u>	310, 013	73.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	240, 454	44, 305	69, 938	0	31, 774	96.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 H0SPI CE	2, 862, 491	11, 114		0	242, 891	1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	315, 491, 883	12, 991, 052	2, 081, 103	0	16, 076, 434	]118.00 ]
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 518, 569	0		0		192.00
	07950 RENTAL SPACE	4, 699, 687	0	475, 590	0		194.00
	07951 FOUNDATI ON	470, 268	5, 145		0	26, 280	
	07952 RETAIL SERVICES	167, 629	58, 440		0		194. 02
	07953 REID CONTRACTED SERVICES	382, 879	0	1 1	0		194. 03
	07954 REID PHYSICIAN ASSOC.	0	0	7, 598	0		194. 04
	07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	1, 404, 702 135, 202	0 1 747 022	0 418, 071	0		194. 05 194. 06
	707950 VACANT SPACE	135, 202	1, 767, 023 6, 987, 748		0		194. 06
	07958 CAMBRI DGE RHC	0	0, 987, 748		0		194. 07
	to the state of th	, 91		. 91			

Health Financial Systems	REID HOSPITAL & HEA	ID HOSPITAL & HEALTH CARE SERVICES			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS				Peri od:	Worksheet B		
				From 01/01/2020 To 12/31/2020		nared:	
				10 12/31/2020	7/8/2021 10: 3	7 am	
		CAP	TAL RELATED C	OSTS			
			I	1			
Cost Center Description	Net Expenses	NEW BLDG &	NEW CAP BLDG		EMPLOYEE		
	for Cost	FLXT	& FIXT -	EQUI P	BENEFI TS		
	Allocation		OFFSI TE		DEPARTMENT		
	(from Wkst A						
	col. 7)						
	0	1. 00	1. 01	2. 00	4. 00		
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers		0	) (	0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	326, 270, 819	21, 809, 408	6, 707, 864	4 0	16, 162, 627	202. 00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

7/8/2021 10: 37 am Cost Center Description NONPATI ENT DATA PURCHASI NG ADMI TTI NG CASHI ERI NG/AC RECEIVING AND COUNTS TELEPHONES 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 5.01 5.01 0 5.02 00550 DATA PROCESSING 14, 480, 696 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 320, 665 5.03 0 5.04 00570 ADMITTING 1, 415, 236 800 8, 906, 269 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 0 0 67, 789 5.05 00590 OTHER A&G 849.142 1.454 5.06 5.06 0 0 00700 OPERATION OF PLANT 7 00 33, 966 1, 381 0 0 7.00 0 8.00 00800 LAUNDRY & LINEN SERVICE 22, 644 137 0 0 8.00 9.00 00900 HOUSEKEEPI NG 56, 609 12, 798 0 0 9.00 000000000 0 10.00 01000 DI ETARY 532, 129 10.00 5.841 0 11.00 01100 CAFETERI A 0 0 0 11.00 01300 NURSING ADMINISTRATION 0 13 00 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 192, 472 14.00 38, 142 0 14.00 01500 PHARMACY 15.00 645, 348 37, 328 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 215, 116 370 0 0 0 17.00 01701 INSERVICE EDUCATION 17.01 883, 107 675 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD Ω 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 271, 725 74 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 271, 725 115 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1,641,674 37.897 544, 595 4, 152 30.00 03100 INTENSIVE CARE UNIT 0 103, 216 31.00 283, 047 14, 145 787 31.00 0 04000 SUBPROVI DER - I PF 169, 828 3.417 84.094 40.00 40.00 641 04100 SUBPROVI DER - I RF 0 41.00 113, 219 2.850 52,827 403 41.00 43.00 04300 NURSERY 1,757 15, 516 118 43.00 ANCILLARY SERVICE COST CENTERS 1, 469, 523 11, 094 50 00 05000 OPERATING ROOM 0 713, 279 35 453 50 00 00000 05200 DELIVERY ROOM & LABOR ROOM 52.00 56, 609 4,625 84, 878 647 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 879, 434 32, 978 1, 392, 378 10, 615 54.00 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 113, 219 23,070 896, 105 6,831 59.00 06000 LABORATORY 5, 794 1, 001, 588 7, 636 60 00 724, 601 60 00 06500 RESPIRATORY THERAPY 65.00 135, 863 14,636 236, 089 1,800 65.00 06600 PHYSI CAL THERAPY 2,023 200, 399 66.00 1, 415, 236 1,528 66.00 69 00 06900 ELECTROCARDI OLOGY 0 0 215, 116 1.781 317, 999 2, 424 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 90, 575 827 41,078 313 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 C 0 291, 164 2, 220 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 239, 214 73 00 Ω 9.447 73 00 74.00 07400 RENAL DIALYSIS 45, 288 811 11, 647 89 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 8, 473 76.97 67, 931 382 76.97 65 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 951, 039 18, 637 804, 531 6, 133 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 93.00 0 3, 350 436 169, 828 57, 168 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 6, 204 4, 575 96.00 22, 644 35 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 203, 794 5.784 49, 212 375 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 14, 401, 443 315, 536 8, 906, 269 67, 789 118. 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 11, 322 132 0 0 192.00 194.00 07950 RENTAL SPACE 3, 192 0 0 194.00 0 0 0 194. 01 07951 FOUNDATI ON 56, 609 0 0 0 194. 01 436 194. 02 07952 RETAIL SERVICES 0 194 02 11, 322 60 194. 03 07953 REID CONTRACTED SERVICES 0 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. 0 0 0 0 194.04 C 194. 05 07955 CONNERSVILLE LOCATION 0 194, 05 C 1, 307 0 194.06 194.06 07956 VACANT SPACE 0 C 0 194.07 07957 HOME OFFICE 0 0 0 194. 07 0 194. 08 07958 CAMBRI DGE RHC 0 0 0 194.08 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 14, 480, 696 320, 665 8, 906, 269 67, 789 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	7/8/2021 10: 3 HOUSEKEEPI NG	7 am
5550 55111611 255511 211 611			PLANT	LINEN SERVICE		
GENERAL SERVICE COST CENTERS	5A. 05	5. 06	7. 00	8. 00	9. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
1. 01 O0101 NEW CAP BLDG & FLXT - 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   ADMI TTI NG						5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06   00590 OTHER A&G	35, 092, 718	35, 092, 718				5.06
7. 00 00700 OPERATION OF PLANT	1, 320, 431	159, 138				7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	956, 668 4, 233, 066	115, 298 510, 169		1, 091, 088	4, 755, 438	8. 00 9. 00
10. 00   01000 DI ETARY	3, 135, 874	377, 936		0	186, 571	10.00
11. 00 01100 CAFETERI A	2, 471, 900	297, 913		o O	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	373, 035	44, 958		ol	3, 902	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	6, 689, 986	806, 277		ol	63, 136	14. 00
15. 00 01500 PHARMACY	41, 726, 210	5, 028, 843		o	81, 226	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	114, 965	13, 856		o	0	16.00
17.00 01700 SOCIAL SERVICE	4, 355, 237	524, 893	679	o	34, 760	17.00
17. 01 01701 INSERVICE EDUCATION	3, 817, 321	460, 064	14, 451	0	112, 439	17. 01
21.00   02100   I &R SERVICES-SALARY & FRINGES APPRVD	2, 249, 263	271, 081	0	0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	760, 745	91, 685		0	0	22.00
23. 00   02300   PARAMED ED PRGM	719, 003	86, 654	4, 351	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	40.400.400	5 004 750	170 444	222 227	1 050 040	
30. 00   03000   ADULTS & PEDI ATRI CS	42, 190, 632	5, 084, 750		328, 287	1, 852, 942	30.00
31. 00   03100   NTENSI VE CARE UNI T	8, 450, 194	1, 018, 417			314, 263	31.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	5, 263, 578	634, 366 378, 088		75, 713 31, 374	205, 725	40.00
43. 00   04300   NURSERY	3, 137, 139 1, 146, 757	138, 207	· ·		149, 683 10, 286	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS	1, 140, 757	130, 207	4, 150	<u> </u>	10, 200	43.00
50. 00 05000 OPERATING ROOM	26, 589, 381	3, 204, 552	62, 975	166, 043	371, 369	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 622, 770	195, 576		58, 676	137, 623	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21, 393, 974	2, 578, 402			205, 370	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 437, 176	1, 016, 848		o	58, 880	59.00
60. 00   06000   LABORATORY	17, 190, 261	2, 071, 770	31, 304	59, 185	166, 708	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 253, 118	392, 066	1, 851	0	44, 692	65.00
66. 00   06600   PHYSI CAL THERAPY	12, 257, 999	1, 477, 334			46, 465	66.00
69. 00 06900 ELECTROCARDI OLOGY	2, 842, 947	342, 632			54, 624	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	682, 448	82, 249		4, 419	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	14 020 224	2 040 101	0	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	16, 928, 234 1, 248, 661	2, 040, 191 150, 489	0	O O	0	72. 00 73. 00
74. 00 07400 RENAL DIALYSIS	975, 140	117, 524	2, 310	0	55, 688	74.00
76. 00   03950   ANCI LLARY - OTHER	973, 140	117, 324 N	2,310	0	0.000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	823, 815	99, 286	-	Ö	14, 188	76. 97
OUTPATIENT SERVICE COST CENTERS	020,010	,,,200	0,077	<u> </u>	1 1,7 100	70.77
91. 00 09100 EMERGENCY	12, 713, 328	1, 532, 210	47, 997	150, 801	344, 412	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		·			92.00
93.00 04040 FAMILY PRACTICE	2, 916, 627	351, 512	0	32, 404	90, 803	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	419, 929	50, 610	5, 816	0	0	96. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	3, 375, 661	406, 835		0	82, 290	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	301, 876, 191	32, 152, 679	754, 357	1, 091, 088	4, 688, 045	118. 00
NONREI MBURSABLE COST CENTERS	ما	0	0	ام	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	742 012	147 400	0	53, 205	190.00
194. 00 07950 RENTAL SPACE	6, 164, 225 5, 183, 588	742, 912 624, 726		0	·	194.00
194. 01 07951 FOUNDATI ON	558, 738	67, 339		0		194.00
194. 02 07952  RETAI L SERVI CES	260, 832	31, 435		0	10, 641	
194. 03 07953 REID CONTRACTED SERVICES	414, 292	49, 930		ol Ol		194. 03
194. 04 07954 REID PHYSICIAN ASSOC.	7, 598	916		n N		194. 04
194. 05 07955 CONNERSVILLE LOCATION	1, 406, 009	169, 452		ol		194. 05
194. 06 07956 VACANT SPACE	2, 320, 298	279, 642		o		194.06
194. 07 07957 HOME OFFICE	8, 079, 048	973, 687	376, 392	o		194. 07
194. 08 07958 CAMBRI DGE RHC	O	0	0	o	0	194. 08
200.00 Cross Foot Adjustments	0					200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	326, 270, 819	35, 092, 718	1, 479, 569	1, 091, 088	4, 755, 438	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

7/8/2021 10:37 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00570 ADMITTING 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5 05 00590 OTHER A&G 5.06 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 3, 728, 765 10.00 10.00 11.00 01100 CAFETERI A 2, 784, 479 11.00 01300 NURSING ADMINISTRATION 13 00 0 2, 137 427, 063 13.00 01400 CENTRAL SERVICES & SUPPLY 0 44.806 7, 617, 244 14.00 14.00 0 0 46, 985, 791 15 00 01500 PHARMACY 134, 568 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 89, 679 0 0 53 17.00 01701 INSERVICE EDUCATION 0 0 17.01 41,097 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 40, 412 0 0 21.00 22.00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD 5, 353 0 0 0 22.00 02300 PARAMED ED PRGM 7, 109 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 559, 517 829, 394 196, 352 22, 813 4, 165 30.00 03100 INTENSIVE CARE UNIT 31.00 368, 214 118, 385 28, 027 25, 225 830 31.00 04000 SUBPROVI DER - I PF 492.034 28, 223 40.00 40.00 119, 213 1, 369 18 04100 SUBPROVI DER - I RF 309,000 41.00 57, 476 13,607 4,777 123 41.00 43.00 04300 NURSERY 21, 752 5, 150 22 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 54, 163 12 823 3. 983. 338 147, 999 50 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 23, 246 5,503 11, 909 1,057 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 231, 954 54, 914 56, 970 757, 955 54.00 54.00 0 59.00 05900 CARDI AC CATHETERI ZATI ON 55, 025 13,027 2, 815, 784 2, 209 59.00 06000 LABORATORY 0 0 183, 945 524, 071 60 00 60 00 0 154 06500 RESPIRATORY THERAPY 65.00 55, 464 13, 131 8, 592 997 65.00 06600 PHYSI CAL THERAPY 66.00 214, 403 655 133 66.00 69 00 06900 ELECTROCARDI OLOGY 0 0 36, 531 O 49, 385 282, 700 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 13, 318 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 ol 72.00 0 07300 DRUGS CHARGED TO PATIENTS 45, 616, 453 0 73 00 0 73 00 C 74.00 07400 RENAL DIALYSIS 30 7 31 11 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 07697 CARDIAC REHABILITATION 0 76.97 16, 139 3,821 76.97 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 221, 667 52, 478 24, 712 11, 123 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 0 0 93.00 78, 465 1, 142 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 11, 079 0 87, 591 158, 669 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 50, 035 116. 00 11600 HOSPI CE  $\cap$ 0 116,00 3, 728, <u>765</u> SUBTOTALS (SUM OF LINES 1 through 117) 2, 756, 845 427, 063 7, 617, 244 46, 985, 791 118. 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 1, 380 0 0 0 194.00 0 194. 01 07951 FOUNDATI ON 6, 567 0 0 0 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 194, 02 7.942 0 0 194. 03 07953 REID CONTRACTED SERVICES 11, 745 0 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 0 194.04 0 0 C 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 194, 05 C 194.06 07956 VACANT SPACE 0 0 194.06 C 194.07 07957 HOME OFFICE 0 0 0 0 194. 07 C 194. 08 07958 CAMBRIDGE RHC 0 0 0 0 194.08 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 728, 765 2, 784, 479 427, 063 7, 617, 244 46, 985, 791 202. 00 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				INTERNS &	7/8/2021 10: 3 RESI DENTS	7 am
Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE		SERVI CES-OTHE	
cost center bescription	RECORDS &	SERVI CE	EDUCATI ON		R PRGM. COSTS	
	LI BRARY 16. 00	17. 00	17. 01	21. 00	22. 00	
GENERAL SERVICE COST CENTERS	10.00	17.00	17.01	21.00	22.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01   00101   NEW CAP BLDG & FIXT - OFFSITE 2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5. 01
5. 02   00550 DATA PROCESSING 5. 03   00560 PURCHASING RECEIVING AND STORES						5. 02 5. 03
5. 04   00570 ADMITTING						5.03
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5. 06   00590   OTHER A&G						5. 06
7. 00   00700   0PERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
8. 00   00800  LAUNDRY & LI NEN SERVI CE 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 14. 00   01400   CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00   01500   PHARMACY						15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	128, 821					16.00
17. 00 01700 SOCI AL SERVI CE	0	5, 005, 301				17.00
17. 01   01701   INSERVICE EDUCATION 21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRVD	0	0	4, 445, 372 0			17. 01 21. 00
22. 00   02200   1&R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	0	2, 560, 756	857, 783	22.00
23. 00 02300 PARAMED ED PRGM	0	Ō	10, 169			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	7 000	0.007.050	1 000 (10	0.400.055	744 000	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	7, 882 1, 494	3, 237, 858 290, 144	1, 382, 613		711, 233	30. 00 31. 00
40. 00   04000   SUBPROVI DER -   1 PF	1, 217	290, 144	201, 421 220, 011		26, 133 0	40.00
41. 00   04100   SUBPROVI DER -   I RF	765	ō	78, 622		0	41.00
43. 00 04300 NURSERY	225	0	42, 427	0	0	43.00
ANCILLARY SERVICE COST CENTERS 50. 00   05000   OPERATING ROOM	21, 184	ol	288, 463	140, 734	47, 142	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 228	o	43, 958		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 153	o	402, 077		0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	12, 970	0	102, 788		0	59.00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	14, 497 3, 417	0	317, 659 96, 774		0 4, 099	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 900	Ö	377, 911		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	4, 603	0	71, 733		12, 810	69. 00
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	595 0	0	24, 713	0	0	70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   72.00   07200   MPL. DEV. CHARGED TO PATIENT	4, 214	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	17, 936	Ö	0	Ō	Ö	73.00
74. 00   07400   RENAL DI ALYSI S	169	0	0	0	0	74.00
76. 00   03950   ANCI LLARY - OTHER	0 123	0	0 32, 149	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	123	U <sub>I</sub>	32, 149	0	0	76. 97
91. 00 09100 EMERGENCY	11, 644	1, 477, 299	511, 426	168, 270	56, 366	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	007		100 704			92.00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	827	0	133, 734	0	0	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	66	0	19, 136	0	0	96.00
SPECIAL PURPOSE COST CENTERS						440.00
113. 00 11300   NTEREST EXPENSE 116. 00 11600 HOSPI CE	712	0	62, 110			113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	128, 821	5, 005, 301	4, 419, 894		857, 783	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190. 00 192. 00
194. 00 07950 RENTAL SPACE	0	0	0	0		194.00
194. 01 07951 FOUNDATI ON	Ö	ō	12, 028	0		194. 01
194. 02 07952 RETAI L SERVI CES	0	0	13, 450	0		194. 02
194. 03 07953 RELD CONTRACTED SERVICES 194. 04 07954 RELD PHYSICIAN ASSOC.	0	0	0	0		194. 03 194. 04
194. 04 07954 REID PHYSICIAN ASSOC. 194. 05 07955 CONNERSVILLE LOCATION		ol Ol	0			194. 04
194. 06 07956 VACANT SPACE	ő	ő	Ö	0	0	194. 06
194. 07 07957 HOME OFFICE	0	o	0	0		194. 07
194.08 07958 CAMBRIDGE RHC 200.00  Cross Foot Adjustments	0	0	0	0		194. 08 200. 00
201.00 Negative Cost Centers	О	О	0	0		200.00
				•	-	

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre 7/8/2021 10:3	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVI CES-SALA	RESI DENTS  SERVI CES-OTHE R PRGM. COSTS	
	16. 00	17. 00	17. 01	21. 00	22. 00	
202.00 TOTAL (sum lines 118 through 201)	128, 821	5, 005, 301	4, 445, 37	2, 560, 756	857, 783	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

| Peri od: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared:

				То	12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	77072021 10. 37 8111
	<b>'</b>	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
1. 01 2. 00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 NEW CAP REL COSTS-MVBLE EQUIP					1.01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00540 NONPATI ENT TELEPHONES					5. 01
5. 02	00550 DATA PROCESSING					5. 02
5.03	00560 PURCHASING RECEIVING AND STORES					5.03
5.04	00570 ADMITTING					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
9. 00	00900 HOUSEKEEPING					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						14.00
15.00						15.00
	01600 MEDICAL RECORDS & LIBRARY					16. 00 17. 00
17. 00 17. 01	1					17.00
21. 00	1					21.00
22. 00	· ·					22.00
23. 00	02300 PARAMED ED PRGM	827, 286				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	0	60, 711, 139		57, 876, 651	30.00
31.00	· ·	0	11, 025, 684	-104, 149	10, 921, 535	31.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	7, 076, 098 4, 188, 399	0	7, 076, 098 4, 188, 399	40. 00 41. 00
43. 00	1	0	1, 368, 982	o	1, 368, 982	43.00
	ANCILLARY SERVICE COST CENTERS	-1	.,, .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-1	.,,	
50.00		0	35, 090, 166	-187, 876	34, 902, 290	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 114, 437	0	2, 114, 437	52.00
54.00		827, 286	26, 719, 488	0	26, 719, 488	54.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	12, 521, 827 20, 559, 554	0	12, 521, 827 20, 559, 554	59. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		3, 886, 439	-16, 337	3, 870, 102	65. 00
66. 00	06600 PHYSI CAL THERAPY	l o	14, 462, 966		14, 462, 966	66.00
69.00	06900 ELECTROCARDI OLOGY	O	3, 737, 071	-51, 053	3, 686, 018	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	816, 113	0	816, 113	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	18, 972, 639	0	18, 972, 639	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	47, 033, 539 1, 150, 910	0	47, 033, 539 1, 150, 910	73. 00 74. 00
	03950 ANCI LLARY - OTHER		1, 130, 910	0	1, 130, 910	74.00
	07697 CARDI AC REHABI LI TATI ON	l o	995, 198		995, 198	76. 97
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-,,	
	09100 EMERGENCY	0	17, 323, 733	-224, 636	17, 099, 097	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0 (05 544	0	0 (05 51)	92.00
93.00	04040 FAMILY PRACTICE  OTHER REIMBURSABLE COST CENTERS	0	3, 605, 514	0	3, 605, 514	93.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	O	752, 896	0	752, 896	96.00
70.00	SPECIAL PURPOSE COST CENTERS	91	7027070	<u> </u>	, 02, 0, 0	70.00
113.00	11300 I NTEREST EXPENSE					113.00
	11600 H0SPI CE	0	3, 977, 643		3, 977, 643	116.00
118.00		827, 286	298, 090, 435	-3, 418, 539	294, 671, 896	118. 00
100.00	NONREI MBURSABLE COST CENTERS		٥		0	100.00
	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19200 PHYSICIANS' PRIVATE OFFICES	0	0 7, 128, 030		0 7, 128, 030	190. 00 192. 00
	07950 RENTAL SPACE		5, 845, 224	0	5, 845, 224	194. 00
	I 07951 FOUNDATI ON	o	648, 538	0	648, 538	194. 01
194. 02	07952 RETAIL SERVICES	0	325, 360	0	325, 360	194. 02
194. 03	07953 REID CONTRACTED SERVICES	0	475, 967	0	475, 967	194. 03
	1 07954 REID PHYSICIAN ASSOC.	0	8, 514		8, 514	194. 04
	5 07955 CONNERSVILLE LOCATION	0	1, 575, 461	0	1, 575, 461	194. 05
	5 07956 VACANT SPACE 7 07957 HOME OFFICE	0	2, 744, 163		2, 744, 163	194. 06 194. 07
	07957 HOME OFFICE BO7958 CAMBRI DGE RHC		9, 429, 127 0	0	9, 429, 127	194.07
200.00			0	0	0	200. 00
201.00		o o	Ö		Ö	201. 00
		·		<u> </u>		

Health Financial Systems	REID HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	_	Provi der Co		Period: From 01/01/2020 To 12/31/2020	
Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	23. 00	24. 00	25. 00	26.00	
202.00 TOTAL (sum lines 118 through 201	) 827, 286	326, 270, 819	-3, 418, 53	9 322, 852, 280	202.00

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

					72/31/2020	7/8/2021 10: 3	
			CAP	ITAL RELATED CO	STS		
	Cost Center Description	Directly	NEW BLDG &	NEW CAP BLDG	NEW MVBLE	Subtotal	
	oost denter bescription	Assigned New	FLXT	& FIXT -	EQUI P	Subtotal	
		Capi tal		OFFSI TE			
		Related Costs	4 00	1.01	2.00	0.4	
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	2. 00	2A	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						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	403	0	9, 741	0	10, 144	
5. 01	00540 NONPATI ENT TELEPHONES	0	02 741	0	0	0	
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	223, 905 8, 072	82, 741 221, 549		0	333, 311 229, 621	5. 02 5. 03
5. 04	00570 ADMITTING	48, 284	11, 538	1	0	105, 701	5.04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	5, 462	0		0	195, 893	1
5.06	00590 OTHER A&G	47, 974	95, 702		0	160, 333	
7.00	00700 OPERATION OF PLANT	45, 984	274, 820	1	0		1
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	57, 721 67, 224	308, 061 203, 742		0	365, 782 270, 966	1
10.00	•	101, 232	457, 284	1	0	558, 516	1
11. 00	l l	0	240, 105	1	0	240, 105	1
13.00	l l	0	48, 825	1	0	48, 825	1
14.00		507, 907	210, 061	0	0	717, 968	1
15. 00		424, 741	246, 524		0	671, 265	
16.00		0 2 720	20.003	114, 965	0	114, 965	1
17. 00 17. 01		2, 728 22, 582	30, 993 259, 960		0	33, 721 282, 542	
21. 00		22, 302	237, 700		0	202, 342	1
22. 00		21, 423	0	Ö	0		
23.00		2, 970	26, 498	65, 263	0	94, 731	23. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00		713, 816	2, 918, 623	1	0		
31. 00 40. 00		502, 236 26, 171	613, 175 557, 931	0	0	1, 115, 411 584, 102	1
41. 00		44, 317	446, 994	_	0	l .	1
43. 00		8, 036	66, 957	1	0		1
	ANCILLARY SERVICE COST CENTERS						
50.00		1, 263, 208	1, 140, 387		0	_,,	1
52.00		39, 549	207, 688		0	247, 237	
54. 00 59. 00	•	1, 660, 618 237, 344	1, 746, 769 339, 129		0	3, 446, 350 576, 473	1
60.00		696, 001	726, 634	1	0	1, 422, 635	1
65. 00		68, 346	41, 133		0	109, 479	1
66.00		101, 485	201, 894	1, 030, 469	0	1, 333, 848	66.00
69. 00		147, 449	195, 026	1	0	342, 475	1
70.00		33, 147	0	94, 777	0	127, 924	1
71. 00 72. 00		0	0	0	0	0	1
73.00			0		0	1	
74. 00	•	10, 685	37, 212	1	0	1	
76.00	03950 ANCI LLARY - OTHER	0	0	1	0		
76. 97	07697 CARDI AC REHABI LI TATI ON	5, 850	204, 417	0	0	210, 267	76. 97
04.00	OUTPATIENT SERVICE COST CENTERS	200 404	770 0/4	1 0		4 455 (07	04.00
91. 00 92. 00		382, 426	773, 261	0	0	1, 155, 687 0	1
93.00	,	31, 988	0	20, 626	0		1
73.00	OTHER REIMBURSABLE COST CENTERS	31, 700		20,020		32,014	75.00
96.00		2, 405	44, 305	69, 938	0	116, 648	96.00
	SPECIAL PURPOSE COST CENTERS						
	0 11300 INTEREST EXPENSE						113.00
	0 11600 HOSPI CE	222	11, 114		0		116.00
118. 00	O SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	7, 563, 911	12, 991, 052	2, 081, 103	0	22, 636, 066	1118.00
190 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	102, 102	0	2, 634, 202	0		
	0 07950 RENTAL SPACE	99, 513	0	475, 590	0	575, 103	194. 00
	1 07951 FOUNDATI ON	1, 841	5, 145	1	0		194. 01
	2 07952 RETAIL SERVICES	143	58, 440	0	0		194. 02
	3 07953 RELD CONTRACTED SERVICES	0	0	7 500	0		194. 03 194. 04
	4 07954 REID PHYSICIAN ASSOC. 5 07955 CONNERSVILLE LOCATION	87, 383	0	7, 598 0	0		194. 04
	607956 VACANT SPACE	4, 932	1, 767, 023	418, 071	0	2, 190, 026	
194.0	7 07957 HOME OFFICE	0	6, 987, 748		0	8, 079, 048	
	8 07958 CAMBRI DGE RHC	0	0	0	0	0	194. 08
200.00	O Cross Foot Adjustments					0	200. 00

		REID HOSPITAL & HEALTH CARE SERVICES			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITA	AL RELATED COSTS		Provi der C		Period: From 01/01/2020	Worksheet B	
						Date/Time Pre 7/8/2021 10:3	pared:
			CAP	ITAL RELATED C	0STS	17072021 10.3	7 aiii
Cost Cen	nter Description	Di rectly	NEW BLDG &	NEW CAP BLDG	NEW MVBLE	Subtotal	
		Assigned New	FLXT	& FIXT -	EQUI P		
		Capi tal		OFFSI TE			
		Related Costs					
		0	1. 00	1. 01	2. 00	2A	

7, 859, 825

21, 809, 408

0 6, 707, 864

0 201. 00 36, 377, 097 202. 00

201. 00 202. 00

Negative Cost Centers TOTAL (sum lines 118 through 201)

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

7/8/2021 10:37 am Cost Center Description **EMPLOYEE** NONPATI ENT DATA PURCHASI NG ADMI TTI NG **BENEFITS** RECEIVING AND **TELEPHONES** PROCESSI NG DEPARTMENT **STORES** 5. 01 5. 02 5. 04 4 00 5.03 GENERAL SERVICE COST CENTERS 1.00 00100 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 10, 144 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 29 0 333, 340 5.02 00560 PURCHASING RECEIVING AND STORES 229, 628 5.03 7 C 5.03 5.04 00570 ADMITTING 32, 578 139, 298 5.04 446 573 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 0 0 5.05 00590 OTHER A&G 301 0 19.547 1.041 5.06 5.06 0 00700 OPERATION OF PLANT 0 7 00 67 782 989 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 42 521 98 0 8.00 9.00 00900 HOUSEKEEPI NG 257 1, 303 9, 165 0 9.00 01000 DI ETARY 10.00 10.00 0 117 12, 249 4.182 0 11.00 01100 CAFETERI A 244 0 0 11.00 01300 NURSING ADMINISTRATION 13 00 27 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 74 0 4.431 14.00 14.00 27, 312 0 01500 PHARMACY 15.00 435 C 14,856 26, 731 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 300 0 4, 952 265 0 17.00 01701 INSERVICE EDUCATION 17.01 123 0 20, 329 483 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 182 0 0 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 11 0 6, 255 53 0 22.00 02300 PARAMED ED PRGM 0 23.00 23.00 27 6, 255 82 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2,596 0 37, 791 27, 138 8,544 30.00 03100 INTENSIVE CARE UNIT 31.00 402 0 6,516 10, 129 1,619 31.00 04000 SUBPROVI DER - I PF 0 3.909 1, 319 40.00 40.00 334 2.447 04100 SUBPROVI DER - I RF 0 41.00 190 2,606 2,041 829 41.00 43.00 04300 NURSERY 80 0 1, 259 243 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 160 n 16, 419 25 388 22, 624 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 83 C 1, 303 3, 312 1, 332 52.00 05400 RADI OLOGY-DI AGNOSTI C 756 0 43, 263 23, 615 21, 845 54.00 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 188 0 2,606 16, 520 14,059 59.00 06000 LABORATORY 16, 680 4. 149 60 00 447 Ω 15, 714 60 00 06500 RESPIRATORY THERAPY 65.00 183 0 3, 128 10, 481 3,704 65.00 1, 448 06600 PHYSI CAL THERAPY 66.00 701 32, 578 3, 144 66.00 69 00 06900 ELECTROCARDI OLOGY 108 0 4.952 1, 276 4, 989 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 31 0 2,085 592 644 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 ol 4,568 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 73 00 0 19, 442 74.00 07400 RENAL DIALYSIS 0 0 1,043 581 183 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 41 0 274 133 76.97 1, 564 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 730 0 21, 893 13, 346 12, 622 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 199 93.00 3, 909 2, 399 897 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 20 0 521 4, 443 72 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 152 C 4, 691 4, 142 772 116.00 225, 954 SUBTOTALS (SUM OF LINES 1 through 117) 10,090 0 331, 515 139, 298 118. 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 C 261 95 0 192.00 194.00 07950 RENTAL SPACE 3 2, 286 0 194.00 194. 01 07951 FOUNDATI ON 0 1, 303 0 194. 01 16 312 194. 02 07952 RETAIL SERVICES 15 0 194.02 C 261 43 194. 03 07953 REID CONTRACTED SERVICES 20 C 0 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. 0 194.04 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 936 0 194, 05 194.06 07956 VACANT SPACE 0 0 0 194.06 0 194.07 07957 HOME OFFICE 0 0 0 0 194. 07 0 194. 08 07958 CAMBRI DGE RHC 0 C 0 0 0 194.08 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 10, 144 333, 340 229, 628 139, 298 202. 00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

				'	0 12/31/2020	Date/lime Pre   7/8/2021 10:3	
	Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 05	5. 06	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS			T			1 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 11. 00 14. 00 15. 00 17. 01 21. 00 22. 00 23. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	69, 733 0 0 0 0 0 0 0 0 0 0	181, 222 821 595 2, 633 1, 951 1, 538 232 4, 161 25, 954 72 2, 709 2, 374 1, 399 473	361, 403 4, 671 2, 981 6, 933 3, 582 740 3, 185 3, 650 0 166 3, 530	371, 709 0 0 0 0 0 0 0 0 0	287, 305 11, 272 0 236 3, 814 4, 907 0 2, 100 6, 793 0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00
25.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	777	1,003		<u> </u>	23.00
30. 00 31. 00 40. 00 41. 00 43. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	4, 272 810 660 414 122	26, 353 5, 256 3, 274 1, 951 713	9, 297 8, 459 6, 777	22, 778 25, 794 10, 688	111, 949 18, 987 12, 429 9, 043 621	31. 00 40. 00
F0 00	ANCILLARY SERVICE COST CENTERS	11 207	1/ 520	15 202	F/ F/3	22 427	   FO 00
	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER	11, 397 666 10, 922 7, 029 7, 857 1, 852 1, 572 2, 495 322 0 2, 284 9, 721 91	16, 539 1, 009 13, 307 5, 248 10, 692 2, 023 7, 624 1, 768 424 0 10, 529 777 607	3, 149 20, 402 1, 739 7, 646 452 18, 259 211 2, 045 0 0 0 564	19, 989 36, 421 0 20, 163 0 3, 548 0 1, 505 0 0		54.00 59.00 60.00 65.00 66.00 70.00 71.00 72.00 73.00 74.00 76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	66	512	1, 387	0	857	76. 97
91. 00 92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	6, 311 448	7, 908 1, 814			20, 808 5, 486	92.00
96. 00	OTHER REIMBURSABLE COST CENTERS  O9600 DURABLE MEDICAL EQUIP-RENTED	36	261	1, 421	o	0	96.00
113. 0	SPECIAL PURPOSE COST CENTERS 0 11300   INTEREST EXPENSE 0 11600   HOSPI CE	386 69, 733	2, 100 166, 048	0	O		113. 00 116. 00
192. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 RENTAL SPACE 1 07951 FOUNDATION 2 07952 RETAIL SERVICES 3 07953 REID CONTRACTED SERVICES 4 07954 REID PHYSICIAN ASSOC. 5 07955 CONNERSVILLE LOCATION 6 07956 VACANT SPACE 7 07957 HOME OFFICE 8 07958 CAMBRIDGE RHC C C C S FOOT Adjustments Negative Cost Centers	0 0 0 0 0 0 0 0 0 0 0 0 126, 160 195, 893	0 3, 834 3, 224 348 162 258 5, 875 1, 443 5, 025 0	8, 679 78 259 0 0 0 35, 228 91, 937 0	0 0 0 0 0 0 0	3, 214 0 214 643 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 05 194. 05 194. 06 194. 07 194. 08 200. 00 201. 00 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

CHANGAL SERVICE COST CENTERS   10.00   11.00   13.00   14.00   15.00		Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	7/8/2021 10: 3 PHARMACY	7 am
10.00   11.00   13.00   14.00   15.00   14.00   15.00					ADMINISTRATIO	SERVI CES &		
1.00			10. 00	11. 00			15. 00	
1.01   ORDIN INPLICED BING & FIRST OFFSITE   1.02   0.00000   ORDINO ORDIN ORD	1 00							1 00
2 0.0 02000 NEW CAP REL COSTS-MANUEL EQUIP 4.00 D04000 JANUARY TEST TELERHONES 5.01 00500 JANUARY TEST TELERHONES 5.01 00500 JANUARY TEST TELERHONES 5.04 00500 JANUARY TEST TELERHONES 5.06 00500 JANUARY TEST TELERHONES 5.07 00500 JANUARY TEST TEST TEST TEST TEST TEST TEST TES								1
4 - 0. 00-040   DAMONT FIRST TERPHONES   5 - 0. 00-050   DAMONT FIRST TERPHONE								2.00
5.00   OSSO  DIATA PROCESSING								4.00
5.03   OSCO  PURCHASI NG RECEL WING AMO STORES     5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   5.06   OSCO  COMERY AND STORES   OSCO								5. 01
5.04   00570   ADMITTING								5. 02
5.06   GOSSPO CASHIER INKCACCOUNTS RECEIVABLE								5.03
5.0 6 00000 OTHER AAG 7.0 00000 OTHER AAG 8.0 0 00000 OTHER AAG 9.0 000000 OTHER AAG 9.0 00000  OTHER AAG 9.0 000000 OTHER AAG 9.0 000000 OTHER AAG 9.0 000000 OTHER AAG 9.0 00000000000000000000000000000000000								1
7. 00 007000 DERADITION OF PLANTI 8. 00 008000 LAURIONY & LIEW SERVICE 9. 00 00900 LOURINEY & SURPRIVE SERVICE 9. 00 011000 CAFETERIA AM INISTRATION 10. 011000 PHARMACY EXPICES & SUPPLY 10. 011000 CAFETERIA AM INISTRATION 10. 011000 LAR SERVICES & SUPPLY 10. 011000								5.06
9.00   009900   HOUSEKEEPING   9.00   11.00   01000   DIETARY   595,220   0.245,469   11.00   01100   CAFETERI A   0.00   11.00   01100   CAFETERI A   0.00   11.00   01100   CAFETERI A   0.00   11.00   01100   URSIN MA DUNIS INS ADMINISTRATION   0.00   18.80   50,248   11.00   11.00   11.00   01100   URSIN MA DUNIS INS ADMINISTRATION   0.00								7. 00
10.00   01000   DETARY								8. 00
11.00   01100   CAFETERIA   0   245, 469   11.0   13.0   01300   NRES ING ADMIN STRATION   0   188   50, 248   11.0   13.0   01300   NRES ING ADMIN STRATION   0   18.0   3, 950   0   764,895   14.0   0   16.0   01600   PARABACY   0   1.1   863   0   0   759,661   14.0   0   16.0   01600   PARABACY   0   0   0   0   0   0   0   0   0								9. 00
13.00   01300   NURSING ADMINISTRATION   0   188   50,248   13.0   15.00   11.00   1100   CENTRAL SERVICES & SUPPLY   0   3,950   0   764,895   15.00   11.00   1100   PHARIMACY   0   11.863   0   0   759,661   15.00   1100   PHARIMACY   0   0   0   0   0   0   0   0   0				245 440				10.00
14. 00   01-400   CENTRAL SERVI CES & SUPPLY   0   3, 950   0   764, 895   14. 0   15. 0   1150   01-500   MARIMACY   0   18. 0   10-50   MARIMACY   0   0   0   0   0   0   0   15.			- 1					1
15.00   O1500   PHARMACY			0			764. 895		14. 00
17.00   O1700   SOCIAL SERVI CE   0   7,906   0   0   1   17.0   17.01   17.			Ō			0	759, 661	15.00
17.0   0.7701   NSERVI CE EDUCATION   0   3.623   0   0   0   17.0	16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	О	0	16.00
21.00			0			0	1	17.00
22.00   02200   IAR SERVI CES-OTHER PREMI. COSTS APPRVD   0   0   0   0   0   0   0   0   0			0			0		
23.00   02300  PARMED ED PROM   0   627   0   0   0   23.0						0		1
INPATI ENT ROUTINE SERVICE COST CENTERS			- 1			0		23. 00
31.00   03100   INTENSIVE CARE LINIT   58,778   10,436   3,298   2,533   13   31.0   0.00   400.00   40000   SUBPROVI DER - I RF   49,325   5,067   1,601   480   2   41.0   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   43.00   47.75   1,509   39.990   2,393   50.0   52.00   65.00   6	20.00		<u> </u>	02,		<u>~</u> 1		20.00
40.00   04000  Subprovi DER - I PF	30.00	03000 ADULTS & PEDIATRICS	408, 574	73, 116	23, 100	2, 291	67	30.00
41.00   04100   SUBPROVI DER - I REF   49, 325   5, 0.67   1, 601   480   2   41. 0   43. 0   43.00   AUSTRY   SERVI CE COST CENTERS		1						ı
A3200   04300   NURSERY								
ANCI LLARY SERVICE COST CENTERS						1		1
50.00	43.00		<u> </u>	1, 710	000	۷-		1 43.00
54.00   05400   RADIOLOGY-DI AGNOSTIC   0   20,448   6,461   5,721   12,254   54.0	50.00		0	4, 775	1, 509	399, 990	2, 393	50.00
59.00   05900   CARDI AC CATHETERI ZATI ON   0   4, 851   1, 533   282, 752   36   59.00			- 1					52.00
60. 00   06000   LABORATORY   0   16, 216   0   52, 625   2   60. 0   65. 00   06500   RESPIRATORY THERAPY   0   4, 889   1,545   863   16   65. 0   65. 00   06600   PHYSI CAL THERAPY   0   18, 901   0   66   2   66. 0   06600   PHYSI CAL THERAPY   0   18, 901   0   66   2   66. 0   0600   PHYSI CAL THERAPY   0   18, 901   0   64   2   66. 0   0600   PHYSI CAL THERAPY   0   0   3, 220   0   4, 959   4, 571   69. 0   070. 0   07000   ELECTROCARDI OLOGY   0   3, 220   0   4, 959   4, 571   69. 0   07100   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0			- 1					1
65.00			- 1					1
66.00   06600   PHYSICAL THERAPY   0   18,901   0   666   2   66.00   69.00   06900   ELECTROCARDIOLOGY   0   3,220   0   4,959   4,571   69.00   07000   ELECTROCARDIOLOGY   0   3,220   0   4,959   4,571   69.00   07000   ELECTROCROEPHALOGRAPHY   0   1,174   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   76.00   03950   ANCILLARY - OTHER   0   0   0   0   0   0   76.00   03950   ANCILLARY - OTHER   0   0   0   0   0   76.97   07697   CARDIAC REHABILITATION   0   1,423   450   0   0   0   76.99   07000   EMERGENCY   0   19,541   6,175   2,481   180   79.00   09200   09SERVATION BEDS (NON-DISTINCT PART)   92.00   79.00   09200   09SERVATION BEDS (NON-DISTINCT PART)   92.00   70.00   09000   DURABLE MEDICAL EQUIP-RENTED   0   977   0   8,796   2,565   70   09000   DURABLE MEDICAL EQUIP-RENTED   0   977   0   8,796   2,565   713.00   13000   INTEREST EXPENSE   113.00   11000   HOSPIC CEST CENTERS   710.00   19000   00   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   19000   00   00   00   00   710.00   00   00   00   00   00   710.00   00   00   00   00   00   710.00   00   00   00   00   00   710.00   00   00   00   00   00   710.00   00   00   00   00   00   710.00   00   00   00   00   00   710.00			- 1					1
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   1,174   0   0   0   70. 0			Ō			•		66.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71. 0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   3   1   3   3   73. 524   75. 00   07400   RENAL DI ALYSIS   0   3   1   3   3   0   74. 0   76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LITATION   0   1, 423   450   0   0   0   76. 97   07697   CARDI AC REHABI LITATION   0   19, 541   6, 175   2, 481   180   791. 00   09200   BERGRICY   0   09200   BERGRICY   792. 00   09200   BERGRICY   0   0   0   18   793. 00   04040   FAMILY PRACTICE   0   0   6, 917   0   0   0   18   794. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   977   0   8, 796   2, 565   796. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   977   0   8, 796   2, 565   796. 01   113. 00   11300   INTEREST EXPENSE   113. 00   11600   HOSPI CE   0   4, 411   0   0   0   0   116. 00   797. 113. 00   1176REST EXPENSE   113. 00   11600   HOSPI CE   0   0   0   0   0   0   797. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   797. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   798. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   122   0   0   0   0   799. 00   194. 00   07950   RENTAL SPACE   0   194. 00   799. 00   194. 00   07951   RENTAL SPACE   0   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   194. 00   07955   CONNERSYI LLE LOCATION   0   0   0   0   799. 00   00   00   00   0   0   0   799. 00   00   00   00   0   0   799. 00   00			0	3, 220	0	4, 959	4, 571	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   72. 073. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   737, 524   73. 074. 00   07400   RENAL DI ALYSIS   0   3   1   3   3   0. 74. 00   0. 0   0. 0   0   0   0   0   0. 0			0		0	0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 737, 524 73. 074. 00 07400 RENAL DIALYSIS 0 3 1 3 0 74. 00 07400 RENAL DIALYSIS 0 0 3950 ANCILLARY - OTHER 0 0 0 0 0 0 0 0 76. 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	-	71.00
74. 00   07400  RENAL DI ALYSIS   0   3   1   3   0   74. 076. 076. 076. 076. 076. 076. 076. 076			0	0	0	0		1
76. 00   03950   ANCILLARY - OTHER			0	3	1	3		1
91.00   09100   EMERGENCY   0   19,541   6,175   2,481   180   91.00   92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   6,917   0   0   18   93.00   04040   FAMI LY PRACTICE   0   6,917   0   0   8,796   2,565   96.00   0900   0DURABLE MEDICAL EQUIP-RENTED   0   977   0   8,796   2,565   96.00   0900   0DURABLE MEDICAL EQUIP-RENTED   0   977   0   8,796   2,565   96.00   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000	76.00	03950 ANCI LLARY - OTHER	0	0	0	o	0	76.00
91. 00	76. 97		0	1, 423	450	0	0	76. 97
92. 00	01 00		ما	10 541	/ 175	2 401	100	01 00
93. 00			۷	19, 541	0, 1/5	2, 481	180	
OTHER REIMBURSABLE COST CENTERS   O9600 DURABLE MEDICAL EQUIP-RENTED   O 977   O 8,796   2,565   O96.00   O977   O 8,796   2,565   O96.00   O977   O 8,796   O96.00   O977   O9		' ' '	0	6, 917	0	o	18	1
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   11400   HOSPI CE   0   4, 411   0   0   0   116.00			- 1		- 1	- 1		
113. 00	96.00		0	977	0	8, 796	2, 565	96.00
116. 00	112 00							1112 00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   595, 220   243, 033   50, 248   764, 895   759, 661   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   192.00   194.00   07950   RENTAL SPACE   0   122   0   0   0   194.00   194.01   194.01   197.01   194.02   197.01   197.02   197.02   RETAI L SERVI CES   0   700   0   0   194.00   197.02   197.03   REI D CONTRACTED SERVI CES   0   1,035   0   0   0   197.0			0	<i>A A</i> 11	0	0	0	1
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00   192.						-1		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192. 0 194. 00 07950 RENTAL SPACE 0 122 0 0 0 194. 0 194. 01 07951 FOUNDATI ON 0 579 0 0 0 194. 0 194. 02 07952 RETAI L SERVI CES 0 700 0 0 194. 0 194. 03 07953 REI D CONTRACTED SERVI CES 0 1,035 0 0 194. 0 194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 0 0 194. 0 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 0 0 194. 0 194. 06 07956 VACANT SPACE 0 0 0 0 0 0 194. 0			3.37 == 31	= ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
194. 00 07950       RENTAL SPACE       0       122       0       0       194. 0       0       194. 0       0       194. 0       0       0       194. 0       0       0       0       194. 0       0       0       0       0       194. 0       0       0       0       0       0       194. 0       0       0       0       0       0       0       194. 0       0       0       0       0       0       194. 0        0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			-					
194. 01 07951 FOUNDATI ON     0     579     0     0     194. 02       194. 02 07952 RETAIL SERVICES     0     700     0     0     194. 03       194. 03 07953 REID CONTRACTED SERVICES     0     1,035     0     0     0     194. 03       194. 04 07954 REID PHYSICIAN ASSOC.     0     0     0     0     0     194. 03       194. 05 07955 CONNERSVILLE LOCATION     0     0     0     0     0     194. 03       194. 06 07956 VACANT SPACE     0     0     0     0     0     0     0						0		
194. 02 07952 RETAIL SERVICES       0       700       0       0       194. 03       0       194. 03       0       0       194. 03       0       0       0       194. 03       0       0       0       0       194. 03       0       0       0       0       0       0       0       194. 03       0       0       0       0       0       0       0       0       194. 03       0       0       0       0       0       0       0       0       194. 03       0       0       0       0       0       0       0       0       194. 03       0			- 1			0		
194. 03 07953       REI D CONTRACTED SERVICES       0       1,035       0       0       194. 04         194. 04 07954       REI D PHYSI CI AN ASSOC.       0       0       0       0       0       194. 05         194. 05 07955       CONNERSVI LLE LOCATI ON       0       0       0       0       0       0       0       194. 0         194. 06 07956       VACANT SPACE       0       0       0       0       0       0       194. 0			0			0		
194. 04 07954 REID PHYSICIAN ASSOC.       0       0       0       0       194. 05 07955 CONNERSVILLE LOCATION       0       0       0       0       0       0       194. 06 07956 VACANT SPACE       0       0       0       0       0       0       194. 06 07956 VACANT SPACE			o			o		
194. 06 07956 VACANT SPACE 0 0 0 0 0 194. 0			O			o		
			o	0	0	o		
104 071070E7HIDME OFFICE			0	0	0	0		
194. 07 07957 HOME OFFICE 0 0 0 0 0 194. 0 194. 08 07958 CAMBRI DGE RHC 0 0 0 0 0 194. 0			0	0	0	0		
			U	U		٩	U	200.00
201.00   Negative Cost Centers   0   0   0   0   201.0			o	0	o	o	0	
202.00 TOTAL (sum lines 118 through 201) 595,220 245,469 50,248 764,895 759,661 202.0	202. 00	TOTAL (sum lines 118 through 201)	595, 220	245, 469	50, 248	764, 895	759, 661	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2020 | Part II |
| To | 12/31/2020 | Date/Time | Prepared: | 7/8/2021 | 10:37 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048

				I NTERNS &	7/8/2021 10: 3	
Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVICES-SALA RY & FRINGES	SERVICES-OTHE R PRGM. COSTS	
	LI BRARY					
GENERAL SERVICE COST CENTERS	16. 00	17. 00	17. 01	21. 00	22. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 O0101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2.00   O0200   NEW CAP REL COSTS-MVBLE EQUIP 4.00   O0400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 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   ADMITTING						5. 04
5. 05   00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 06   00590 OTHER A&G						5. 05 5. 06
7. 00   00700   OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00   01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	115, 037					16.00
17. 00 01700 SOCI AL SERVI CE	0	52, 120	040 707			17.00
17. 01   01701   INSERVICE EDUCATION	0	0	319, 797	E 144		17. 01
21.00   02100   I&R SERVICES-SALARY & FRINGES APPRVD 22.00   02200   I&R SERVICES-OTHER PRGM. COSTS APPRVD		ol Ol	0	5, 144	28, 687	21. 00 22. 00
23. 00   02300   PARAMED ED   PRGM	o	o	732		20,007	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		,				
30. 00   03000   ADULTS & PEDI ATRI CS	7, 040	33, 716	99, 463			30.00
31. 00   03100   NTENSI VE CARE UNI T	1, 334	3, 021	14, 490			31.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	1, 087 683	0	15, 827 5, 656			40. 00 41. 00
43. 00   04300   NURSERY	201	o	3, 052			43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	18, 902	0	20, 752			50.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 097 17, 999	0	3, 162 28, 925			52. 00 54. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	11, 584	o	7, 395			59.00
60. 00   06000   LABORATORY	12, 947	ō	22, 852			60.00
65. 00 06500 RESPIRATORY THERAPY	3, 052	0	6, 962			65.00
66. 00   06600   PHYSI CAL THERAPY	2, 591	0	27, 187			66.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	4, 111 531	0	5, 160			69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ol Ol	1, 778 0			70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	3, 764	o	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	16, 019	О	0			73.00
74. 00 07400 RENAL DI ALYSI S	151	0	0			74.00
76. 00   03950   ANCI LLARY - OTHER 76. 97   07697   CARDI AC   REHABI LI TATI ON	0 110	0	0 2, 313			76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	110	<u> </u>	2, 313			70.97
91. 00 09100 EMERGENCY	10, 400	15, 383	36, 792			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04040 FAMILY PRACTICE	739	0	9, 621			93.00
OTHER REIMBURSABLE COST CENTERS  96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	59	ol	1, 377			96. 00
SPECIAL PURPOSE COST CENTERS	37	<u> </u>	1, 377			70.00
113.00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	636	0	4, 468			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	115, 037	52, 120	317, 964	0	0	118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	Ol	0			190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		o	0			192.00
194. 00 07950 RENTAL SPACE	0	o	0			194.00
194. 01 07951 FOUNDATI ON	0	0	865			194. 01
194. 02 07952 RETAIL SERVICES	0	0	968			194. 02
194. 03 07953  RELD CONTRACTED SERVICES 194. 04 07954  RELD PHYSICIAN ASSOC.	0	0	0			194. 03 194. 04
194. 05 07955 CONNERSVILLE LOCATION		0	0			194. 04
194. 06 07956 VACANT SPACE	Ö	Ö	0			194. 06
194.07 07957 HOME OFFICE	0	О	0			194. 07
194. 08 07958 CAMBRI DGE RHC	0	0	0			194. 08
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	o	0	5, 144 0		200. 00 201. 00
201. 00     megati ve oost centers	<u> </u>	Ч	0	ı	١	201.00

Health Financial Systems	REID HOSPITAL 8	HEALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	F	Period: From 01/01/2020 To 12/31/2020		
				INTERNS &	RESI DENTS	
Cost Center Description	MEDI CAI RECORDS LI BRAR'	& SERVICE	I NSERVI CE EDUCATI ON		SERVICES-OTHE R PRGM. COSTS	
	16. 00	17. 00	17. 01	21.00	22. 00	
202.00 TOTAL (sum lines 118 through 20	)1) 115	, 037 52, 120	319, 797	5, 144	28, 687	202. 00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048

				Т	o 12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	77 07 2021 10. 37 dill
		PRGM		Resi dents		
				Cost & Post Stepdown		
				Adjustments		
		23. 00	24. 00	25.00	26. 00	
	RAL SERVICE COST CENTERS			ī		1.00
-	OO NEW CAP REL COSTS-BLDG & FIXT OINEW CAP BLDG & FIXT - OFFSITE					1.00
	OO NEW CAP REL COSTS-MVBLE EQUIP					2.00
	OO EMPLOYEE BENEFITS DEPARTMENT					4.00
	NONPATIENT TELEPHONES					5.01
	DATA PROCESSING					5. 02
	00 PURCHASING RECEIVING AND STORES					5. 03
1	80 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 04
	OO OTHER A&G					5.06
7.00 0070	OO OPERATION OF PLANT					7.00
1	OO LAUNDRY & LINEN SERVICE					8.00
	00 HOUSEKEEPI NG					9.00
	00 DI ETARY 00 CAFETERI A					10.00
	OO NURSI NG ADMI NI STRATI ON					13.00
	OO CENTRAL SERVICES & SUPPLY					14.00
4	OO PHARMACY					15. 00
	00 MEDICAL RECORDS & LIBRARY					16.00
	00 SOCIAL SERVICE 01 INSERVICE EDUCATION					17. 00 17. 01
1	00 & SERVICES-SALARY & FRINGES APPRVD					21.00
	00 I&R SERVICES-OTHER PRGM. COSTS APPRVD					22.00
1	OO PARAMED ED PRGM	103, 964				23.00
	TIENT ROUTINE SERVICE COST CENTERS	T		T		
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT		4, 654, 124	1	1	
	00 SUBPROVI DER – I PF		1, 285, 108 752, 151		,,	
	OO SUBPROVI DER - I RF		588, 664			
	00 NURSERY		84, 825	0	84, 825	43.00
	LLARY SERVICE COST CENTERS		0.057.440	1	0.057.440	50.00
	00 OPERATING ROOM 00 DELIVERY ROOM & LABOR ROOM		3, 357, 618 294, 564			
	00 RADI OLOGY-DI AGNOSTI C		3, 721, 097			54.00
	OO CARDI AC CATHETERI ZATI ON		935, 570			
	DO LABORATORY		1, 620, 697		,	,
1	OO RESPIRATORY THERAPY		151, 329			,
	00 PHYSI CAL THERAPY 00 ELECTROCARDI OLOGY		1, 454, 276 383, 595		,	
	00 ELECTROCARDI OLOGI 00 ELECTROENCEPHALOGRAPHY		139, 055		,	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0			
1	OO IMPL. DEV. CHARGED TO PATIENT		21, 145	0	21, 145	72.00
	DO DRUGS CHARGED TO PATIENTS		783, 483			
	00 RENAL DIALYSIS 50 ANCILLARY - OTHER		54, 488			
4	07 CARDI AC REHABI LI TATI ON		219, 397	0		
	PATIENT SERVICE COST CENTERS		217, 377		217, 377	76. 77
91.00 0910	OO EMERGENCY		1, 393, 355	0	1, 393, 355	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
	O FAMILY PRACTICE		96, 100	0	96, 100	93.00
	R REIMBURSABLE COST CENTERS OO DURABLE MEDICAL EQUIP-RENTED		137, 196	0	137, 196	96.00
	CLIAL PURPOSE COST CENTERS		137, 170		137, 170	76. 66
	00 I NTEREST EXPENSE					113. 00
116. 00 1160			38, 066	•		
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	22, 165, 903	0	22, 165, 903	118. 00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
	00 PHYSICIANS' PRIVATE OFFICES		2, 784, 668			,
	50 RENTAL SPACE		589, 417		,	,
194. 01 0795	51 FOUNDATI ON		10, 701	0	10, 701	194. 01
	52 RETAIL SERVICES		61, 634		61, 634	
	33 REID CONTRACTED SERVICES		1, 313		1, 313 7, 603	
	54 REID PHYSICIAN ASSOC. 55 CONNERSVILLE LOCATION		7, 603 89, 194			
	66 VACANT SPACE		2, 226, 699			
	77 HOME OFFICE		8, 176, 010			194. 07
194. 08 0795	68 CAMBRI DGE RHC		0	0	0	194. 08
200. 00	Cross Foot Adjustments	103, 964	137, 795		· ·	
201. 00	Negative Cost Centers	0	126, 160	0	126, 160	201.00

Health Financial Systems	REID HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od: From 01/01/2020	Worksheet B Part II
				To 12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25. 00	26.00	
202.00 TOTAL (sum lines 118 through 201	) 103, 964	36, 377, 097		0 36, 377, 097	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

				To	12/31/2020	Date/Time Pre 7/8/2021 10:3	
		CAP	TAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FIXT - OFFSITE (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATI ENT TELEPHONES (PHONES)	
	GENERAL SERVICE COST CENTERS	1. 00	1. 01	2.00	4. 00	5. 01	
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO101 NEW CAP BLDG & FIXT - OFFSITE OO200 NEW CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O0540 NONPATIENT TELEPHONES O0550 DATA PROCESSING O0560 PURCHASING RECEIVING AND STORES O0570 ADMITTING O0580 CASHIERING/ACCOUNTS RECEIVABLE O0590 OTHER A&G O0700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DIETARY	873, 266 0 0 3, 313 8, 871 462 0 3, 832 11, 004 12, 335 8, 158	275, 457 400 0 1, 095 0 1, 884 7, 820 684 1, 558		103, 111, 331 0 298, 997 71, 472 4, 550, 289 0 3, 071, 440 686, 763 430, 933 2, 618, 845 1, 191, 697	0 0 0 0 0 0 0	5. 03 5. 04 5. 05 5. 06 7. 00 8. 00
11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	9, 614 1, 955 8, 411 9, 871 0 1, 241 10, 409 0 0 1, 061	0 0 4, 721 0 0 0		2, 489, 172 280, 277 755, 306 4, 439, 147 0 3, 065, 023 1, 259, 091 1, 859, 564 108, 420 278, 072	0 0 0 0 0 0 0 0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 01 21. 00 22. 00 23. 00
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	116, 864 24, 552 22, 340 17, 898 2, 681	0	0	26, 079, 466 4, 099, 953 3, 405, 363 1, 933, 943 813, 211	0 0 0 0	31. 00 40. 00 41. 00
73. 00 74. 00 76. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	45, 662 8, 316 69, 942 13, 579 29, 095 1, 647 8, 084 7, 809 0 0 0 0 1, 490 8, 185	0 1,600 0 0 42,316 0 3,892 0 0		1, 632, 297 849, 531 7, 717, 253 1, 921, 873 4, 558, 196 1, 868, 623 7, 151, 580 1, 100, 621 316, 892 0 0 0 1, 074 0 422, 999	0 0 0 0 0 0 0 0 0 0 0	52. 00 54. 00 59. 00 60. 00 65. 00 66. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 00
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	30, 962			7, 453, 008 2, 028, 802	0	92.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1, 774	2, 872	0	202, 707	0	96. 00
	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE ) 11600 HOSPICE ) SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	445 520, 172			1, 549, 551 102, 561, 451		113. 00 116. 00 118. 00
192. 00 194. 00 194. 02 194. 02 194. 03 194. 04 194. 06 194. 06	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 RENTAL SPACE 07951 FOUNDATION 207952 RETAIL SERVICES 807953 REID CONTRACTED SERVICES 107954 REID PHYSICIAN ASSOC. 507955 CONNERSVILLE LOCATION 507956 VACANT SPACE 707957 HOME OFFICE 807958 CAMBRIDGE RHC	0 0 206 2, 340 0 0 70, 753 279, 795	0 0 312 0 17, 168 44, 814	0 0 0	0 0 32, 660 167, 657 149, 160 200, 403 0 0 0	0 0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 07 194. 08

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

From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am CAPITAL RELATED COSTS NEW CAP BLDG NEW BLDG & NEW MVBLE **EMPLOYEE** NONPATI ENT Cost Center Description & FIXT -EQUI P **TELEPHONES** FLXT **BENEFITS** (SQUARE FEET) OFFSI TE (SQUARE FEET) (PHONES) DEPARTMENT (SQUARE FEET) (GROSS SALARI ES) 4. 00 1. 00 1.01 2.00 5. 01 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 21, 809, 408 6, 707, 864 0 16, 162, 627 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 24. 974530 24. 351765 0.000000 0. 156749 0. 000000 203. 00 Cost to be allocated (per Wkst. B, 0 204.00 204.00 10, 144 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000098 0.000000 205.00 II) 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
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

			To	12/31/2020	Date/Time Pre 7/8/2021 10:3	
Cost Center Description	DATA	PURCHASI NG	ADMI TTI NG		Reconciliatio	
	PROCESSING (TERMINALS)	RECEIVING AND STORES	(TOTAL REVENUE)	COUNTS RECEI VABLE	n	
	(TERWITNALS)	(SUPPLY	KEVENOL)	(TOTAL		
		EXPENSE)		REVENUE)		
GENERAL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5A. 06	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
1. 01   00101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2.00   OO200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01   00540 NONPATI ENT TELEPHONES 5. 02   00550 DATA PROCESSI NG	1 270					5. 01
5. 03 00560 PURCHASING RECEIVING AND STORES	1, 279	l i				5. 02 5. 03
5. 04   00570   ADMI TTI NG	125		984, 014, 640			5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0		0	984, 014, 640		5.05
5. 06   00590   OTHER A&G	75		0	0	-35, 092, 718	5.06
7. 00 00700 OPERATION OF PLANT	3	36, 564	0	0	0	7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	5	3, 627 338, 937	0	0	0	8. 00 9. 00
10. 00   01000 DI ETARY	47	154, 680	0	0	0	10.00
11. 00   01100   CAFETERI A	0	0	0	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0		0	0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	17		0	0	0	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	57 0	988, 595	0	0	0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	19		0	0	0	17. 00
17. 01 01701 I NSERVI CE EDUCATI ON	78		0	o	0	17. 01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00   02200   1&R SERVICES-OTHER PRGM. COSTS APPRVD	24		0	0	0	22.00
23. 00   O2300   PARAMED ED PRGM   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	24	3, 038	0	0	0	23. 00
30. 00 O3000 ADULTS & PEDIATRICS	145	1, 003, 654	60, 169, 616	60, 169, 616	0	30. 00
31. 00 03100 INTENSIVE CARE UNIT	25		11, 403, 776	11, 403, 776	0	31.00
40. 00   04000   SUBPROVI DER - I PF	15		9, 291, 130	9, 291, 130	0	40.00
41. 00   04100   SUBPROVI DER -   RF	10		5, 836, 638	5, 836, 638	0	41.00
43. 00 04300 NURSERY	0	46, 544	1, 714, 258	1, 714, 258	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	63	938, 939	162, 365, 438	162, 365, 438	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5		9, 377, 711	9, 377, 711	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	166	873, 374	153, 836, 943	153, 836, 943	0	54.00
59. 00   05900   CARDI AC CATHETERI ZATI ON	10		99, 006, 132	99, 006, 132	0	59.00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	64 12	153, 459 387, 627	110, 660, 526 26, 084, 310	110, 660, 526 26, 084, 310	0	60. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	125		22, 141, 113	22, 141, 113	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	19		35, 134, 132	35, 134, 132	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	8	21, 908	4, 538, 492	4, 538, 492	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0		32, 169, 316	32, 169, 316	0	72.00
73. 00   07300   DRUGS CHARGED TO PATLENTS 74. 00   07400   RENAL DLALYSES	0	0 21, 485	136, 914, 597 1, 286, 781	136, 914, 597 1, 286, 781	0	73. 00 74. 00
76. 00 03950 ANCI LLARY - OTHER	Ö		1, 200, 701	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	6	10, 130	936, 186	936, 186	0	76. 97
OUTPATIENT SERVICE COST CENTERS		100 555	00 000 5==	<u> </u>		04 00
91.00   09100   EMERGENCY 92.00   09200   0BSERVATION   BEDS (NON-DISTINCT PART)	84	493, 580	88, 888, 587	88, 888, 587	0	91. 00 92. 00
93. 00 04040 FAMILY PRACTICE	15	88, 713	6, 316, 224	6, 316, 224	0	93.00
OTHER REIMBURSABLE COST CENTERS		00,7.0	0,010,221	0,0.0,22.1		70.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2	164, 315	505, 498	505, 498	0	96. 00
SPECIAL PURPOSE COST CENTERS		1				
113. 00 11300   NTEREST EXPENSE 116. 00 11600 HOSPI CE	18	153, 192	5, 437, 236	5, 437, 236	0	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 272				-35, 092, 718	
NONREI MBURSABLE COST CENTERS	1,2,2	0,000,010	701, 011, 010	701, 011, 010	00, 072, 710	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1	3, 496	0	0		192.00
194. 00 07950 RENTAL SPACE 194. 01 07951 FOUNDATI ON	0	84, 532	0	0		194. 00 194. 01
194. 01 07951 FOUNDATTON 194. 02 07952  RETALL SERVI CES	5	11, 546 1, 581	0	0		194. 01 194. 02
194. 03 07953 REID CONTRACTED SERVICES		1, 361	n	0		194. 02
194. 04 07954 REID PHYSICIAN ASSOC.	0	o	0	o		194. 04
194. 05 07955 CONNERSVILLE LOCATION	0	34, 626	0	0		194. 05
194. 06 07956 VACANT SPACE	0	58	0	0		194.06
194. 07 07957  HOME OFFICE 194. 08 07958  CAMBRIDGE RHC	0	0	0	0		194. 07 194. 08
200.00 Cross Foot Adjustments			U	٩		200.00
201.00 Negative Cost Centers						201.00
	_	_	-	_	_	

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

					From 01/01/2020		
					Го 12/31/2020	Date/Time Pre 7/8/2021 10:3	
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	Reconciliatio	
		PROCESSI NG	RECEIVING AND	(TOTAL	COUNTS	n	
		(TERMI NALS)	STORES	REVENUE)	RECEI VABLE		
			(SUPPLY		(TOTAL		
			EXPENSE)		REVENUE)		
		5. 02	5. 03	5. 04	5. 05	5A. 06	
202. 00	Cost to be allocated (per Wkst. B,	14, 480, 696	320, 665	8, 906, 269	67, 789		202. 00
000 00	Part I)	44 004 00007/	0.007750	0 00005	0.0000/0		000 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	11, 321. 888976					203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	333, 340	229, 628	139, 298	195, 893		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	260. 625489	0. 027039	0. 000142	0. 000071		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048 Pe

Peri od: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/8/2021 10:37 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 1 01 00101 NEW CAP BLDG & FIXT - OFFSITE 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 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 291, 178, 101 5.06 5.06 7.00 00700 OPERATION OF PLANT 1, 320, 431 954, 446 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 956, 668 12, 335 2, 296, 990 8.00 00900 HOUSEKEEPI NG 13, 407 9.00 4, 233, 066 7,872 9.00 0 64, 294 10.00 01000 DI ETARY 3, 135, 874 18, 310 0 526 10.00 11.00 01100 CAFETERI A 2, 471, 900 9, 461 11.00 01300 NURSING ADMINISTRATION 13.00 373, 035 1, 955 0 0 11 13.00 6, 689, 986 01400 CENTRAL SERVICES & SUPPLY 0 14 00 8.411 178 0 14 00 15.00 01500 PHARMACY 41, 726, 210 9,640 229 0 15.00 01600 MEDICAL RECORDS & LIBRARY 114, 965 0 16.00 0 0 16.00 01700 SOCIAL SERVICE 4, 355, 237 438 0 98 17.00 17.00 0 01701 INSERVICE EDUCATION 0 17.01 3, 817, 321 9, 322 317 0 17.01 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 2, 249, 263 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 760, 745 0 0 0 22.00 23 00 02300 PARAMED ED PRGM 719 003 2 807 O 23 00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 42, 190, 632 115, 758 691, 121 5, 224 44, 133 30.00 31.00 03100 INTENSIVE CARE UNIT 8, 450, 194 140, 758 6.349 31.00 24, 552 886 04000 SUBPROVI DER - I PF 159.393 8, 484 40.00 5, 263, 578 22, 340 580 40.00 04100 SUBPROVI DER - I RF 66, 050 41.00 3, 137, 139 17,898 422 5, 328 41.00 04300 NURSERY 2, 681 43.00 1, 146, 757 29 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 26, 589, 381 40,624 349, 559 1,047 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 622, 770 8, 316 123, 526 388 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 21, 393, 974 53,880 225, 068 579 0 54.00 05900 CARDI AC CATHETERI ZATI ON 4, 593 59 00 59 00 8, 437, 176 0 0 166 60.00 06000 LABORATORY 17, 190, 261 20, 194 124, 597 470 0 60.00 3, 253, 118 1, 194 06500 RESPIRATORY THERAPY 65.00 126 0 65.00 66.00 06600 PHYSI CAL THERAPY 12, 257, 999 48, 220 21, 928 131 0 66.00 06900 ELECTROCARDI OLOGY 2.842.947 69 00 69 00 557 0 154 0 70.00 07000 ELECTROENCEPHALOGRAPHY 682, 448 5, 400 9, 302 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 16, 928, 234 72.00 0 0 72.00 0 C 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 248, 661 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 975, 140 1, 490 0 157 0 74.00 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 823, 815 0 40 0 76.97 3, 662 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 12, 713, 328 317, 470 91.00 91.00 30, 962 971 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 93.00 2, 916, 627 68, 218 256 0 OTHER REIMBURSABLE COST CENTERS 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 419, 929 3, 752 0 0 0 96.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3, 375, 661 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 266, 783, 473 486, 624 2, 296, 990 13, 217 64, 294 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 6, 164, 225 108, 173 0 150 0 194.00 07950 RENTAL SPACE 5, 183, 588 22, 920 0 0 194.00 194. 01 07951 FOUNDATI ON 558, 738 0 10 0 194.01 206 194. 02 07952 RETAIL SERVICES 260, 832 684 30 0 194.02 194. 03 07953 REID CONTRACTED SERVICES 414, 292 0 0 194.03 C 0 0 194. 04 07954 RELD PHYSICIAN ASSOC. 7.598 C 0 0 194.04 194. 05 07955 CONNERSVILLE LOCATION 0 0 194.05 1, 406, 009 194.06 07956 VACANT SPACE 2, 320, 298 93, 036 0 0 0 194.06 194.07 07957 HOME OFFICE 0 8, 079, 048 242, 803 0 0 194. 07 194. 08 07958 CAMBRI DGE RHC O 0 194.08 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10							
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1		
					From 01/01/2020 Fo 12/31/2020			
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		(ACCUM. COST)	PLANT	LINEN SERVICE	,	(MEALS		
			(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)		
				LAUNDRY)				
		5. 06	7. 00	8. 00	9. 00	10.00		
202.00	Cost to be allocated (per Wkst. B,	35, 092, 718	1, 479, 569	1, 091, 088	4, 755, 438	3, 728, 765	202.00	
	Part I)							
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 120520	1. 550186			57. 995536	203. 00	
204.00	Cost to be allocated (per Wkst. B,	181, 222	361, 403	371, 709	287, 305	595, 220	204.00	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 000622	0. 378652	0. 161824	21. 429477	9. 257785	205. 00	
206.00	NAHE adjustment amount to be allocated						206.00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00	
	Parts III and IV)							

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048 | Period: From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

					o 12/31/2020	Date/Time Pre 7/8/2021 10:3	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	/ aiii
		(MANHOURS)	ADMI NI STRATI O	SERVICES & SUPPLY	(DRUGS)	RECORDS & LI BRARY	
			(DI RECT	(MED		(TOTAL	
		11. 00	NURSING HRS) 13.00	SUPPLI ES) 14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS		10.00		10.00	10.00	
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FIXT   OO101 NEW CAP BLDG & FIXT - OFFSITE						1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5. 01 5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00570 ADMITTING						5.04
5. 05 5. 06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5. 05 5. 06
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 710, 541					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 080 43, 616		18, 617, 019			13. 00 14. 00
15. 00	01500 PHARMACY	130, 995		10, 017, 019			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	(	1	984, 014, 640	16.00
17. 00 17. 01	01700 SOCIAL SERVICE 01701 INSERVICE EDUCATION	87, 298 40, 006		(	39	0	17. 00 17. 01
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	39, 339		C		0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	5, 211	0	(	-	0	22.00
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	6, 920	0	(	)	0	23. 00
30.00	03000 ADULTS & PEDIATRICS	807, 372		55, 757		60, 169, 616	30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	115, 241 116, 047	115, 241 116, 047	61, 651 3, 34 <i>6</i>	I	11, 403, 776 9, 291, 130	31. 00 40. 00
41. 00	04100 SUBPROVI DER – T PF	55, 950		11, 675	I	5, 836, 638	41.00
43. 00	04300 NURSERY	21, 174	21, 174	53	8 0	1, 714, 258	43.00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	52, 725	52, 725	9, 735, 532	109, 867	162, 365, 438	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 629		29, 106		9, 377, 711	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	225, 795		139, 237		153, 836, 943	54.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	53, 564 179, 061	53, 564 0	6, 881, 950 1, 280, 862		99, 006, 132 110, 660, 526	59. 00 60. 00
65. 00	06500 RESPI RATORY THERAPY	53, 991	53, 991	21, 000	740	26, 084, 310	65. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	208, 710 35, 561	0	1, 601 120, 700		22, 141, 113 35, 134, 132	66. 00 69. 00
70. 00	07000 ELECTROCARDI GEGGI	12, 964	o	120, 700		4, 538, 492	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	o	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0		(	-1	32, 169, 316 136, 914, 597	1
74. 00	07400 RENAL DIALYSIS	29	_	75		1, 286, 781	
76. 00 76. 97	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON	15 710		(		037 187	76.00
76. 97	OUTPATIENT SERVICE COST CENTERS	15, 710	15, 710	(	)	936, 186	76. 97
91. 00	09100 EMERGENCY	215, 781	215, 781	60, 397	8, 257	88, 888, 587	91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	76, 381	0	(	848	6, 316, 224	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS		- 1		) 040	0, 310, 224	75.00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	10, 785	0	214, 077	117, 788	505, 498	96.00
113.00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	48, 706		(	o	5, 437, 236	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 683, 641	1, 756, 008	18, 617, 019	34, 879, 872	984, 014, 640	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	(	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	o	(	o		192. 00
	07950 RENTAL SPACE 07951 FOUNDATION	1, 343 6, 393		(			194. 00 194. 01
	07952 RETAIL SERVICES	7, 731				0	194. 02
	07953 REID CONTRACTED SERVICES	11, 433		(	o  o		194.03
	07954 REID PHYSICIAN ASSOC. 07955 CONNERSVILLE LOCATION	0	1	(			194. 04 194. 05
	07956 VACANT SPACE	0					194.05
	07957 HOME OFFICE	0	0	(			194. 07
200.00	Cross Foot Adjustments	0			ή	0	194. 08 200. 00
201.00							201.00

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

COST A	LEGGATION - STATISTICAL BASIS		Trovider co		From 01/01/2020	WOLKSHEET D-1	
					To 12/31/2020		
	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)		REVENUE)	
		11. 00	13. 00	14.00	15. 00	16.00	
202.00	Cost to be allocated (per Wkst. B,	2, 784, 479	427, 063	7, 617, 24	46, 985, 791	128, 821	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 027278	0. 243201	0. 40915	1. 347075	0. 000131	203.00
204.00	Cost to be allocated (per Wkst. B,	245, 469	50, 248	764, 89	5 759, 661	115, 037	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 090561	0. 028615	0. 04108	6 0. 021779	0.000117	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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0048

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/8/2021 10: 37 am

						7/8/2021 10: 3	
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	·	SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM. COSTS	PRGM	
		(TIME SPENT)	(IN HOUSE ED)	(ASSIGNED	(ASSIGNED TIME)	(TIME SPENT)	
		17. 00	17. 01	TI ME) 21.00	22. 00	23. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						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 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING						5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 05
5.06	00590 OTHER A&G						5. 06
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE	47, 268					17. 00
17. 01	01701 I NSERVI CE EDUCATI ON	0	40, 653				17. 01
21.00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0	1, 674			21.00
22. 00 23. 00	02300 PARAMED ED PRGM	0	l .		1, 674	100	22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
30.00	03000 ADULTS & PEDIATRICS	30, 577	12, 644			0	30.00
31. 00 40. 00	03100   NTENSI VE CARE UNI T 04000   SUBPROVI DER - I PF	2, 740			51	0	31. 00 40. 00
41. 00	04100 SUBPROVI DER – TFF	0			-	0	41.00
43.00	04300 NURSERY	0				0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS			1 00			
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0			92	0	50. 00 52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			_	100	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			O	0	59.00
60.00	06000 LABORATORY	0	, , , , , ,			0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	885 3, 456	8		0	65. 00 66. 00
69. 00	06900 ELECTROCARDI OLOGY		656			0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	226		O	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	_		0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	-			0	74.00
76.00	03950 ANCI LLARY - OTHER	0		0	O	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	294	0	0	0	76. 97
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	13, 951	4, 677	110	110	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 751	4,077	110	110	O	92.00
93. 00	04040 FAMILY PRACTICE	0	1, 223	0	0	0	93. 00
0, 00	OTHER REIMBURSABLE COST CENTERS		1 475	1			
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED SPECIAL PURPOSE COST CENTERS	0	175	0	0	0	96. 00
113. 00	11300 I NTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	568				116. 00
118.00		47, 268	40, 420	1, 674	1, 674	100	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1 0		0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES			l	0		190.00
194.00	07950 RENTAL SPACE	Ö			-	0	194. 00
	07951 FOUNDATION	0	110	•	0		194. 01
	2 07952  RETAI L SERVI CES 3 07953  REI D CONTRACTED SERVI CES	0	123	0	0		194. 02 194. 03
	107954 REID CONTRACTED SERVICES	0	0	0	0		194. 03
194. 05	07955 CONNERSVILLE LOCATION	0	Ö	0	o	0	194. 05
	07956 VACANT SPACE	0	0	0	0		194.06
	7 07957 HOME OFFICE 3 07958 CAMBRIDGE RHC	0	0	0	0		194. 07 194. 08
200.00							200.00
	i jest se	1	1	1	·		

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0048	Peri od: From 01/01/2020	Worksheet B-1
				Date/Time Prepared:

				Į l	0 12/31/2020	7/8/2021 10:3	
				INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM. COSTS	PRGM	
		(TIME SPENT)	(IN HOUSE ED)	(ASSI GNED	(ASSI GNED	(TIME SPENT)	
				TIME)	TIME)		
		17. 00	17. 01	21. 00	22. 00	23.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	5, 005, 301	4, 445, 372	2, 560, 756	857, 783	827, 286	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	105. 891957	109. 349175	1, 529. 722820	512. 415173	8, 272. 860000	203.00
204.00	Cost to be allocated (per Wkst. B,	52, 120	319, 797	5, 144	28, 687	103, 964	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	1. 102649	7. 866504	3. 072879	17. 136798	1, 039. 640000	205.00
	11)						
206.00	NAHE adjustment amount to be allocated					0	206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0.000000	207.00
	Parts III and IV)						

						7/8/2021 10: 3	7 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	57, 876, 651		57, 876, 651	72, 992	57, 949, 643	30.00
31.00	03100 INTENSIVE CARE UNIT	10, 921, 535		10, 921, 535		10, 921, 535	31.00
40.00	04000 SUBPROVI DER - I PF	7, 076, 098		7, 076, 098	o o	7, 076, 098	40.00
41.00	04100 SUBPROVI DER - I RF	4, 188, 399		4, 188, 399	o	4, 188, 399	41.00
43.00	04300 NURSERY	1, 368, 982		1, 368, 982	ol ol	1, 368, 982	43.00
A	NCILLARY SERVICE COST CENTERS				<u>'</u>	· · · ·	
50.00	05000 OPERATING ROOM	34, 902, 290		34, 902, 290	0	34, 902, 290	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 114, 437		2, 114, 437	ol	2, 114, 437	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 719, 488		26, 719, 488		26, 719, 488	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	12, 521, 827		12, 521, 827		12, 521, 827	59.00
	06000 LABORATORY	20, 559, 554		20, 559, 554		20, 559, 554	60.00
	06500 RESPIRATORY THERAPY	3, 870, 102	0	3, 870, 102	I I	3, 870, 102	65.00
	06600 PHYSI CAL THERAPY	14, 462, 966	0	14, 462, 966		14, 462, 966	
	06900 ELECTROCARDI OLOGY	3, 686, 018	_	3, 686, 018	1	3, 686, 018	
	07000 ELECTROENCEPHALOGRAPHY	816, 113		816, 113		816, 113	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(	I I	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	18, 972, 639		18, 972, 639	ol	18, 972, 639	72.00
	07300 DRUGS CHARGED TO PATIENTS	47, 033, 539		47, 033, 539	I I	47, 033, 539	
	07400 RENAL DI ALYSI S	1, 150, 910		1, 150, 910		1, 150, 910	74.00
	03950 ANCI LLARY - OTHER	0		(		0	76.00
	07697 CARDI AC REHABI LI TATI ON	995, 198		995, 198	- 1	995, 198	76. 97
	OUTPATIENT SERVICE COST CENTERS	7,011,0		7707170	,	7,071,0	70.77
	09100 EMERGENCY	17, 099, 097		17, 099, 097	0	17, 099, 097	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 093, 550		6, 093, 550		6, 093, 550	
	04040 FAMILY PRACTICE	3, 605, 514		3, 605, 514		3, 605, 514	
	OTHER REIMBURSABLE COST CENTERS	0,000,011		0,000,01	-1	0,000,011	70.00
	09600 DURABLE MEDICAL EQUIP-RENTED	752, 896		752, 896	0	752, 896	96. 00
	SPECIAL PURPOSE COST CENTERS	, 02, 0, 0		7027070	,ı	, 02, 0, 0	70.00
	1300 I NTEREST EXPENSE						113. 00
	1600 HOSPI CE	3, 977, 643		3, 977, 643	3	3, 977, 643	
200.00	Subtotal (see instructions)	300, 765, 446	0		I	300, 838, 438	
201.00	Less Observation Beds	6, 093, 550	Ü	6, 093, 550	1	6, 093, 550	
202.00	Total (see instructions)	294, 671, 896	0		I		
_02.00	1.2.2. (000 1.101 401.01.0)	_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ü	, , , , , , , , , , ,		_,,,,,,,,,	

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 49, 405, 519 49, 405, 519 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 11, 403, 776 11, 403, 776 31.00 9, 291, 130 04000 SUBPROVI DER - I PF 9, 291, 130 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 5, 836, 638 5, 836, 638 41.00 04300 NURSERY 43.00 1, 714, 258 1, 714, 258 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 47, 582, 446 114, 782, 992 162, 365, 438 0.214961 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 9, 377, 711 0. 225475 52.00 8, 456, 537 921, 174 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 153, 836, 943 0.000000 54.00 40, 118, 828 113, 718, 115 0.173687 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 35, 148, 973 63, 857, 159 99, 006, 132 0.126475 0.000000 59.00 60.00 06000 LABORATORY 42, 217, 615 68, 442, 911 110, 660, 526 0. 185789 0.000000 60.00 26, 084, 310 65.00 06500 RESPIRATORY THERAPY 22, 974, 892 0.000000 3, 109, 418 0.148369 65.00 66.00 06600 PHYSI CAL THERAPY 9, 699, 736 12, 441, 377 22, 141, 113 0.653218 0.000000 66.00 06900 ELECTROCARDI OLOGY 16, 044, 429 19, 089, 703 0.104913 0.000000 69 00 35, 134, 132 69.00 07000 ELECTROENCEPHALOGRAPHY 0.179820 0.000000 70.00 5,665 4, 532, 827 4, 538, 492 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 15, 861, 161 16, 308, 155 32, 169, 316 0.589774 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 136, 914, 597 73.00 55, 069, 614 81, 844, 983 0.343525 0.000000 73.00 07400 RENAL DIALYSIS 74, 631 1, 286, 781 0.894410 74.00 1, 212, 150 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0.000000 76.00 76.97 07697 CARDIAC REHABILITATION 658 935, 528 936, 186 1.063034 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 27, 494, 350 61, 394, 237 88, 888, 587 0.192365 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3, 184, 813 7, 579, 284 10, 764, 097 0.566100 0.000000 92.00 04040 FAMILY PRACTICE 6, 300, 972 0.570834 93.00 15, 252 6, 316, 224 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 505, 498 1. 489414 0.000000 96.00 0 505, 498 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 385, 764 4, 051, 472 5, 437, 236 116 00 200.00 Subtotal (see instructions) 404, 124, 204 579, 890, 436 984, 014, 640 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 404, 124, 204 579, 890, 436 984, 014, 640 202.00

			To 12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u>'                                    </u>	
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - I PF				40.00
41. 00   04100   SUBPROVI DER - I RF				41.00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 214961			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 225475			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 173687			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 126475			59.00
60. 00   06000   LABORATORY	0. 185789			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 148369			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 653218			66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104913			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 179820			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 589774			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 343525			73.00
74.00 07400 RENAL DIALYSIS	0. 894410			74.00
76. 00   03950   ANCI LLARY - OTHER	0. 000000			76.00
76. 97 07697 CARDIAC REHABILITATION	1. 063034			76. 97
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 192365			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 566100			92.00
93. 00   04040   FAMILY PRACTICE	0. 570834			93.00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 489414			96.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	. '			•

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 am Title XIX Hospi tal Cost Costs Total Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF 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 57, 876, 651 57, 876, 651 72, 992 57, 949, 643 30.00 03100 INTENSIVE CARE UNIT 10, 921, 535 10, 921, 535 10, 921, 535 31.00 0 31.00 40.00 04000 SUBPROVI DER - I PF 7, 076, 098 7,076,098 0 7, 076, 098 40.00 04100 SUBPROVI DER - I RF 4, 188, 399 4, 188, 399 41.00 0 4, 188, 399 41.00 43.00 04300 NURSERY 1, 368, 982 1, 368, 982 1, 368, 982 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 34, 902, 290 34, 902, 290 34, 902, 290 50.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 2, 114, 437 2, 114, 437 2, 114, 437 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 26, 719, 488 26, 719, 488 0 26, 719, 488 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 12, 521, 827 12, 521, 827 0 12, 521, 827 59.00 0 06000 LABORATORY 20, 559, 554 60.00 20, 559, 554 20, 559, 554 60.00 06500 RESPIRATORY THERAPY 65.00 3, 870, 102 0 3, 870, 102 3, 870, 102 65.00 66.00 06600 PHYSI CAL THERAPY 14, 462, 966 14, 462, 966 0 14, 462, 966 66.00 69.00 06900 ELECTROCARDI OLOGY 3, 686, 018 3, 686, 018 0 0 3, 686, 018 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 816, 113 816, 113 816, 113 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 18, 972, 639 18, 972, 639 18, 972, 639 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 47, 033, 539 47, 033, 539 47, 033, 539 73.00 73.00 07400 RENAL DIALYSIS 74.00 1, 150, 910 1, 150, 910 1, 150, 910 74.00 76.00 03950 ANCILLARY - OTHER 0 0 76.00 07697 CARDIAC REHABILITATION 995, 198 995, 198 76.97 0 995, 198 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 17, 099, 097 17, 099, 097 0 17, 099, 097 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 6, 093, 550 6, 093, 550 6, 093, 550 92.00 3, 605, 514 04040 FAMILY PRACTICE 93.00 93.00 3, 605, 514 3, 605, 514 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 752, 896 752, 896 0 752, 896 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 3, 977, 643 3, 977, 643 3, 977, 643 116. 00 200.00 Subtotal (see instructions) 300, 765, 446 0 300, 765, 446 72, 992 300, 838, 438 200. 00 6, 093, 550 201. 00 201.00 Less Observation Beds 6, 093, 550 6,093,550 202.00 294, 671, 896 72 992 294, 744, 888 202. 00 Total (see instructions) 294, 671, 896

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 49, 405, 519 49, 405, 519 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 11, 403, 776 11, 403, 776 31.00 9, 291, 130 04000 SUBPROVI DER - I PF 9, 291, 130 40.00 40.00 41.00 04100 SUBPROVI DER - I RF 5, 836, 638 5, 836, 638 41.00 04300 NURSERY 43.00 1, 714, 258 1, 714, 258 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 47, 582, 446 114, 782, 992 162, 365, 438 0.214961 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 9, 377, 711 0. 225475 52.00 8, 456, 537 921, 174 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 153, 836, 943 0.000000 54.00 40, 118, 828 113, 718, 115 0.173687 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 35, 148, 973 63, 857, 159 99, 006, 132 0.126475 0.000000 59.00 60.00 06000 LABORATORY 42, 217, 615 68, 442, 911 110, 660, 526 0. 185789 0.000000 60.00 26, 084, 310 65.00 06500 RESPIRATORY THERAPY 22, 974, 892 0.000000 3, 109, 418 0.148369 65.00 66.00 06600 PHYSI CAL THERAPY 9, 699, 736 12, 441, 377 22, 141, 113 0.653218 0.000000 66.00 06900 ELECTROCARDI OLOGY 16, 044, 429 19, 089, 703 0.104913 0.000000 69 00 35, 134, 132 69.00 07000 ELECTROENCEPHALOGRAPHY 0.179820 0.000000 70.00 5,665 4, 532, 827 4, 538, 492 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 15, 861, 161 16, 308, 155 32, 169, 316 0.589774 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 136, 914, 597 73.00 55, 069, 614 81, 844, 983 0.343525 0.000000 73.00 07400 RENAL DIALYSIS 74, 631 1, 286, 781 0.894410 74.00 1, 212, 150 0.000000 74.00 76.00 03950 ANCI LLARY - OTHER 0.000000 0.000000 76.00 936, 186 76.97 07697 CARDIAC REHABILITATION 658 935, 528 1.063034 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 27, 494, 350 61, 394, 237 88, 888, 587 0.192365 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 3, 184, 813 7, 579, 284 10, 764, 097 0.566100 0.000000 92.00 04040 FAMILY PRACTICE 6, 300, 972 0.570834 93.00 15, 252 6, 316, 224 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 505, 498 1. 489414 0.000000 96.00 0 505, 498 96.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 385, 764 4, 051, 472 5, 437, 236 116 00 200.00 Subtotal (see instructions) 404, 124, 204 579, 890, 436 984, 014, 640 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 404, 124, 204 579, 890, 436 984, 014, 640 202.00

				To 12/31/2020		
			Title XIX	Hospi tal	Cost	or alli
	Cost Center Description	PPS Inpatient Ratio 11.00			9651	
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30.00	03000 ADULTS & PEDIATRICS					30.00
	03100   NTENSI VE CARE UNI T					31.00
	04000 SUBPROVI DER - I PF					40.00
	04100 SUBPROVI DER - I RF					41.00
	04300 NURSERY					43.00
10.00	ANCILLARY SERVICE COST CENTERS					10.00
50.00	05000 OPERATING ROOM	0. 000000				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000				76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
	OUTPATIENT SERVICE COST CENTERS					
	09100 EMERGENCY	0. 000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
93.00	04040 FAMILY PRACTICE	0. 000000				93.00
	OTHER REIMBURSABLE COST CENTERS					
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				96.00
440.00	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00	, ,					200.00
201.00						201.00
202.00	Total (see instructions)					202.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-1						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2020	Worksheet D Part I	
				To 12/31/2020		pared:
					7/8/2021 10: 3	7 am €
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col . 1 -			
	col . 26) 1.00	2.00	col . 2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	4, 654, 124	0	4, 654, 12	4 49, 319	94. 37	30.00
31. 00 INTENSIVE CARE UNIT	1, 285, 108		1, 285, 10			
40. 00   SUBPROVI DER - I PF	752, 151	_	752, 15			
41. 00   SUBPROVI DER - I RF	588, 664	0	588, 66			
43. 00   NURSERY	84, 825		84, 82			
200.00 Total (lines 30 through 199)	7, 364, 872		7, 364, 87			200.00
Cost Center Description	Inpati ent	Inpati ent	7, 304, 07.	71,230		200.00
cost center bescription	Program days	Program				
	11 ogram days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6, 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	19, 417	1, 832, 382				30.00
31.00 INTENSIVE CARE UNIT	2, 778	562, 295				31.00
40. 00 SUBPROVI DER - I PF	4, 421	391, 966				40.00
41. 00 SUBPROVI DER - I RF	2, 934	320, 804				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	29, 550	3, 107, 447				200. 00

Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3	pared: 7 am
	_		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Rel ated 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		T			T	
50. 00   05000   OPERATI NG ROOM	3, 357, 618		•	· · · · · ·		
52.00   05200   DELIVERY ROOM & LABOR ROOM	294, 564					
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 721, 097		•			
59. 00   05900   CARDI AC   CATHETERI ZATI ON	935, 570					
60. 00   06000   LABORATORY	1, 620, 697			· · · · ·		60.00
65. 00 06500 RESPIRATORY THERAPY	151, 329					65.00
66. 00 06600 PHYSI CAL THERAPY	1, 454, 276		1	· · · · ·		66. 00
69. 00 06900 ELECTROCARDI OLOGY	383, 595			· · · · · ·		
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 055				174	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_	0.00000		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	21, 145					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	783, 483					
74.00 07400 RENAL DIALYSIS	54, 488	1, 286, 781	1		32, 684	
76. 00   03950   ANCI LLARY - OTHER	0	ļ	0. 00000		0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	219, 397	936, 186	0. 23435	52 83	19	76. 97
OUTPAȚI ENT SERVI CE COST CENTERS						
91. 00   09100   EMERGENCY	1, 393, 355	88, 888, 587			232, 864	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	489, 391	10, 764, 097	0. 04546	923, 763	41, 999	92.00
93. 00 04040 FAMILY PRACTICE	96, 100	6, 316, 224	0. 01521	5 15, 227	232	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	137, 196		•		0	, 0. 00
200.00 Total (lines 50 through 199)	15, 252, 356	900, 926, 083	<b> </b>	156, 297, 756	2, 319, 631	200.00

	HOSPITAL & HEA			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		Period: From 01/01/2020 To 12/31/2020		epared: 37 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	0	0		0 0	0	
40. 00   04000   SUBPROVI DER -   PF		0		0 0	0	
41. 00   04100   SUBPROVI DER -   RF	l ol	0		0 0	0	
43. 00   04300   NURSERY	ol	0		0	0	
200.00 Total (lines 30 through 199)	ol	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	49, 31			
31.00 03100 INTENSIVE CARE UNIT		0	6, 34		,	
40. 00   04000   SUBPROVI DER - 1 PF	0	0	8, 48			
41. 00   04100   SUBPROVI DER - I RF	0	0	5, 38		,	
43. 00   04300   NURSERY		0	1, 70			
200.00   Total (lines 30 through 199)		0	71, 23	6	29, 550	200.00
Cost Center Description	Inpatient					
	Program					

| Period: | Worksheet D | From 01/01/2020 | Part IV | Date/Time Prepared: | 7/8/2021 10:37 am 
 Heal th Financial
 Systems
 REID HOSPITAL & HEALTH CARE SERVICES

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

					7/8/2021 10: 3	7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	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		0	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	827, 286	54.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0		0	0	59.00
60. 00   06000   LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65.00
66. 00   06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0	0	74.00
76.00 03950 ANCILLARY - OTHER	0	0		0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	(	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
93. 00   04040 FAMILY PRACTICE	0	0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS	<u>.                                      </u>					
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0	0	96.00
200.00 Total (lines 50 through 199)	0	0	(	0	827, 286	200.00
	•	•	•			

In Lieu of Form CMS-2552-10 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 01/01/2020 To 12/31/2020 Part IV Date/Time Prepared: THROUGH COSTS 7/8/2021 10:37 am Title XVIII Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. Outpati ent (from Wkst. C, Part I, (col. 5 ÷ Educati on 1, 2, 3, and Cost (sum of 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 162, 365, 438 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 9, 377, 711 0.000000 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 153, 836, 943 0.005378 54.00 54.00 827, 286 827, 286 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 99, 006, 132 0.000000 59.00 60.00 06000 LABORATORY 0 110, 660, 526 0.000000 60.00 65. 00 06500 RESPIRATORY THERAPY 0 0 26, 084, 310 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 22, 141, 113 0.000000 66.00 0 69.00 06900 ELECTROCARDI OLOGY 0 35, 134, 132 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 4, 538, 492 0.000000 70.00

0 0 0 0 0 0 0 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 32, 169, 316 0.000000 72.00 C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 136, 914, 597 0.000000 73.00 07400 RENAL DIALYSIS 0 1, 286, 781 0.000000 74.00 0 74.00 0 03950 ANCILLARY - OTHER 76 00 0 0.000000 76 00 07697 CARDIAC REHABILITATION 0 76. 97 936, 186 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 0 0 88, 888, 587 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 10, 764, 097 C 0.000000 92 00 92 00 04040 FAMILY PRACTICE 93.00 0 0 6, 316, 224 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 505, 498 0.000000 96.00 827, 286 200.00 Total (lines 50 through 199) 827, 286 900, 926, 083 200.00

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0048		Worksheet D
THROUGH COSTS			From 01/01/2020	Part IV

Title XVIII	THROUG	H COSTS				From 01/01/2020 To 12/31/2020		
Cost Center Description				Title	XVIII	Hospi tal		<u>/ alli</u>
to Charges (col . 6 + col . 7)		Cost Center Description	Outpati ent	I npati ent	Inpati ent		Outpati ent	
Col   6 + col   7   Costs (col   8   x col   10)   x col   12   20   20   20   20   20   20   20			Ratio of Cost	Program	Program	Program	Program	
COI   7     X   COI   10   11   10   12   10   13   10   15   10			to Charges	Charges	Pass-Through	Charges	Pass-Through	
ANCILLARY SERVICE COST CENTERS   9.00   10.00   11.00   12.00   13.00								
ANCI LLARY SERVI CE COST CENTERS								
S0.00   O5000   OPERATING ROOM   O.000000   27, 363, 876   O   41, 449, 664   O   50. 50. 50. 05200   DELI VERY ROOM & LABOR ROOM   O.000000   21, 718   O   84   O   52. 54. 00   O5400   RADI OLOGY-DI AGNOSTI C   O.005378   22, 095, 813   118, 831   45, 640, 004   245, 452   54. 59. 00   O5900   CARDI AC CATHETERI ZATI ON   O.000000   17, 527, 225   O   32, 250, 451   O   59. 60. 00   O6000   LABORATORY   O.000000   20, 998, 863   O   10, 041, 372   O   60. 65. 00   O6500   RESPI RATORY THERAPY   O.000000   9, 960, 288   O   1, 231, 022   O   65. 66. 00   O6600   PHYSI CAL THERAPY   O.000000   2, 803, 474   O   79, 588   O   66. 00   O6600   PHYSI CAL THERAPY   O.000000   3, 782, 695   O   9, 728, 145   O   69. 00   O7000   ELECTROCARDI OLOGY   O.000000   3, 782, 695   O   9, 728, 145   O   69. 00   O7000   ELECTROENCEPHALOGRAPHY   O.000000   O   O   O   O   O   O   O   O			9. 00	10. 00	11. 00	12.00	13. 00	
52. 00         05200         DELI VERY ROOM & LABOR ROOM         0.000000         21,718         0         84         0         52.           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0.005378         22,095,813         118,831         45,640,004         245,452         54.           59. 00         05900         CARDI AC CATHETRI ZATI ON         0.000000         17,527,225         0         32,250,451         0         59.           60. 00         06000         LABORATORY         0.000000         20,998,863         0         10,041,372         0         60.           65. 00         06500         RESPI RATORY THERAPY         0.000000         9,960,288         0         1,231,022         0         65.           66. 00         06600         PHYSI CAL THERAPY         0.000000         2,803,474         0         79,588         0         66.           69. 00         O6900         ELECTROCARDI OLOGY         0.000000         3,782,695         0         9,728,145         0         69.           70. 00         O7000         ELECTROCARDI OLOGY         0.000000         5,664         0         1,631,676         0         70.           71. 00         07100         MEDI CAL SUPPLI ESCHARGED TO PATI								
54. 00						41, 449, 664	0	50.00
59. 00         05900         CARDI AC CATHETERI ZATI ON         0.000000         17, 527, 225         0         32, 250, 451         0         59.           60. 00         06000         LABORATORY         0.000000         20, 998, 863         0         10, 041, 372         0         60.           65. 00         06500         RESPI RATORY THERAPY         0.000000         9, 960, 288         0         1, 231, 022         0         65.           66. 00         06600         PHYSI CAL THERAPY         0.000000         2, 803, 474         0         79, 588         0         65.           69. 00         06900         ELECTROCARDI OLOGY         0.000000         3, 782, 695         0         9, 728, 145         0         69.           70. 00         07000         ELECTROENCEPHALOGRAPHY         0.000000         5, 664         0         1, 631, 676         0         70.           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         0         0         0         0         0         0         71.         72.         73.         73.         73.         73.         73.         73.         73.         74.         73.         74.         74.         74.         74.				•				52.00
60. 00			1 1			45, 640, 004	245, 452	54.00
65. 00			1 1					59.00
66. 00   06600   PHYSI CAL THERAPY   0. 000000   2, 803, 474   0   79, 588   0   66. 69. 00   06900   ELECTROCARDI OLOGY   0. 000000   3, 782, 695   0   9, 728, 145   0   69. 70. 00   07000   ELECTROENCEPHALOGRAPHY   0. 000000   5, 664   0   1, 631, 676   0   70. 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0. 000000   0   0   0   0   0   71. 72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 000000   9, 282, 558   0   7, 033, 411   0   72. 73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 000000   25, 888, 855   0   34, 349, 941   0   73. 74. 00   07400   RENAL DI ALYSI S   0. 000000   0   0   49, 599   0   74. 76. 00   03950   ANCI LLARY - OTHER   0. 000000   771, 867   0   49, 599   0   76. 76. 97   07697   CARDI AC REHABI LI TATI ON   0. 000000   83   0   571, 534   0   76. 76. 00   09200	60.00	06000 LABORATORY	0. 000000	20, 998, 863	(	10, 041, 372	0	60.00
69. 00   06900   ELECTROCARDI OLOGY   0.000000   3,782,695   0   9,728,145   0   69.  70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   5,664   0   1,631,676   0   70.  71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   0   0   0   0   0    72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0.000000   9,282,558   0   7,033,411   0   72.  73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   25,888,855   0   34,349,941   0   73.  74. 00   07400   RENAL DI ALYSI S   0.000000   771,867   0   49,599   0   74.  76. 00   03950   ANCI LLARY - OTHER   0.000000   771,867   0   49,599   0   76.  76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   83   0   571,534   0   76.  0017PATI ENT SERVI CE COST CENTERS  91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.000000   14,855,787   0   15,270,122   0   91.  92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.000000   15,227   0   2,834,807   0   93.  0THER REI MBURSABLE COST CENTERS	65.00	06500 RESPI RATORY THERAPY	0. 000000	9, 960, 288	(	1, 231, 022	0	65.00
70. 00   07000   ELECTROENCEPHALOGRAPHY   0.000000   5,664   0   1,631,676   0   70.   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.000000   0   0   0   0   0   0   71. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   9,282,558   0   7,033,411   0   72.   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   25,888,855   0   34,349,941   0   73.   74. 00   07400   RENAL DI ALYSI S   0.000000   771,867   0   49,599   0   74.   76. 00   03950   ANCI LLARY - OTHER   0.000000   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LITATI ON   0.000000   83   0   571,534   0   76. 97   0017PATI ENT SERVI CE COST CENTERS    91. 00   09100   EMERGENCY   0.000000   14,855,787   0   15,270,122   0   91.   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.000000   923,763   0   1,731,443   0   92.   93. 00   04040   FAMI LY PRACTI CE   0.000000   15,227   0   2,834,807   0   0THER REI MBURSABLE COST CENTERS			0. 000000	2, 803, 474	(	79, 588	0	66.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0.000000   0   0   0   0   0   71.   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.000000   9, 282, 558   0   7, 033, 411   0   72.   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.000000   25, 888, 855   0   34, 349, 941   0   73.   74. 00   07400   RENAL DI ALYSI S   0.000000   771, 867   0   49, 599   0   74.   76. 00   03950   ANCI LLARY - OTHER   0.000000   0   0   0   0   0   76.   76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   83   0   571, 534   0   76.    OUTPATI ENT SERVI CE COST CENTERS   0.000000   14, 855, 787   0   15, 270, 122   0   91.   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.000000   923, 763   0   1, 731, 443   0   92.   93. 00   04040   FAMI LY PRACTI CE   0.000000   15, 227   0   2, 834, 807   0   93.    OTHER REI MBURSABLE COST CENTERS						9, 728, 145	0	69.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0.000000   9, 282, 558   0   7, 033, 411   0   72.    73. 00   73. 00   73. 00   73. 00   74. 00			0. 000000	5, 664	(	1, 631, 676	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 25, 888, 855 0 34, 349, 941 0 73. 74. 00 07400 RENAL DI ALYSI S 0. 000000 771, 867 0 49, 599 0 74. 76. 00 03950 ANCI LLARY - OTHER 0. 000000 0 0 0 0 0 0 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 83 0 571, 534 0 76.  91. 00 09100 EMERGENCY 0. 000000 14, 855, 787 0 15, 270, 122 0 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 923, 763 0 1, 731, 443 0 92. 93. 00 04040 FAMI LY PRACTI CE 0. 0.000000 15, 227 0 2, 834, 807 0 93.  OTHER REI MBURSABLE COST CENTERS			0. 000000	0	(	0	0	71.00
74. 00 07400 RENAL DI ALYSI S 0. 000000 771, 867 0 49, 599 0 74. 76. 00 03950 ANCI LLARY - OTHER 0. 000000 0 0 0 0 0 76. 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 83 0 571, 534 0 76.  91. 00 09100 EMERGENCY 0.000000 14, 855, 787 0 15, 270, 122 0 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 15, 227 0 2, 834, 807 0 93.  01 07404 FAMI LY PRACTI CE 0.000000 15, 227 0 2, 834, 807 0 93.  01 07405 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	9, 282, 558	(	7, 033, 411	0	72.00
76. 00 03950 ANCI LLARY - OTHER 0. 000000 0 0 0 0 0 76. 77. 78. 79. 79. 79. 79. 79. 79. 79. 79. 79. 79	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	25, 888, 855	(	34, 349, 941	0	73.00
76. 97	74.00	07400 RENAL DIALYSIS	0. 000000	771, 867	(	49, 599	0	74.00
OUTPATIENT SERVICE COST CENTERS  91.00	76.00	03950 ANCI LLARY - OTHER	0. 000000	•		0	0	76. 00
91. 00	76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	83	(	571, 534	0	76. 97
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0. 000000   923, 763   0   1, 731, 443   0   92. 93. 00   04040   FAMI LY PRACTI CE   0. 000000   15, 227   0   2, 834, 807   0   93. 0THER REI MBURSABLE COST CENTERS								
93. 00   04040   FAMILY PRACTICE   0.000000   15,227   0   2,834,807   0   93.			0. 000000	14, 855, 787	(	15, 270, 122	0	91.00
OTHER REI MBURSABLE COST CENTERS	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	923, 763	(	1, 731, 443	0	92.00
	93.00		0. 000000	15, 227	(	2, 834, 807	0	93.00
		09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0				
200.00   Total (lines 50 through 199)   156, 297, 756   118, 831   203, 892, 863   245, 452 200.	200.00	Total (lines 50 through 199)		156, 297, 756	118, 831	203, 892, 863	245, 452	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 41, 449, 664 0. 214961 8, 910, 061 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0. 225475 52.00 52.00 84 19 05400 RADI OLOGY-DI AGNOSTI C 45, 640, 004 54.00 0. 173687 7, 927, 075 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0. 126475 32, 250, 451 0 4, 078, 876 59.00 60.00 06000 LABORATORY 0. 185789 10, 041, 372 0 1, 865, 576 60.00 0 06500 RESPIRATORY THERAPY 0 182, 646 65.00 0.148369 1, 231, 022 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0. 653218 79, 588 51, 988 66.00 0 69.00 06900 ELECTROCARDI OLOGY 0. 104913 9, 728, 145 0 1, 020, 609 69.00 1, 631, 676 0 07000 ELECTROENCEPHALOGRAPHY 0.179820 293, 408 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 Ω 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.589774 7, 033, 411 0 0 4, 148, 123 72.00 07300 DRUGS CHARGED TO PATIENTS 34, 349, 941 0 11, 800, 063 73.00 0.343525 39, 270 73.00 07400 RENAL DIALYSIS 0 74 00 0.894410 49, 599 44, 362 74 00 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 1.063034 571, 534 0 607, 560 76.97 OUTPATIENT SERVICE COST CENTERS 0 91.00 91 00 0 192365 15, 270, 122 1, 201 2, 937, 437 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.566100 1, 731, 443 980, 170 92.00 696 04040 FAMILY PRACTICE 0.570834 2, 834, 807 0 93.00 93.00 1, 618, 204 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 1.489414 96.00 0 0 200.00 Subtotal (see instructions) 203, 892, 863 41, 167 46, 466, 177 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 203, 892, 863 0 46, 466, 177 202. 00 41, 167

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048

Period:
From 01/01/2020
To 12/31/2020

To 12/31/

cost center bescription	0031	0031	
	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	C	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0	54.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	C	0	59.00
60. 00   06000   LABORATORY	C	0	60.00
65. 00 06500 RESPIRATORY THERAPY	C	0	65.00
66. 00 06600 PHYSI CAL THERAPY	C	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	C	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	13, 490	73.00
74.00 07400 RENAL DIALYSIS	C	0	74.00
76.00 03950 ANCILLARY - OTHER	C	0	76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	C	0	76. 97
OUTPATIENT SERVICE COST CENTERS			
91. 00   09100   EMERGENCY	C	231	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	92.00
93.00 04040 FAMILY PRACTICE	C	397	93.00
OTHER REIMBURSABLE COST CENTERS			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0	96. 00
200.00 Subtotal (see instructions)	C	14, 118	200. 00
201.00 Less PBP Clinic Lab. Services-Program	C	)	201.00
Only Charges			1
202.00   Net Charges (line 200 - line 201)		14, 118	202. 00

Hoal th	Financial Systems REID	HOSPITAL & HEA	ITH CADE SERVI	CES	Inlia	u of Form CMS-2	2552_10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	2332-10
			,	CCN: 15-S048	From 01/01/2020 To 12/31/2020		pared: 7 am
			Title	· XVIII	Subprovi der - I PF	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 OPERATING ROOM	3, 357, 618	162, 365, 438			1, 795	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	294, 564	9, 377, 711	0. 03141	1 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 721, 097	153, 836, 943	0. 02418	9 346, 532	8, 382	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	935, 570	99, 006, 132	0. 00945	530	5	59.00
60.00	06000 LABORATORY	1, 620, 697	110, 660, 526	0. 01464	5 708, 041	10, 370	60.00
65.00	06500 RESPI RATORY THERAPY	151, 329	26, 084, 310	0. 00580	2 388, 534	2, 254	65.00
66.00	06600 PHYSI CAL THERAPY	1, 454, 276	22, 141, 113	0. 06568	276, 350	18, 151	66.00
69.00	06900 ELECTROCARDI OLOGY	383, 595	35, 134, 132	0. 01091	23, 163	253	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	139, 055	4, 538, 492	0. 03063	9 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	21, 145	32, 169, 316	0. 00065	7 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	783, 483	136, 914, 597	0. 00572	1, 076, 669	6, 161	73.00
74.00	07400 RENAL DIALYSIS	54, 488	1, 286, 781	0.04234	4 3, 250	138	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	0.00000	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	219, 397	936, 186	0. 23435	2 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 393, 355	88, 888, 587	0. 01567	5 444, 502	6, 968	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	10, 764, 097	0.00000	0	0	92.00
93.00	04040 FAMILY PRACTICE	96, 100	6, 316, 224	0. 01521	5 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS				•		
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	137, 196	505, 498	0. 27140	3 0	0	96. 00
200.00	Total (lines 50 through 199)	14, 762, 965	900, 926, 083		3, 354, 352	54, 477	200. 00

Report I ONMENT OF I NPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0048   Prov	Health Financial Systems REID	HOSPITAL & HEA	ALTH CARE SERVI	CES	In Li∈	eu of Form CMS-2	2552-10
Component CCN: 15-S048   To 12/31/2020   Date/Time Prepared: 7/8/2021 10: 37 am	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	SS Provider C	CN: 15-0048			
Non Physician   Anesthetist   School   School   Post-Stepdown   Adjustments   Post-Stepdown	THROUGH COSTS		Component	CCN: 15-S048		Date/Time Pre	epared:
Non Physician   Anesthetist   Cost			Title	XVIII	Subprovi der -		7 aiii
Anesthetist   Cost   Post-Stepdown   Adjustments   Adjus			11110	, ,,,,,,,		110	
ANCILLARY SERVICE COST CENTERS   1.00   2A   2.00   3A   3.00	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments   1.00   2A   2.00   3A   3.00		Anesthetist	School	School	Post-Stepdown		
1.00   2A   2.00   3A   3.00   3D   3A   3.00   3D   3D   3A   3.00   3D   3D   3D   3D   3D   3D   3D		Cost	Post-Stepdown		Adjustments		
ANCI LLARY SERVI CE COST CENTERS			Adjustments				
50. 00   05000   0FERATING ROOM   0   0   0   0   0   0   0   0   0		1. 00	2A	2. 00	3A	3. 00	
52.00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00							
54. 00		0	0		0 0	0	
59. 00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0       0       59. 00         60. 00       06000       LABORATORY       0		0	0		0 0	1	
60. 00		0	0		0 0	827, 286	54.00
65. 00		0	0		0 0	0	
66. 00		0	0		0 0	0	
69. 00		0	0		0 0	0	
70. 00		0	0		0 0	0	
71. 00		0	0		0 0	0	
72. 00		0	0		0 0	0	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   0   76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   0   0   0   76. 97   0UTPATI ENT SERVI CE COST CENTERS   0   0   0   0   0   0   76. 97   09100   EMERGENCY   0   0   0   0   0   0   77. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   78. 00   04040   FAMI LY PRACTI CE   0   0   0   0   0   79. 00   07HER REI MBURSABLE COST CENTERS   0   0   0   0   0   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   0   96. 00   0   0   0   0   0   97. 00   0   0   0   0   0   98. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   0   99. 00   0   0   0   0   0   90. 00   0   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   0   0   90. 00   0   90. 00   0   0   90. 00		0	0		0 0	0	
74. 00		0	0		0 0	0	
76. 00		0	0		0 0	0	
76. 97   07697   CARDI AC REHABI LI TATI ON   O   O   O   O   O   O   O   O   O		0	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS     O   O   O   O   O   O   O   O   O		0	0		0 0	0	
91. 00		0	0		0 0	1 0	76. 97
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00   0   0   0   0   0   0   0   0   0		_	1	ı			
93. 00   04040   FAMILY PRACTICE   0   0   0   0   0   93. 00   0   0   0   0   0   0   0   0   0		0	0		0	1	
OTHER REI MBURSABLE COST CENTERS           96. 00         09600 DURABLE MEDI CAL EQUI P-RENTED         0         0         0         0         96. 00		0			0		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00		0	0		0 0	0	93.00
				ı			
200.00    Total (Tines 50 through 199)   0  0  0  827, 286   200.00				1		l .	
	200.00    10tal (11nes 50 through 199)	1	U U	1	UJ C	827, 286	J200. 00

ANCILLARY SERVICE COST CENTERS   Provider CCN: 15-0048   Component CN: 15-00	Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-S048   To   12/31/2020   Date/Time Prepared: 7/8/2021 10: 37 am   Frepared: 7/8/2021 10: 37 am   Frepare	APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co				
Cost Center Description	THROUG	SH COSTS		Component (				narod:
Cost Center Description				Component	CCN. 13-3040	0 12/31/2020	7/8/2021 10: 3	7 am
ANCILLARY SERVICE COST CENTERS   A. 0.0000000   A. 0.000000   A. 0.0000000   A. 0.000000   A. 0.0000000   A. 0.000000   A. 0.000000   A. 0.000000   A. 0.000000   A. 0.000000   A. 0.000000   A. 0.0000000   A. 0.0000000   A. 0.0000000   A. 0.000000   A. 0.000000   A. 0.000000   A. 0.000000   A.				Title	XVIII			
Medical Education Cost								
Education   Cost   A)		Cost Center Description						
Cost   4)   Cols. 2, 3, and 4)   Cols. 2, 3, and 4)   Cols. 7)   (see instructions)								
ANCILLARY SERVICE COST CENTERS								
A.00   S.00   O.0000   DERATI NG ROOM   O.000000   O.00000   O.000000   O.000000   O.000000   O.000000   O.000000   O.0000000   O.000000   O.0000000   O.0000000000			Cost	4)		col. 8)		
ANCI LLARY SERVI CE COST CENTERS   SO					and 4)			
ANCI LLARY SERVICE COST CENTERS						7.00		
50. 00   05000   OPERATING ROOM   0   0   0   0   162, 365, 438   0.000000   50. 00   52. 0		ANOLILIARY OFFICE OCCUPANTED	4.00	5.00	6.00	7.00	8.00	
52.00   05200   DELI VERY ROOM & LABOR ROOM   0   0   0   0   0   3777, 711   0.000000   52.00	F0 00					4/0 0/5 400	0.000000	 
54. 00			0	0				
59. 00			0					
60. 00 06000 LABORATORY 0 0 0 0 110, 660, 526 0.000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 26, 084, 310 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 22, 141, 113 0.000000 66. 00 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 35, 134, 132 0.000000 69. 00 0 0.00000 070. 00 0.00000 071. 00 0.00000 071. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 4, 538, 492 0.000000 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0.00000 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 32, 169, 316 0.00000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 136, 914, 597 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 136, 914, 597 0.000000 73. 00 074. 00 07400 RENAL DI ALYSI S 0 0 0 0 1, 286, 781 0.000000 74. 00 076. 70 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 936, 186 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0 0.000000 76. 00 0.			0	827, 286				
65. 00		l	0	0	· -			
66. 00		· · · · · · · · · · · · · · · · · · ·	0	0		· · ·		1
69. 00			0	0	· ·			
70. 00			0	0				
71. 00			0	0				
72. 00			0	0	(			
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   136, 914, 597   0.000000   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   1, 286, 781   0.000000   74. 00   76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   0   0.000000   76. 00   0.000000   76. 00   0.000000   76. 00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.00000000			0	0	(	,		
74. 00			0	0	·			
76. 00			0	0	(			
76. 97 O7697 CARDI AC REHABI LI TATI ON O O O 936, 186 O. 000000 76. 97 OUTPATI ENT SERVI CE COST CENTERS  91. 00 O9100 EMERGENCY O O O 88, 888, 587 O. 000000 91. 00 O O O O O O O O O O O O O O O O O O			0	0	(			
OUTPATIENT SERVICE COST CENTERS   O   O   O   88, 888, 587   O. 000000   91. 00			0	0	`	, i		
91. 00	76. 97		0	0	(	936, 186	0.000000	76. 97
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   10, 764, 097   0.000000   92. 00   0   0   0   0   0   0   0   0   0			•		,			
93. 00   04040 FAMILY PRACTICE   0   0   6, 316, 224   0.000000   93. 00   07HER REIMBURSABLE COST CENTERS   0   0   0   505, 498   0.000000   96. 00   0   0   0   0   0   0   0   0   0			0	0				
OTHER REI MBURSABLE COST CENTERS           96. 00         09600 DURABLE MEDI CAL EQUI P-RENTED         0         0         505, 498         0.000000         96.00			0	_				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 505, 498 0. 000000 96. 00	93. 00		0	0	(	6, 316, 224	0. 000000	93. 00
200.00   Total (lines 50 through 199)   0  827, 286  827, 286  900, 926, 083   200.00				_				1
	200.00	Total (lines 50 through 199)	0	827, 286	827, 286	900, 926, 083		200. 00

Heal th	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10								
APP0R1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider Co		Peri od:	Worksheet D			
THROUG	SH COSTS		Component (		From 01/01/2020 To 12/31/2020		pared: 7 am		
			Title	XVIII	Subprovi der - I PF	PPS			
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent			
	oust denter beson per on	Ratio of Cost	Program	Program	Program	Program			
		to Charges	Charges	Pass-Through		Pass-Through			
		(col . 6 ÷	onal goo	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	86, 781	(	0	0	50.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(	0	0	52.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 005378	346, 532	1, 864	4, 353	23	54.00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	530	(	0	0	59.00		
60.00	06000 LABORATORY	0. 000000	708, 041	(	9, 601	0	60.00		
65.00	06500 RESPIRATORY THERAPY	0. 000000	388, 534	(	444	0	65.00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	276, 350	(	0	0	66.00		
69.00	06900 ELECTROCARDI OLOGY	0. 000000	23, 163	(	179	0	69.00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(	0	0	70.00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	0	0	71.00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	(	0	0	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 076, 669	(	1, 889	0	73.00		
74.00	07400 RENAL DIALYSIS	0. 000000	3, 250	(	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	444, 502	(	84	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		, , , , , ,		
200.00	Total (lines 50 through 199)		3, 354, 352	1, 864	16, 550	23	200. 00		

Health Financial Systems RE	ELD HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provi der C		Peri od: From 01/01/2020	Worksheet D Part V	
	Component	CCN: 15-S048	To 12/31/2020	Date/Time Pre 7/8/2021 10:3	pared: 7 am	
		Title	e XVIII	Subprovi der -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	0		(ccc : nc+ )	(ccc : no+ )		

	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 214961	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 225475	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 173687	4, 353	0	0	756	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 126475	0	0	0	0	59.00
60.00	06000 LABORATORY	0. 185789	9, 601	0	0	1, 784	60.00
65.00	06500 RESPIRATORY THERAPY	0. 148369	444	0	0	66	65.00
66.00	06600 PHYSI CAL THERAPY	0. 653218	0	0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 104913	179	0	0	19	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 179820	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 589774	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 343525	1, 889	0	2, 336	649	73.00
74.00		0. 894410	0	0	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0. 000000	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1. 063034	l .	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS				1		1
91.00	09100 EMERGENCY	0. 192365	84	0	0	16	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 566100	0	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0. 570834	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS		•				1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	1. 489414	0	0	0	0	96.00
200.0	Subtotal (see instructions)		16, 550	0	2, 336	3, 290	200.00
201.0	Less PBP Clinic Lab. Services-Program			0	0	·	201.00
	Only Charges						
202.0			16, 550	0	2, 336	3, 290	202. 00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider Component (	CN: 15-0048 CCN: 15-S048	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pr 7/8/2021 10:	epared: 37 am
		Title	XVIII	Subprovi der - I PF	PPS	
		sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
D. 00 O5000 OPERATING ROOM	C	0				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	C	0				52.0
4. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0				54.0
9. 00   05900   CARDI AC   CATHETERI ZATI ON	C	0				59. (
D. 00   06000   LABORATORY	C	0				60.0
5. 00 06500 RESPIRATORY THERAPY	C	0				65.0
5. 00 06600 PHYSI CAL THERAPY	C	0				66.
9. 00 06900 ELECTROCARDI OLOGY	C	0				69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	C	0				70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0				71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS		802				73.
4. 00   07400   RENAL DIALYSIS 5. 00   03950   ANCILLARY - OTHER		0				74. 76.
5. 00   03950  ANCIELARY - OTHER 5. 97   07697  CARDIAC REHABILITATION		1				76.
OUTPATIENT SERVICE COST CENTERS		<u>,                                     </u>				<b>-</b> / 0. ·
1. 00 09100 EMERGENCY	C	0				91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			•			92. (
3. 00   04040   FAMILY PRACTICE						93. (
OTHER REIMBURSABLE COST CENTERS						
5. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	C	0				96. (
00.00 Subtotal (see instructions)	C	802				200. (
D1.00 Less PBP Clinic Lab. Services-Program	C					201.
Only Charges						
D2.00 Net Charges (line 200 - line 201)	C	802				202.

Health Financial Systems	HOCDITAL ® HEA	LTU CADE CEDVI	CEC	ملاها	u of Form CMC 1	DEED 10
Health Financial Systems REID APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	HOSPITAL & HEA	Provider C		Peri od:	u of Form CMS-2 Worksheet D	2552-10
ALTONITONIMENT OF THE ATTENT AND LEARLY SERVICE CALLED	AL 00313		F	From 01/01/2020 To 12/31/2020	Part II	
			· XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	3, 357, 618				1, 768	
52.00   05200   DELIVERY ROOM & LABOR ROOM	294, 564		0. 031411		0	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 721, 097	153, 836, 943			2, 793	54.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	935, 570	99, 006, 132				59.00
60. 00   06000   LABORATORY	1, 620, 697	110, 660, 526	0. 014646	480, 494	7, 037	60.00
65. 00 06500 RESPIRATORY THERAPY	151, 329	26, 084, 310	0. 005802	261, 278	1, 516	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 454, 276	22, 141, 113	0. 065682	2, 537, 241	166, 651	66.00
69. 00 06900 ELECTROCARDI OLOGY	383, 595	35, 134, 132	0. 010918	7, 197	79	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	139, 055	4, 538, 492	0. 030639	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	21, 145	32, 169, 316	0.000657	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	783, 483	136, 914, 597	0.005722	717, 752	4, 107	73.00
74. 00   07400   RENAL DI ALYSI S	54, 488	1, 286, 781	0. 042344	24, 700	1, 046	74.00
76. 00   03950   ANCI LLARY - OTHER	0	0	0. 000000	0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	219, 397	936, 186	0. 234352	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	1, 393, 355	88, 888, 587	0. 015675	10, 661	167	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	10, 764, 097	0.000000	0	0	92.00
93. 00 04040 FAMILY PRACTICE	96, 100	6, 316, 224	0. 015215	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	137, 196	505, 498	0. 271408	3 0	0	96.00
200.00   Total (lines 50 through 199)	14, 762, 965	900, 926, 083		4, 248, 657	185, 243	200. 00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI				Peri od:	Worksheet D		
THROUGH COSTS		Component	CCN: 15-T048	From 01/01/202 To 12/31/202		epared: 37 am	
		Title	· XVIII	Subprovi der - I RF	PPS		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Healt	h Allied Health		
	Anestheti st	School	School	Post-Stepdow	n		
	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   O5200   DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00	
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 827, 286	54.00	
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	59.00	
60. 00   06000   LABORATORY	0	0		0	0 0	60.00	
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0 0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00	
69. 00  06900   ELECTROCARDI OLOGY	0	0		0	0 0	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	1 / 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	1 /2.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0		
74. 00   07400   RENAL DI ALYSI S	0	0		0	0		
76. 00  03950   ANCI LLARY - OTHER	0	0		0	0		
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0	0 0	76. 97	
OUTPATIENT SERVICE COST CENTERS	_				_		
91. 00   09100   EMERGENCY	0	0		0	0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0		
93. 00 04040 FAMILY PRACTICE	0	0		0	0 0	93.00	
OTHER REIMBURSABLE COST CENTERS			1				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	l .		0	0 0		
200.00   Total (lines 50 through 199)	0	0	1	0	0 827, 286	200. 00	

APPROXIT OMNEMT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0048   Period: From 01/01/2020   Date/Time Prepared: 7/8/2021 10: 37 am	Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-T048   To   12/31/2020   Date/Time Prepared: 7/8/2021 10: 37 am   Fire   Title XVIII   Subprovider   Fire	APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider Co				
Title XVIII   Subprovider   RE   PPS   Subprovider   IRE   Subprovider   IRE   PPS   Retail	THROUG	SH COSTS		Component (				narod:
Title XVIII   Subprovider - IRF				Component	CCN. 13-1046	0 12/31/2020	7/8/2021 10: 3	pareu. 7 am
All Other   Medical   Education   Cost   C				Title	XVIII	Subprovi der -		
Medical Education Cost								
Education   Cost   A)		Cost Center Description						
Cost   4)   Cols 2, 3, and 4)   Col 8 2, 3, and 4, 3, and 4)   Col 8 2, 3, and 4, 3, and 4, and 5,								
ANCILLARY SERVICE COST CENTERS								
A.00   S.00   O.000   O.0000   O.00000   O.0000   O.00000   O.000000   O.0000000   O.000000   O.0000000   O.0000000000			Cost	4)		col. 8)		
ANCI LLARY SERVI CE COST CENTERS   SOLUTION   SOLUTIO					and 4)			
ANCI LLARY SERVICE COST CENTERS								
50. 00   05000   OPERATING ROOM   0   0   0   0   162, 365, 438   0.000000   50. 00   52. 0		ANOUT ARY OFRICA OF SOUT OFFITTERS	4. 00	5.00	6.00	7.00	8. 00	
52. 00         05200         DELIVERY ROOM & LABOR ROOM         0         0         9,377,711         0.000000         52.00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         827,286         827,286         153,836,943         0.005378         54.00           59. 00         05900         CARDI AC CATHETEI ZATI ON         0         0         0         99,006,132         0.00000         59.00           60. 00         06000         LABORATORY         0         0         0         110,660,526         0.000000         60.00           65. 00         06500         RESPI RATORY THERAPY         0         0         0         26,084,310         0.000000         65.00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         22,141,113         0.000000         66.00           70. 00         06900         ELECTROCARDI OLOGY         0         0         0         35,134,132         0.000000         70.00           70. 00         07000         ELECTROCARDI ALDGRAPHY         0         0         0         4,538,492         0.000000         71.00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENT         0         0			_			1.0 0.5 100	0.00000	
54. 00			0	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 99, 006, 132 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 110, 660, 526 0.000000 60. 00 65. 00 06000 RESPI RATORY THERAPY 0 0 0 0 26, 084, 310 0.000000 60. 00 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 22, 141, 113 0.000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 35, 134, 132 0.000000 69. 00 0.000000 070. 00 0.0000000 070. 00 0.000000 070. 00 0.00000000			0					
60. 00			0	827, 286				
65. 00		l	0	0	· -			
66. 00   06600   PHYSI CAL THERAPY   0   0   0   22, 141, 113   0.000000   66. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   35, 134, 132   0.000000   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   4, 538, 492   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   32, 169, 316   0.000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0   0   0   32, 169, 316   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   136, 914, 597   0.000000   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   1, 286, 781   0.000000   74. 00   76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   936, 186   0.000000   76. 97   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   936, 186   0.000000   76. 97   791. 00   09100   EMERGENCY   0   0   0   0   88, 888, 587   0.000000   91. 00   792. 00   09200   DSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   6, 316, 224   0.000000   93. 00   793. 00   07600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   505, 498   0.000000   794. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   0   505, 498   0.000000   794. 00   0000000   00000000   0000000   000000		· · · · · · · · · · · · · · · · · · ·	0	0		· · ·		1
69. 00			0	0	· ·			
70. 00			0	0				
71. 00			0	0				
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   32, 169, 316   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   136, 914, 597   0.000000   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   1, 286, 781   0.000000   74. 00   76. 00   03950   ANCI LLARY - OTHER   0   0   0   0   0   0.000000   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   0   0   0   936, 186   0.000000   76. 97   0000000   0000000   0000000   0000000			0	0	(			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 136, 914, 597 0. 000000 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 1, 286, 781 0. 000000 74. 00 76. 00 03950 ANCI LLARY - OTHER 0 0 0 0 0 0. 000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 936, 186 0. 000000 76. 97  OUTPATIENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 0 0 0 88, 888, 587 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 10, 764, 097 0. 000000 92. 00 93. 00 04040 FAMI LY PRACTI CE 0 0 0 0 6, 316, 224 0. 000000 93. 00  OTHER REI MBURSABLE COST CENTERS  96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 505, 498 0. 000000 96. 00			0	0		,		
74. 00			0	0	·			
76. 00			0	0	(			
76. 97 O7697 CARDI AC REHABILITATION O O O 936, 186 O. 000000 76. 97 OUTPATIENT SERVICE COST CENTERS  91. 00 O9100 EMERGENCY O O O 88, 888, 587 O. 000000 91. 00 O O O O O O O O O O O O O O O O O O			0	0	(			
OUTPATIENT SERVICE COST CENTERS   91.00   O   0   88, 888, 587   O.000000   91.00			0	0	`	, i		
91. 00	76. 97		0	0	(	936, 186	0. 000000	76. 97
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   10, 764, 097   0.000000   92. 00   000000   00000000000000000000000					r			
93. 00   04040 FAMILY PRACTICE   0   0   6, 316, 224   0.000000   93. 00   07HER REIMBURSABLE COST CENTERS   0   0   0   505, 498   0.000000   96. 00   0   0   0   0   0   0   0   0   0			0	_				
OTHER REIMBURSABLE COST CENTERS           96. 00         09600 DURABLE MEDI CAL EQUI P-RENTED         0         0         505, 498         0.000000         96.00			0	_				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 505, 498 0. 000000 96. 00	93. 00		0	0	(	6, 316, 224	0. 000000	93.00
200.00   Total (lines 50 through 199)   0  827, 286  827, 286  900, 926, 083   200.00				_				1
	200.00	Total (lines 50 through 199)	0	827, 286	827, 286	900, 926, 083		200. 00

Heal th	Financial Systems REID	HOSPITAL & HEAI	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provi der Co		Peri od:	Worksheet D	
THROUG	H COSTS		Component (		From 01/01/2020 To 12/31/2020	Part IV Date/Time Prepared: 7/8/2021 10:37 am	
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati 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)		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	85, 513	(	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	· '	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 005378	115, 451	62 <sup>-</sup>	1 0	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	8, 370	(	0	0	59.00
60.00	06000 LABORATORY	0. 000000	480, 494	(	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	261, 278	(	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 537, 241	(	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	7, 197	(	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	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	717, 752	(	1, 279	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	24, 700	(	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	10, 661	(	0	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 MEDICAL EQUIP-RENTED	0. 000000	0	(	0	0	96. 00
200.00	Total (lines 50 through 199)		4, 248, 657	62 <sup>-</sup>	1, 279	0	200. 00

Health Financial Systems REID	REID HOSPITAL & HEALTH CARE SERVICES In Li					2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	OTHER HEALTH SERVICES AND VACCINE COST		CN: 15-0048	Period: From 01/01/2020	Worksheet D	
		Component (	CCN: 15-T048		Date/Time Pre 7/8/2021 10:3	
		Title	XVIII	Subprovi der – I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio From	Reimbursed Services (see	Reimbursed Services	Reimbursed Services Not	(see inst.)	

				<u>I RF</u>		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0. 214961	0	C	0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 225475	0	C	0	0	52.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 173687	0	C	0	0	54.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0. 126475	0	C	0	0	59.00
60. 00   06000   LABORATORY	0. 185789	0	C	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 148369	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 653218	0	l c	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 104913	0	l c	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 179820	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	l c	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 589774	0	l c	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 343525	1, 279	l	1, 869	439	73.00
74. 00 07400 RENAL DIALYSIS	0. 894410	0	l	0	0	74.00
76. 00   03950   ANCI LLARY - OTHER	0. 000000	0	l	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1. 063034	0	l	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			<u>'</u>	•		
91. 00 09100 EMERGENCY	0. 192365	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 566100	0	l c	0	0	92.00
93. 00   04040   FAMILY PRACTICE	0. 570834	0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1. 489414	0	C	0	0	96.00
200.00 Subtotal (see instructions)		1, 279	l c	1, 869	439	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		1, 279	C	1, 869	439	202. 00
	•	•	•	•	•	•

IPPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider Component (	CN: 15-0048 CCN: 15-T048	Peri od: From 01/01/2020 To 12/31/2020		epared: 37 am
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Subject To Ded. & Coins.   (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				_
ANCI LLARY SERVI CE COST CENTERS  0. 0. 00 05000 0PERATI NG ROOM  12. 00 05200 DELI VERY ROOM & LABOR ROOM  14. 00 05400 RADI OLOGY-DI AGNOSTI C  19. 00 05900 CARDI AC CATHETERI ZATI ON  10. 00 06000 LABORATORY  10. 00 06500 RESPI RATORY THERAPY  10. 00 06600 PHYSI CAL THERAPY  10. 00 07000 ELECTROCARDI OLOGY  11. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS  12. 00 07300 DRUGS CHARGED TO PATI ENTS  14. 00 07400 RENAL DI ALYSI S  16. 00 03950 ANCI LLARY - OTHER  16. 97 07697 CARDI AC REHABI LI TATI ON	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				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
OUTPATIENT SERVICE COST CENTERS 01.00 O9100 EMERGENCY	0	0	I			91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 23.00 04040 FAMILY PRACTICE	0	0				92.00
07.00 OTHER REIMBURSABLE COST CENTERS 06.00 O9600 DURABLE MEDICAL EQUIP-RENTED 000.00 Subtotal (see instructions) 001.00 Less PBP Clinic Lab. Services-Program 0nly Charges	0 0 0	0 642				96. 0 200. 0 201. 0
Net Charges (line 200 - line 201)	0	642				202. 0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2020 To 12/31/2020 Part V Date/Time Prepared: 7/8/2021 10:37 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 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 314, 592 50.00 0. 214961 05200 DELIVERY ROOM & LABOR ROOM 55, 450 0 0. 225475 52.00 0 52.00 0 2, 897, 756 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0. 173687 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0. 126475 578, 949 0 0 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0. 185789 1, 893, 321 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.148369 83, 346 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 653218 735, 729 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 104913 308, 055 69.00 71, 409 70.00 07000 ELECTROENCEPHALOGRAPHY 0.179820 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.589774 180, 218 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 343525 0 1, 829, 244 0 73.00 73.00 0 0 07400 RENAL DIALYSIS 0.894410 0 74.00 74 00 Ω 0 76.00 03950 ANCILLARY - OTHER 0.000000 0 Ω 0 76.00 76. 97 07697 CARDIAC REHABILITATION 1.063034 0 3, 881 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 0. 192365 0 91.00 91 00 09100 EMERGENCY 3, 348, 909 0 n 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0.566100 0 401, 202 0 04040 FAMILY PRACTICE 0.570834 120, 627 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 1. 489414 96.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 Ωl 200.00 Subtotal (see instructions) 0 14, 822, 688 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00 14, 822, 688 0

Heal th Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0048

Period:
From 01/01/2020
To 12/31/2020
To 12/

		Title	XIX	Hospi tal	Cost	
	Cos	sts				
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	497, 547	0			50.0	00
52.00   05200   DELIVERY ROOM & LABOR ROOM	12, 503	0			52. C	00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	503, 303	0			54. C	00
59. 00   05900   CARDI AC CATHETERI ZATI ON	73, 223	0			59. C	00
60. 00   06000   LABORATORY	351, 758	0			60.0	00
65. 00 06500 RESPIRATORY THERAPY	12, 366	0			65. C	00
66. 00   06600   PHYSI CAL THERAPY	480, 591	0			66.0	00
69. 00 06900 ELECTROCARDI OLOGY	32, 319	0			69. C	00
70. 00 07000 ELECTROENCEPHALOGRAPHY	12, 841	0			70. C	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. C	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	106, 288	0			72. C	00
73.00 07300 DRUGS CHARGED TO PATIENTS	628, 391	0			73. C	00
74.00 07400 RENAL DIALYSIS	0	0			74. C	00
76. 00   03950   ANCI LLARY - OTHER	0	0			76. C	00
76. 97 07697 CARDI AC REHABI LI TATI ON	4, 126	0			76. 9	97
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	644, 213	0			91. C	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	227, 120	0			92.0	00
93. 00 04040 FAMILY PRACTICE	68, 858	0			93.0	00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96.0	
200.00 Subtotal (see instructions)	3, 655, 447	0			200.0	
201.00 Less PBP Clinic Lab. Services-Program	0				201.0	00
Only Charges						
202.00   Net Charges (line 200 - line 201)	3, 655, 447	0			202.0	00

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0048	Peri od: From 01/01/2020	Worksheet D-1	
				Date/Time Pre 7/8/2021 10:3	pared: 7 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XVIII	Hospi tal	7/8/2021 10: 3 PPS	7 alli		
	Cost Center Description		110001 (41				
	DART I ALL DOOM DED COMPONENTS			1. 00			
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS						
1. 00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		49, 319	1.00		
2.00	Inpatient days (including private room days, excluding swing-			49, 319	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		
4 00	do not complete this line.	ad daya)		44, 133	4 00		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost		4. 00 5. 00		
0.00	reporting period	om dayo, tim odgi. Doddinos			0.00		
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) +brayab Dagambar	21 of the cost	0	7.00		
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	iii days) thi ough beceiliber	31 Of the Cost	١	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	swing-bed and	19, 417	9. 00		
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	room days)	0	10.00		
	through December 31 of the cost reporting period (see instruc		oom dayo,				
11. 00		3 (	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		o room dove)	o	12.00		
12.00	through December 31 of the cost reporting period	A only (frictualing privat	.e 100iii uays)	١	12.00		
13.00		X only (including privat	e room days)	0	13.00		
	after December 31 of the cost reporting period (if calendar y						
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00		
10.00	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.00		
10 00	reporting period	oo often December 21 of	+bs sss+	0.00	10.00		
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es al tel December 31 01	the cost	0.00	18. 00		
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19.00		
20.00	reporting period	<del></del>		0.00	20.00		
20.00	00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 reporting period						
21. 00							
22. 00	00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0						
23 00	5 x line 17)   Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line A	o	23.00		
20.00	x line 18)	or or the cost reportin	ig period (iiiie d		20.00		
24. 00		r 31 of the cost reporti	ng period (line	0	24.00		
25. 00	7 x line 19)   Swing-bed cost applicable to NF type services after December	21 of the cost reporting	noried (line 0	o	25. 00		
25.00	x line 20)	31 of the cost reporting	perrou (Tine 8	١	25.00		
26. 00	Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		57, 949, 643	27.00		
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arnes)	0	28. 00		
29. 00		a and observation bea er	iai ges)	0			
30.00	Semi -pri vate 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				0.00			
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0. 00 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	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	57, 949, 643	37.00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 175. 00			
39.00		•		22, 814, 975			
40.00	Medically necessary private room cost applicable to the Programal Total Program general inpatient routine service cost (line 39)			0 22, 814, 975	40.00		
11.00	1.013 Sgram general impact out foutine service cost (fille 37		ļ	22,017,770	1 11.00		

	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0048	Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
			Title	XVIII	Hospi tal	PPS	, alli
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 0	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	10, 921, 535	6, 349	1, 720. 2	20 2, 778	4, 778, 716	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)			47.00			
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	3 line 200)			1. 00 37, 997, 784	48.00
	Total Program inpatient costs (sum of lines			ons)		65, 591, 475	
-0.00	PASS THROUGH COST ADJUSTMENTS		(£	- WI+ D	D+-	2 204 /77	1 50 00
50. 00	Pass through costs applicable to Program inpulli)	attent routine	services (Tro	π wkst. D, Su	m or Parts I and	2, 394, 677	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	2, 438, 462	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				A 022 120	52.00
52.00	Total Program excludable cost (sum of lines :		elated, non-ph	ysician anest	hetist, and	4, 833, 139 60, 758, 336	
	medical education costs (line 49 minus line	9 1	,		,		
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0. 00	
56. 00	0 Target amount (line 54 x line 55)						56. 00 57. 00
57. 00 58. 00	O Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) O Bonus payment (see instructions)						
59.00							
	market basket						(0.0
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					0.00	1
	which operating costs (line 53) are less than	n expected cost				-	
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payment	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST  ON Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 0)						
64. 00	instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.00
44 00	instructions)(title XVIII only)	no costs (lino	44 plus lino	4E) (+; +  o V\/	II only) For	0	66.00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (Title	64 prus rine	bb)(title xvi	ii oniy). Foi	U	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 31	of the cost r	eporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after [	ecember 31 of	the cost ren	orting period	0	68. 0
50. 00	(line 13 x line 20)			1110 0031 100	or tring period	١	00.0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				)		70.0
71. 00	Adjusted general inpatient routine service c	ost per diem (I			,		71.0
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	n (line 14 v l	ine 35)			72.0
74. 00	Total Program general inpatient routine serv						74.0
75. 00	Capital-related cost allocated to inpatient	•			Part II, column	ļ	75. 0
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
	Program capital-related costs (line 9 x line					ļ	77.0
78.00	Inpatient routine service cost (line 74 minus		arovi don mass:	de)			78. 00 79. 00
79. 00 80. 00							80.0
81. 00	Inpatient routine service cost per diem limi	tati on			<i>'</i>	ļ	81.0
32. 00 33. 00	Inpatient routine service cost limitation (I		* .			ļ	82. 0 83. 0
34. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		13)			ļ	84.0
85.00	Utilization review - physician compensation	(see instruction				ļ	85.0
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)				86.0
						5, 186	87. 0
37. 00	Total observation bed days (see instructions)	)				5, 100	107.0

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: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		
		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, 654, 124	57, 949, 643	0. 08031	3 6, 093, 550	489, 391	90.00
91.00 Nursing School cost	0	57, 949, 643	0.00000	0 6, 093, 550	0	91.00
92.00 Allied health cost	0	57, 949, 643	0.00000	6, 093, 550	0	92.00
93.00 All other Medical Education	0	57, 949, 643	0. 00000	6, 093, 550	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-S048		
	Title XVIII	Subprovi der -	PPS
		IDF	

		In the XVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			8, 484	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		vata room days	8, 484 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pir	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		8, 484	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through December	31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December 3	11 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) ar ter becember e	The cost	G	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	in days, area becomes or	or the cost	G	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	4, 421	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		om days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therdaing private	( Toolii days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter O on this line am (excluding swing-bed d	e)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed d	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	the cost	0.00	17. 00
17.00	reporting period	es till ough becember 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o trii dagir becember or or	the dost	0.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to service reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Teportring perrou  Total general inpatient routine service cost (see instruction	s)		7, 076, 098	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ng period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	noried (line A	0	23. 00
23.00	x line 18)	31 of the cost reporting	perrou (ime u	O	23.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reportin	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or or the cost reporting	perrou (rine o	0	20.00
26.00	Total swing-bed cost (see instructions)	(1) 21 1: 2()		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		7, 076, 098	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed cha	irges)	0	28. 00
29. 00	Private 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)	. Title 20)		0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruct	i ons)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	ferential (line	7, 076, 098	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			834. 05	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		3, 687, 335	39. 00
40.00	Medically necessary private room cost applicable to the Progr			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ II ne 40)		3, 687, 335	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL		CES CN: 15-0048	In Lie	u of Form CMS-2 Worksheet D-1	2552-10
				CCN: 15-S048	From 01/01/2020 To 12/31/2020	Date/Time Pre	
-			Title	e XVIII	Subprovi der -	7/8/2021 10: 3 PPS	<u>/ am</u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	9	Program Cost (col. 3 x col. 4)	
40.00	NUIDCERV (11 11 - V o VIV - 1 )	1. 00	2. 00	3.00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0. (	00 0	0	42.00
44. 00 45. 00 46. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	0	C	0. (	00 0	0	43. 00 44. 00 45. 00 46. 00 47. 00
	<u> </u>					1. 00	
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		909, 326 4, 596, 661	
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa  III)	atient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	391, 966	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	56, 341	51.00
	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclude medical education costs (line 49 minus line!	ding capital re	elated, non-ph	ysician anest	hetist, and	448, 307 4, 148, 354	52. 00 53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	
56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	56.00
58. 00	Difference between adjusted inpatient operations Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reparket basket	· ·			,	0 0.00	57. 00 58. 00 59. 00
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60	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 Relief payment (see instructions)	ŕ	roti ono)			0	
	Allowable Inpatient cost plus incentive paymore PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost			e cost report	ing period (See	0	
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	· ·		•		0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	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 routing	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
71. 00 72. 00 73. 00 74. 00	Skilled nursing facility/other nursing facility/other nursing facility Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application of Program general inpatient routine services)	ost per diem (I 71) able to Program	ine 70 ÷ line n (line 14 x l	2) ine 35)	)		70. 00 71. 00 72. 00 73. 00 74. 00
	Capital-related cost allocated to inpatient (26, line 45) Per diem capital-related costs (line 75 ÷ li)		costs (from	Worksheet B,	Part II, column		75. 00 76. 00
78. 00 79. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for compatination routine service cost per diem limitingatient routine service cost limitation (line Reasonable inpatient routine service costs (see Section 2015).	s line 77) s costs (from p arison to the c tation ine 9 x line 81	ost limitatio	*.	nus line 79)		77. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00
85. 00 86. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	structions) (see instructio of lines 83 th S THROUGH COST	ns)				84. 00 85. 00 86. 00
88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	diem (line 27 ÷	,				87. 00 88. 00 89. 00

Health Financial Systems REI	D HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-S048	From 01/01/2020 To 12/31/2020		nared:
		Component	3010. 13 3040	10 12/31/2020	7/8/2021 10: 3	
		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	1 COST					
90.00 Capi tal -related cost	752, 151	7, 076, 098	0. 10629	0 0	0	90.00
91.00 Nursing School cost	0	7, 076, 098	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 076, 098	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 076, 098	0. 00000	0 0	l 0 <sup>1</sup>	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 01/01/2020	Worksheet D-1
	Component CCN: 15	5-T048 To 12/31/2020	Date/Time Prepared: 7/8/2021 10:37 am
	Title XVIII	Subprovi der -	PPS

		In the XVIII	I RF	FF3	
	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			5, 384	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		vate room days	5, 384 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pri	vate room days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			5, 384	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through December	31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om dayo, artor bosombor c		· ·	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December 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	swing-bed and	2, 934	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		om days)	G	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	X only (Therading private	, room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this line am (excluding swing-bed o	e) lave)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exer daring swring bed to	lays)	0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
17.00	reporting period	es through becember 51 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	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	G		0.00	
20. 00	Medicald rate for swing-bed NF services applicable to service reporting period	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		4, 188, 399	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reporti	ng 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 reporting	neriod (line A	0	23. 00
20.00	x line 18)	or or the cost reporting	, perred (Trile o	0	20.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reportir	ng period (line	0	24.00
25. 00	X   Time   197   Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	J			
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Lino 21 minus Lino 26)		0 4, 188, 399	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trie 21 iii lius Triie 20)		4, 100, 377	27.00
	General inpatient routine service charges (excluding swing-be	d and observation bed cha	nrges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0. 00	
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		i ons)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	and materials are seen as the		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost dif	Terential (line	4, 188, 399	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			777. 93	
39.00	Program general inpatient routine service cost (line 9 x line			2, 282, 447	
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 2, 282, 447	40. 00 41. 00
00	1.2.2 Solving golds at Theatront Toutino Solving Godt (Tille G)		1	2,202,147	00

Health Financial Systems REID  COMPUTATION OF INPATIENT OPERATING COST	HOSPITAL & HEAI	LTH CARE SERVI Provider C		In Lie Period:	u of Form CMS-2 Worksheet D-1	
		Component	CCN: 15-T048	From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title	e XVIII	Subprovi der -	7/8/2021 10: 3 PPS	<u>/ am</u>
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42 00 NIIDSEDV (+i+Lo 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	, O. 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	0	0. (	00 0	0	43.00 44.00 45.00 46.00 47.00
· ·					1. 00	
48.00 Program inpatient ancillary service cost (Wks 49.00 Total Program inpatient costs (sum of lines 4			ons)		2, 096, 364 4, 378, 811	1
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpa	atient routine	servi ces (fro	m Wkst. D, su	um of Parts I and	320, 804	50.00
51.00 Pass through costs applicable to Program inpaland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	185, 864	51.00
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost excluded medical education costs (line 49 minus line 54 TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	elated, non-ph	ysician anest	hetist, and	506, 668 3, 872, 143	
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	S			,	0 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 payment	ŕ	ıcti 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 routin 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	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)				oorting period	0	
69.00 Total title V or XIX swing-bed NF inpatient in 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 applications)	ost per diem (I 71) able to Program	ine 70 ÷ line n (line 14 x l	2) ine 35)	")		70.00 71.00 72.00 73.00
74.00 Total Program general inpatient routine servi 75.00 Capital-related cost allocated to inpatient r 26, line 45)	routine service			Part II, column		74. 00 75. 00
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) s line 77)		1.5			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	arison to the c tation ine 9 x line 81	cost limitatio	*.	nus line 79)		79.00 80.00 81.00 82.00 83.00
84.00 Program inpatient ancillary services (see ins 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					84. 00 85. 00 86. 00
87.00   Total observation bed days (see instructions) 88.00   Adjusted general inpatient routine cost per of 89.00   Observation bed cost (line 87 x line 88) (see	diem (line 27 ÷					87. 00 88. 00 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 01/01/2020 To 12/31/2020		pared: 7 am
		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	588, 664	4, 188, 399	0. 14054	6 0	0	90.00
91.00 Nursing School cost	0	4, 188, 399	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 188, 399	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 188, 399	0. 00000	0 0	0	93. 00

Health Financial Systems	REID HOSPITAL & HEALTH	CARE SERVICES	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0048	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XIX	Hospi tal	7/8/2021 10: 3 Cost	7 am
Cost Center Description					
'				1. 00	

		Title XIX	Hospi tal	7/8/2021 10: 3 Cost	/ alli
	Cost Center Description	THE SALA	110001 (41		
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		49, 319	1.00
2.00	Inpatient days (including private room days, excluding swing-			49, 319	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
4 00	do not complete this line.	ad daya)		44, 133	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost		4. 00 5. 00
0.00	reporting period	om dayo, tim odgi. Dodomoc			0.00
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) +brayab Dagambar	21 of the cost	0	7. 00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	iii days) thi ough beceiliber	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 newborn days) (see instructions)	o the Program (excluding	swing-bed and	1, 135	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	3 (	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		o room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (Therduring privat	.e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 1, 700	14. 00 15. 00
	Nursery days (title V or XIX only)			44	16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
.0.00	reporting period		5551	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	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 t	he cost	0.00	20.00
20.00	reporting period			0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			57, 876, 651	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23. 00
	x line 18)	·			
24. 00	] 3 11 31	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or or the dest reperting	, po. 1 ou (11110 o		20.00
26.00	, , , , , , , , , , , , , , , , , , , ,	(1)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		57, 876, 651	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)		3 ,	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	, ,	·	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	rrerential (line	57, 876, 651	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see	,		1, 173. 52	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		1, 331, 945 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			1, 331, 945	
		-	!		•

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0048	Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
			Ti +l	e XIX	Hospi tal	7/8/2021 10: 3 Cost	7 alli
	Cost Center Description	Total	Total	Average Per		Program Cost	
	<b>'</b>	Inpatient	I npati ent	Diem (col.		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
2 00	NURSERY (title V & XIX only)	1. 00 1, 368, 982	2. 00 1, 700	3. 00 805. 1	4. 00	5. 00	42
2. 00	Intensive Care Type Inpatient Hospital Units	1, 308, 982	1, 700	805.	28 44	35, 432	42.
3. 00	INTENSIVE CARE UNIT	10, 921, 535	6, 349	1, 720. 2	20 164	282, 113	43.
1. 00	CORONARY CARE UNIT	, , , , , , , , , , , , , , , , , , , ,		,		,	44.
5. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.
	cost center bescription					1. 00	
3. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			2, 172, 372	48.
9. 00		41 through 48)(	(see instructi	ons)		3, 821, 862	49.
	PASS THROUGH COST ADJUSTMENTS	-41441		- Wi+ D	£ Dt- 1		-
. 00	Pass through costs applicable to Program inp.	atient routine	services (Tro	m WKSt. D, St	im or Parts I and	0	50.
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.
	and IV)		`				
2. 00	Total Program excludable cost (sum of lines					0	
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anest	hetist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	54.
. 00	Target amount per discharge					0. 00	55
. 00	Target amount (line 54 x line 55)				>	0	
. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	s line 53)	0	1 .
. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1996	undated and c	compounded by the	0.00	
. 00	market basket	por tring period	ending 1990,	upuateu anu c	ompounded by the	0.00	37
. 00	Lesser of lines 53/54 or 55 from prior year					0. 00	
. 00	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% c	of the target		
2. 00	Relief payment (see instructions)	instructions)				0	62.
	Allowable Inpatient cost plus incentive payment	ent (see instru	ıcti ons)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ing period (See	0	64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Necemb	oer 31 of the	cost reportir	na neriod (See	0	65.
. 00	instructions)(title XVIII only)	ts arter becenik	bei 31 of the	cost reportir	ig perrou (see	O	03
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66
	CAH (see instructions)		D 1 01	6			
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [	December 31 of	the cost ren	orting period	0	68.
	(line 13 x line 20)						
9. 00	Total title V or XIX swing-bed NF inpatient		·			0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU		•		1)		1 70
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	•		•			70.
. 00	Program routine service cost (line 9 x line		7110 70 . TTHE	2)			72
. 00	Medically necessary private room cost application	abĺe to Program	n (line 14 x l	ine 35)			73.
. 00	Total Program general inpatient routine serv			•	5		74.
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	worksheet B,	Part II, column		75.
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
. 00	Program capital-related costs (line 9 x line	,					77
. 00	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess			,			79
. 00	Total Program routine service costs for compa		cost limitatio	n (line 78 mi	nus line 79)		80
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81.
3. 00	Reasonable inpatient routine service costs (		* .				83
. 00	Program inpatient ancillary services (see in						84
~~	Utilization review - physician compensation	/	`				85

85. 00 86. 00

87.00

5, 186

1, 173. 52 88. 00 6, 085, 875 89. 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

Total observation bed days (see instructions)

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)

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: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
		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 THROUGH	COST					
90.00 Capital-related cost	4, 654, 124	57, 876, 651	0. 08041	5 6, 085, 875	489, 396	90.00
91.00 Nursing School cost	0	57, 876, 651	0.00000	0 6, 085, 875	0	91.00
92.00 Allied health cost	0	57, 876, 651	0.00000	0 6, 085, 875	0	92.00
93.00 All other Medical Education	0	57, 876, 651	0. 00000	0 6, 085, 875	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 01/01/2020	Worksheet D-1
	Component CCN: 15-S048		
	Ti tle XIX	Subprovi der -	Cost

			I PF		
	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,			8, 484	1.00
2.00	Inpatient days (including private room days, excluding swing-be		ivete meem deve	8, 484	2.00
3. 00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). It you have only pr	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed	d days)		8, 484	4.00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5.00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period	<i>3</i> ,			
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eveluding	swing had and	366	9. 00
7.00	newborn days) (see instructions)	the Frogram (excruding	swifig-bed and	300	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		oom days) after	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XLX $$			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year	•	′	0	14.00
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	uays)		15.00
	Nursery days (title V or XIX only)			44	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
20.00	reporting period	arter becomber or or t	110 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)			7, 076, 098	1
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	31 of the cost report	ing period (line	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportin	a period (line 6	0	23. 00
	x line 18)		]	_	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	of the cost reporting	perrod (Trile o	O	25.00
	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		7, 076, 098	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed	and observation hed ch	arges)	0	28.00
	Private room charges (excluding swing-bed charges)	and observation bed on	lai ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 $\div$	line 28)		0.000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	io line 22) (occ instrue	ti ana)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 minu		LI ONS)	0.00	ı
36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	5 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost ar	nd private room cost di	fferential (line	-	•
300	27 minus line 36)				]
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		T. T	004.05	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			834. 05 305, 262	ı
	Medically necessary private room cost applicable to the Program	•		305, 202	ı
	Total Program general inpatient routine service cost (line 39	,		305, 262	ı
			·		

	Financial Systems REID TATION OF INPATIENT OPERATING COST	HOSPITAL & HEAI	LTH CARE SERVI Provider C	CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component				me Prepared: 21 10:37 am	
			Title XIX Subprovider -				7 diii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.0	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						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)		0 305, 262	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	of Parts I and	0	50.00
51. 00		atient ancillar	rv services (f	rom Wkst. D. s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines		,			0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	elated, non-ph	ysician anesth	etist, and	0	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	56.00 57.00
58.00	Bonus payment (see instructions)	· ·			ŕ	0.00	58. 00
59. 00	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	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 (lines 54 x 60), or 1% of the target							61.00
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	1
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							64. 00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See						0	65.00
66. 00							66. 00
67. 00	CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period						67. 00
68. 00							68. 00
69. 00	(line 13 x line 20) 99.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ine 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Program	•	,			73. 00
74. 00 75. 00	O Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column						74.00 75.00
76.00							76.00
78.00	77.00   Program capital-related costs (line 9 x line 76) 18.00   Inpatient routine service cost (line 74 minus line 77)						77. 00 78. 00
79. 00 80. 00							79. 00 80. 00
81.00							81.00
82. 00 83. 00							82. 00 83. 00
84.00	84.00 Program inpatient ancillary services (see instructions)						84.00
85. 00 86. 00							85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		· line 2)			0 0. 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se					0	89. 00

Health Financial Systems REII	LTH CARE SERVI	CES	In Lieu of Form CMS-2		2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0048		Peri od:	Worksheet D-1	
		Component (		From 01/01/2020 To 12/31/2020		pared:
					7/8/2021 10: 3	
		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	752, 151	7, 076, 098	0. 10629	0 0	0	90.00
91.00 Nursing School cost	0	7, 076, 098	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 076, 098	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 076, 098	0. 00000	0 0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0048	Peri od: From 01/01/2020	Worksheet D-1	
	Component CCN: 15-T048			
	Title XIX	Subprovi der -	Cost	
		IDE		

Rent Lat. Reproto Excourage Description    Rent Lat. Reproto Excourage Description			II ti e xi x	I RF	COST	
NeXT IT - ALL PROVIDER COMPONENTS   NeXT ITEM TO		Cost Center Description			1.00	
INPATIENT DAYS		PART I - ALL PROVINER COMPONENTS			1.00	
Inpatient days (Including private room days, excluding swing-bed and newborn days)   1,300   2,000   3,000						
A continued of the complete this line.  5 private room days (excluding swing-bed and observation bed days). If you have only private room days. (excluding swing-bed and observation bed days) through December 31 of the cost of 5.00 for the cost swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of 5.00 for reporting period (if calendary eyer, enter 0 on this line)  1.00 for the swing-bed NF type inpatient days (including private room days) after December 31 of the cost of 5.00 for reporting period (if calendary eyer, enter 0 on this line)  1.01 for the swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary eyer, enter 0 on this line)  1.02 Swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary eyer, enter 0 on this line)  1.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and reporting period (if calendary eyer, enter 0 on this line)  1.04 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.04 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (if calendary eyer, enter 0 on this line)  1.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.05 Swing-bed NF type inpatient days applicable to the Program (excluding private room days)  2.05 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  2.06 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (in the Swing-bed SNF services applicable to services through December 31 of the cost reporting period (in the Swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 8 of the						
do not complete this line.  do not complete this line.  3.00 Seleph vivate room days (excluding swing-bed and observation bed days)  1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost rotal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting peri				ivata room days		
Semi-peri vate room days (excluding swing-bed API type inpatient days (including private room days) after December 31 of the cost of corporting period (if calendar year, enter 0 on this line)  7.00	3.00					3.00
reporting period (if calendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0	4.00	•	ed days)		5, 384	4. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if Cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   Program (excluding swing-bed and newborn days) (see instructions)   Program (excluding swing-bed and newborn days) (see instructions)   Program (excluding swing-bed and newborn days) (see instructions)   Program (excluding private room days)   Program (excluding swing-bed and newborn days) (see instructions)   Program (excluding private room days)   Program (excluding excluding	5. 00		om days) through Decembe	r 31 of the cost	0	5.00
reporting period (if Calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and enabore) days including private room days applicable to the Program (excluding swing-bed and oneshorn days) and in patient days including private room days) 11.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Saing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Saing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 SMND RED ADJISTMENT 18.00 Medical variety of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Medical variety of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Medical variety of the cost reporting period (if calendar year) 18.00 Medical variety of the cost reporting period (if year) 18.00 Medical variety of the cost reporting period (if year) 18.00 Medical variety of year year year year year year year year	6 00		om days) after December :	31 of the cost	0	6 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 14. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 16. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 17. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 18. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Medically necessary private room days applicable to services through December 31 of the cost room of the Cost reporting period (including private room days) 19. 00 Medical rore for swing-bed SNF services applicable to services through December 31 of the cost room of the Cost reporting period (including private room days) 19. 00 Medical drafe for swing-bed SNF services applicable to services through December 31 of the cost room of the Cost reporting period (including private room days) 19. 00 Medical drafe for swing-bed SNF services applicable to services through December 31 of the cost room of the Cost reporting period (line of SNF type services through December 31 of the cost reporting period (line of SNF type services through December 31 of the cost reporting period (line of SNF type services through December 31 of the	0.00		om days) arter becomber t	01 01 1110 0031		0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 December 31 of the cost reporting period (isce instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (isce instructions)  12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  16.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  17.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  18.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  18.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  18.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost  18.00 Swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medical rate for swing-bed SNF services applicable to services through December 31 of the cost  18.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  18.00 Swing-bed Cost applicable to SNF type services through December 31 of the cost reporting period (lin	7. 00		m days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SN Type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) and through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Education of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 17.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Interest of the cost of the cost reporting period (if calendar year,	8 00	1 91	m davs) after December 3	1 of the cost	0	8 00
newborn days) (see Instructions)   0   10   0   10   10   10   10   10	0.00		iii days) arter becember o	1 01 1110 0031		0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (See instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendary year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 3.00 after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 1 4.00 1 5.00 Total nursery days (title V or XIX only) 1 5.00 Total nursery days (title V or XIX only) 1 5.00 Total nursery days (title V or XIX only) 1 5.00 Nursery days (title V or XIX on	9. 00	. , , , , , , , , , , , , , , , , , , ,	o the Program (excluding	swi ng-bed and	0	9. 00
through December 31 of the cost reporting period (see Instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical ly necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicader are for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medicader are for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line S x line 17)  20.01 Total general inpatient routine service cost (see Instructions)  21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 18)  22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 19)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S x line 19)  24.00 General	10 00		nly (including private r	nom days)	0	10 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   20.00	10.00			Join days)	١	10.00
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through December 31 of the cost reporting period  13.00 Swin-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Noursery days (title V or XIX only)  17.00 Mind BED ADJUSTMENT  17.00 Medicare rate For swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 17)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 19)  27.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x line 19)  28.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 3)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost repo	12 00			a room days)		12 00
after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  1. 00 Molically necessary private room days applicable to the Program (excluding swing-bed days)  1. 700 Total nursery days (title V or XIX only)  2. 00 Norsery days (title V or XIX only)  3. 00 Norsery days (title V or XIX only)  4. 00 Norsery days (title V or XIX only)  4. 00 Norsery days (title V or XIX only)  4. 00 Norsery days (title V or XIX only)  4. 00 Norsery days (title V or XIX only)  4. 10 Norsery days (title V or XIX only)  5. 10 Norsery days (title V or XIX only)  5. 10 Norsery days (title V or XIX only)  6. 10 Norsery days (title V or XIX only)  6. 10 Norsery days (title V or XIX only)  7. 10 Norsery days (title V or XIX only)  7. 10 Norsery days (title V or XIX only)  8. 10 Norsery days (title V or XIX only)  8. 10 Norsery days (title V or XIX only)  8. 10 Norsery days (title Vor XIX only)  8. 10 Norsery days (title Vor XIX only)  8. 10 Norsery days (title V or XIX only)  9. 10 Norsery days (title Vor XIX only)  9. 10	12.00		X only (Therading private	e room days)		12.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
15.00 Total nursery days (title V or XIX only)  15.00 Total nursery days (title V or XIX only)  17.00 Total swing BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Total general inpatient routine service cost (see instructions)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 20)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 20)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  20.00 Swing-bed cost (see instructions)  20.00 Swing-bed cost (see instructions)  20.00 Total swing-bed cost (see instructions)  20.00 Tot	14 00	after December 31 of the cost reporting period (if calendar y	ear, enter O on this line	e)		14 00
16.00 Nursery days (title V or XIX only)  Wind BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting reporting reporting reporting period reporting repor			am (excruding swriig-bed to	uays)		
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18. 00   18. 00   18. 00   19.	16. 00	Nursery days (title V or XIX only)				
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 period reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 period reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29. 00 Privater room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost period (line 27 * line 28)  31. 00 General inpatient routine service cost period (line 27 * line 28)  32. 00 Average semi-private room per diem charge (line 30 * line 4)  33. 00 Average per diem private room charge (line 30 * line 4)  34. 00 Average per diem private room charge (line 30 * line 31)  35. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  37. 00 Foreit in patient routine service cost net of swing-bed cost and private room cost differential (line 4 x line 31)  38. 00 Average per diem private room cost differential (line 32 minus line 33)  39. 00 Average per diem private room cost differential (line 32 minus line	17 00		as through December 21 as	f the cost	0.00	17 00
Medicare atte for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   19.	17.00		es inrough becember 31 o	the cost	0.00	17.00
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 4, 188, 399 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 188, 399 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000 Swing-private room charges (excluding swing-bed charges) 0.29.00 Swing-private room charges (excluding swing-bed charges) 0.20.00 Swing-private room per diem charge (line 29 + line 3) 0.00 Average per vate room per diem charge (line 29 + line 3) 0.00 Swing-private room cost differential (line 28 minus line 33) (see instructions) 0.00 32.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Private room cost differential adjustment (line 3 x line 35) 0.00 Private room cost differential adjustment (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per	18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
reporting period  Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.00  Total general inpatient routine service cost (see instructions)  2.00  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  3.00  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  4.100  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed charges)  0.20  29.00  Private room charges (excluding swing-bed charges)  0.20  20.00  Average private room per diem charge (line 29 + line 3)  20.00  Average private room per diem charge (line 29 + line 3)  20.00  Average per diem private room cost differential (line 3 x line 31)  20.00  Average per diem private room cost differential (line 3 x line 35)  37.00  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	10 00		s through Docombor 21 of	the cost	0.00	10 00
reporting period  1. 00 Total general inpatient routine service cost (see instructions)  21. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  20. 00 Semi-private room charges (excluding swing-bed charges)  20. 00 Semi-private room charges (excluding swing-bed charges)  20. 00 Average private room per diem charge (line 29 + line 3)  21. 00 Average per diem private room per diem charge (line 30 + line 4)  22. 00 Average per diem private room cost differential (line 34 x line 31)  23. 00 Average per diem private room cost differential (line 34 x line 31)  24. 00 Average per diem private room cost differential (line 34 x line 31)  25. 00 Average per diem private room cost differential (line 3 x line 35)  27. 00 Average per diem private room cost differential (line 3 x line 35)  28. 00 Average per diem private room cost differential (line 3 x line 35)  29. 00 Average per diem private room cost differential (line 3 x line 35)  20. 00 Average per diem private room cost differential (line 3 x line 35)  29. 00 Average per diem private room cost differential (line 3 x line 35)  20. 00 Average per diem private room cost differential (line 3 x line 35)  20. 00 Average per diem private	19.00		s through becember 31 of	the cost	0.00	19.00
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x line 18)  24.00  X line 20)  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Converse of the cost reporting period (line 8 o 24.00 25.00 cost line 29 in 25.00 o 25.00 cost line 29 in 25.00 o 26.00 o 27 minus line 36)  Private room cost differential adjustment (line 3 x line 31)  Converse of the cost reporting period (line 26 o 26.00 o 26.00 o 26.00 o 27 minus line 36)  Private room cost differential adjustment (line 3 x line 35)  Converse of the cost reporting period (line 26 o 26.00 o 26.00 o 27 minus line 36)  Private room cost differential adjustment (line 3 x line 35)  Converse of the cost reporting period (line 26 o 26.00 o 26.00 o 26.00 o 26.00 o 27 minus line 36)  Private room cost differential o 26.00 o 26.00 o 27 minus line 36)  Private room cost differential of swing-bed cost and private room cost differential (line 4, 188, 399 o 36.00 o 27 minus line 36)	22.00		21 -6			22.00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	23.00		31 of the cost reporting	g period (iine o	٥	23.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.00 Semi-private room charges (excluding swing-bed charges)  9.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  9.00 Average private room per diem charge (line 29 ÷ line 3)  9.00 Average semi-private room per diem charge (line 30 ÷ line 4)  9.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  9.00 Average line private room cost differential (line 3 x line 35)  9.00 Average line private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  9.00 Average line private room cost differential (line 3 x line 35)  9.00 Average line private room cost differential (line 4, 188, 399)  9.00 Average line private room cost differential (line 3 x line 35)  9.00 Average line private room cost differential (line 4, 188, 399)  9.00 Average line private room cost differential (line 4, 188, 399)  9.00 Average line private room cost differential (line 4, 188, 399)	24.00		r 31 of the cost reportio	ng period (line	0	24.00
x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 188, 399  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00  General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00  Average private room per diem charge (line 29 ÷ line 3) 0.00 33.00  Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 33.00  Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00  Average per diem private room cost differential (line 34 x line 31) 0.00 35.00  Private room cost differential adjustment (line 3 x line 35) 0 36.00  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  PRAT II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	25 00		31 of the cost reporting	neriod (line 8		25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  32. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  32. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  33. 00 Average per diem private room cost differential (line 34 x line 31)  34. 00 Average per diem private room cost differential (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	25.00		or the cost reporting	perrod (Trie o	١	23.00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average pri vate room per diem charge (line 29 + line 3)  30.00 Average semi-pri vate room per diem charge (line 30 + line 4)  30.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem pri vate room cost differential (line 34 x line 31)  30.00 Average per diem pri vate room cost differential (line 34 x line 31)  30.00 Average per diem pri vate room cost differential (line 3 x line 35)  30.00 Average per diem pri vate room cost differential (line 3 x line 35)  30.00 Average per diem pri vate room cost differential (line 3 x line 35)  30.00 Average per diem pri vate room cost differential (line 3 x line 35)  30.00 Average per diem pri vate room cost differential (line 3 x line 35)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)  30.00 Average per diem pri vate room cost differential (line 4, 188, 399)		· · · · · · · · · · · · · · · · · · ·	(1)			
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  28.00 29.00  30.00  30.00  30.00  31.00  32.00  34.00  35.00  36.00  37.00  38.00  39.00  30.00  3	27.00		(Tine 21 minus Tine 26)		4, 188, 399	27.00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	28. 00		d and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			÷ line 28)			
33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			- 111le 20)			
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			nus line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 188, 399 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		, ,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	37. 00					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
			USTMENTS			
	38. 00				777. 93	38. 00
39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00						
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   0   41.00	41.00	liotal Program general inpatient routine service cost (line 39	+ IIne 40)		0)	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEA	LTH CARE SERVI Provider C	CN: 15-0048	Peri od:	u of Form CMS-: Worksheet D-1	
		Component CCN: 15-T048		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3		
		Title XIX Subprovider -				Cost	, diii
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00 0	42.00
	Intensive Care Type Inpatient Hospital Units			0.00		0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0.0	0	U	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nns)		0	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	, , , , , , , , , , , , , , , , , , ,		,	of Parts I and		
	Hass through costs applicable to Program inp		•	•			
51. 00	and IV)		y services (i	TOIII WKSt. D, S	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	•	, 			-
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	
60.00	market basket	cost report ur	ndated by the	markat haskat		0.00	60.00
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							61.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							
62.00	Relief payment (see instructions)	ont (soo instri	ictions)			0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swips bed SNE inpatient requires costs through December 31 of the cost reporting period (See							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportino	period (See	0	65. 00
66. 00							66. 00
67. 00	67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period						67. 00
68. 00							68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69. 00
70.00							
71. 00 72. 00							71. 00 72. 00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73. 00
74. 00 75. 00							74. 00 75. 00
76. 00	26, line 45) 5.00 Per diem capital-related costs (line 75 ÷ line 2)						76. 00
77. 00 78. 00	77.00 Program capital-related costs (line 9 x line 76)						77. 00 78. 00
79. 00	.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79. 00
80. 00 81. 00							80. 00 81. 00
82.00	22.00 Inpatient routine service cost limitation (line 9 x line 81)						82. 00
83. 00 84. 00	83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)						83. 00 84. 00
85.00 Utilization review - physician compensation (see instructions)							85. 00
86. 00	86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						86.00
	87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se						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 01/01/2020 To 12/31/2020		
		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	588, 664	4, 188, 399	0. 14054	6 0	0	90.00
91.00 Nursing School cost	0	4, 188, 399	0.00000	0	0	91.00
92.00 Allied health cost	0	4, 188, 399	0.00000	0	0	92.00
93.00 All other Medical Education	0	4, 188, 399	0. 00000	0 0	0	93. 00

	Financial Systems REID HOSPITAL & HEALTH				u of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2020 To 12/31/2020		narod:
				10 12/31/2020	7/8/2021 10: 3	
		Title	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	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 & PEDI ATRI CS			28, 012, 538		30.00
31.00	03100 I NTENSI VE CARE UNI T			5, 245, 117		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
FO 00	ANCILLARY SERVICE COST CENTERS		0.2140/	1 27 2/2 07/	F 000 1//	FO 00
50.00	05000 OPERATING ROOM		0. 21496			
52. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5400   RADI OLOGY-DI AGNOSTI C		0. 22547	· ·	· ·	
59.00	05900   CARDI AC   CATHETERI ZATI ON		0. 17368 0. 12647			
60.00	06000 LABORATORY		0. 12647			
65. 00	06500 RESPIRATORY THERAPY		0. 16376			
66.00	06600 PHYSI CAL THERAPY		0. 14830		1, 831, 280	
69. 00	06900 ELECTROCARDI OLOGY		0. 10491			
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 17982		1, 019	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 58977		- 1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 34352			
74.00	07400 RENAL DI ALYSI S		0. 89441		690, 366	
76. 00	03950 ANCI LLARY - OTHER		0.00000		0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		1. 06303		88	76. 97
	OUTPATIENT SERVICE COST CENTERS		•			
91.00	09100 EMERGENCY		0. 19236	5 14, 855, 787	2, 857, 733	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 56610	0 923, 763	522, 942	92.00
03 00	04040 EAMLLY DRACTICE		0 57093	1 15 227	9 602	02 00

0. 570834

1. 489414

14, 855, 787 923, 763 15, 227

156, 297, 756

156, 297, 756

8, 692

0 96.00 37, 997, 784 200.00

93.00

201. 00 202. 00

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)

	Financial Systems REID HOSPITAL & FENT ANCILLARY SERVICE COST APPORTIONMENT	IEALTH CARE SERVI Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
INIAII	ENT ANCIELANT SERVICE COST ATTORTIONWENT	Trovider C	CN. 13-0040	From 01/01/2020		,
		· ·	CCN: 15-S048	To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
		Titl∈	× XVIII	Subprovi der -	PPS	
	Cook Cooker December of		Ratio of Cos	I PF	1 +: +	
	Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
			10 Charges	Charges	(col. 1 x	
				charges	col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30.00	03000 ADULTS & PEDI ATRI CS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			4, 843, 161		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					4
50.00	05000 OPERATING ROOM		0. 2149		18, 655	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2254		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1736		60, 188	1
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1264		67	
60.00	06000 LABORATORY		0. 18578		131, 546	
65.00	06500 RESPI RATORY THERAPY		0. 1483	· ·	57, 646	
66. 00 69. 00	06600 PHYSI CAL THERAPY		0. 6532		180, 517	
70.00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY		0. 1049 0. 1798		2, 430 0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1798.		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 5897		0	1
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3435		-	
74. 00	07400 RENAL DIALYSIS		0. 8944		2, 907	
	03950 ANCI LLARY - OTHER		0.0000		0	1
76. 97	07697 CARDI AC REHABI LI TATI ON		1. 0630		Ö	
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0. 1923	65 444, 502	85, 507	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 56610	00	0	92.00
93.00	04040 FAMILY PRACTICE		0. 5708:	34 0	0	93.00
	OTHER REIMBURSABLE COST CENTERS					4
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		1. 4894		0	
200.00				3, 354, 352	909, 326	
201.00		narges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1	3, 354, 352		202.00

		HEALTH CARE SERVI			u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0048	Peri od: From 01/01/2020	Worksheet D-3	
		Component	CCN: 15-T048	To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
		Titl∈	XVIII	Subprovi der -	PPS	
				I RF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00				0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER - I RF			3, 214, 168		41.00
43. 00				0,211,100		43. 00
.0.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATING ROOM		0. 21496	85, 513	18, 382	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 22547	75 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 17368	115, 451	20, 052	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 12647	75 8, 370	1, 059	59.00
60.00	06000 LABORATORY		0. 18578			
65.00	06500 RESPI RATORY THERAPY		0. 14836			
66.00	06600 PHYSI CAL THERAPY		0. 65321		1, 657, 371	66.00
69. 00			0. 10491		755	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 17982		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
72.00			0. 58977		0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34352		246, 566	
74.00	07400 RENAL DI ALYSI S		0.8944		22, 092	
76. 00 76. 97	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON		0. 00000 1. 06303		0	
76. 97	OUTPATIENT SERVICE COST CENTERS		1.00303	34  0	U	76.97
91 00	09100 EMERGENCY		0. 19236	55 10, 661	2, 051	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 56610		2,031	1
93.00	· · · · · · · · · · · · · · · · · · ·		0. 57083		0	
	OTHER REIMBURSABLE COST CENTERS		2.27000			1
96. 00			1. 4894	14 0	0	96.00
200.00		8)		4, 248, 657	2, 096, 364	
201.00				0		201.00
202.00				4, 248, 657		202.00

Hool +h	Financial Systems REID HOSPITAL & HEALT	H CADE SEDVI	CES	In Lio	u of Form CMS-2	DEE2 10
	ENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	Worksheet D-3	
INFAII	ENT ANCILLARY SERVICE COST AFFORTIONWENT	Frovider C		From 01/01/2020		
				To 12/31/2020	Date/Time Pre	
		T: +1	e XIX	Hospi tal	7/8/2021 10: 3 Cost	/ am
	Cook Cooker Decordation	11 (1	Ratio of Cos			
	Cost Center Description			i i i i i i i i i i i i i i i i i i i	Inpati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			4.00	0.00	col . 2)	
	LANDATI ENT. DOUTLAND OFFINIA OF COOT OFFITEDO		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			1, 801, 202		30.00
	03100 INTENSIVE CARE UNIT			528, 301		31.00
	04000 SUBPROVI DER - I PF			510, 088		40.00
41.00	04100 SUBPROVI DER - I RF			85, 448		41.00
43.00	04300 NURSERY			274, 614		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 21496	1 1, 105, 604	237, 662	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 22547	5 436, 282	98, 371	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 17368	7 1, 369, 650	237, 890	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 12647	5 402, 624	50, 922	59.00
60.00	06000 LABORATORY		0. 18578	9 1, 476, 994	274, 409	60.00
65.00	06500 RESPI RATORY THERAPY		0. 14836	9 733, 512	108, 830	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 65321	8 204, 840	133, 805	66.00
	06900 ELECTROCARDI OLOGY		0. 10491	· ·	•	
	07000 ELECTROENCEPHALOGRAPHY		0. 17982		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	

0.343525

0.894410

0.000000

1.063034

0. 192365

0.566100

0. 570834

1. 489414

236, 195

31, 200

939, 000

9, 057, 145

9, 057, 145

25

1, 928, 177

139, 302 72. 00

0

0 76.97

14 93.00

0 96.00

2, 172, 372 200. 00

73.00

74.00

76.00

91.00

0 92.00

201. 00 202. 00

662, 377

180, 631

27, 906

72.00 07200 IMPL. DEV. CHARGED TO PATIENT

74. 00 07400 RENAL DIALYSIS

09100 EMERGENCY

93.00 04040 FAMILY PRACTICE

91.00

92.00

200.00

201.00

202.00

76. 00 | 03950 | ANCI LLARY - OTHER | 76. 97 | 07697 | CARDI AC | REHABI LI TATI ON

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS
96.00 OURABLE MEDICAL EQUIP-RENTED

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61)

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 Co		Peri od:	Worksheet D-3	
		Component	CCN: 15-S048	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
		Ti tl	e XIX	Subprovi der -	Cost	
	Cook Cooks Decoded to		Ratio of Cos	I PF		
	Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
			10 charges	Charges	(col. 1 x	
				orial ges	col . 2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			510, 622		40.00
41.00	04100 SUBPROVI DER - I RF			0		41.00
43.00	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 21496			
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 2254			
54. 00 59. 00	O5400   RADI OLOGY-DI AGNOSTI C   O5900   CARDI AC   CATHETERI ZATI ON		0. 17368 0. 1264		0	1
60.00	06000 LABORATORY		0. 1264		0	1
65.00	06500 RESPI RATORY THERAPY		0. 14836			
66. 00	06600 PHYSI CAL THERAPY		0. 6532		1	
	06900 ELECTROCARDI OLOGY		0. 1049			1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 17982			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000	00	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 5897	74 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 34352		0	
74.00	07400 RENAL DIALYSIS		0. 8944		0	
	03950 ANCI LLARY - OTHER		0. 00000			
76. 97	07697 CARDI AC REHABI LI TATI ON		1. 06303	34 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			, =l	1	
	09100 EMERGENCY		0. 1923			
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE		0. 56610 0. 57083			1
93.00	OTHER REIMBURSABLE COST CENTERS		0.5706	04	<u> </u>	93.00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED		1. 4894	14 0	1 0	96.00
200.00			1. 1074	0		200.00
201.00		s (line 61)		0		201.00
202.00				0		202.00
			'	,	1	

	FINANCILLARY SERVICE COST APPORTIONMENT  REID HOSPITAL & HEALT	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0048	From 01/01/2020	worksneet D-3	
		· ·	CCN: 15-T048	To 12/31/2020	Date/Time Pre 7/8/2021 10:3	pared: 7 am
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	_		
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31.00				0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
41.00	04100 SUBPROVI DER - I RF			85, 448 0		41. 00 43. 00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 2149	61 0	0	50.00
52. 00			0. 2254		0	52.00
54.00			0. 1736		0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 1264		0	59.00
60.00	06000 LABORATORY		0. 1857	89 0	0	60.00
65.00	06500 RESPI RATORY THERAPY		0. 1483	69 0	0	65.00
66.00	06600 PHYSI CAL THERAPY		0. 6532	18 0	0	66.00
69.00	06900 ELECTROCARDI OLOGY		0. 1049		0	69.00
70.00			0. 1798		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	71.00
			0. 5897		0	72.00
73.00			0. 3435		0	73.00
74.00	07400 RENAL DI ALYSI S		0. 8944		0	74.00
76. 00 76. 97	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON		0. 0000 1. 0630		0	76. 00 76. 97
76. 97	OUTPATIENT SERVICE COST CENTERS		1.0630	34  0	0	76.97
01 00	09100 EMERGENCY		0. 1923	65 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1923		0	92.00
93. 00	,		0. 5708		0	93.00
,5.00	OTHER REIMBURSABLE COST CENTERS		0.3700	J., J	0	75.00
96.00			1, 4894	14 0	0	96.00
200.00				0	-	200.00
201.00		s (line 61)		0		201.00
202.00				0		202.00

Health Financial Systems	REID HOSPITAL & HEALTH	CARE SERVICES	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0048	Peri od:	Worksheet E
			From 01/01/2020	
			To 12/31/2020	Date/Time Prepared:
				7/0/2021 10: 27 cm

			To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
		Title XVIII	Hospi tal	PPS	7 dili
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1. 00	DRG Amounts Other than Outlier Payments			0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	36, 167, 946	1. 01
4 00	instructions)		4. (	47 040 000	4 00
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	16, 349, 890	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f	or discharges occurring	prior to October	0	1. 03
	1 (see instructions)	3			
1. 04	DRG for federal specific operating payment for Model 4 BPCI f	for discharges occurring	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1	(see instructions)		502, 320	2. 03
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		86, 215	2. 04
3.00	Managed Care Simulated Payments			10, 955, 664	3.00
4.00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	208. 83	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	port od onding on	0.00	5. 00
5.00	or before 12/31/1996. (see instructions)	it recent cost reporting	perrod endring on	0.00	3.00
6.00	FTE count for allopathic and osteopathic programs that meet t	he criteria for an add-	on to the cap for	0.00	6. 00
7.00	new programs in accordance with 42 CFR 413.79(e)		(4) (1 ) (5) (4)		7 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.	42 CFR 9412. 105(1)(1)(1	V)(B)(2) IT the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa	thic and osteonathic pro	narams for	0. 00	8. 00
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	0.00
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap sl	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
0.00	report straddles July 1, 2011, see instructions.			0.00	0.00
8. 02	The amount of increase if the hospital was awarded FTE cap slunder § 5506 of ACA. (see instructions)	ots from a closed teach	ng nospitai	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	es (8, 8,01 and 8,02)	(see	0. 00	9. 00
	instructions)	(1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		2.22	
10.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your reco	nds	0. 00	10.00
	FTE count for residents in dental and podiatric programs.			0. 00	11. 00
	Current year allowable FTE (see instructions)				12.00
	Total allowable FTE count for the prior year.				13.00
14. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or atter Sep	otember 30, 1997,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital clo	sure			17.00
18.00	Adjusted rolling average FTE count			16. 75	18.00
	Current year resident to bed ratio (line 18 divided by line 4	.).		0. 080209	
	Prior year resident to bed ratio (see instructions)			0. 111622	
	Enter the lesser of lines 19 or 20 (see instructions)			0.080209	
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			2, 250, 389 469, 450	1
22.01	Indirect Medical Education Adjustment for the Add-on for § 42	2 of the MMA	l	407, 450	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resid		CFR 412. 105	0.00	23. 00
	(f)(1)(iv)(C).	•			
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	
25. 00	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see	0. 00	25. 00
24 00	instructions)			0.000000	24 00
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
	IME add-on adjustment amount (see instructions)			0.000000	28.00
	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, 250, 389	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		469, 450	29. 01
	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A p	atrent days (see instru	ctions)	5. 42	
	Percentage of Medicaid patient days (see instructions)				31.00
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	)		32. 65 16. 15	
	Disproportionate share adjustment (see instructions)	,		2, 120, 408	
	(222)		ļ	,, .00	

		CARE SERVICES Provider CCN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2020 To 12/31/2020	Part A Date/Time Pre 7/8/2021 10:3	pared: 7 am
		Title XVIII	Hospi tal	PPS	
				On/After 10/1	
	T		1. 00	2. 00	
	Uncompensated Care Adjustment		0.050.500.007	0.000.014.504	
35.00	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
35. 01	Factor 3 (see instructions)	s zoro on this line) (os	0. 000106761	0.000540925	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (se	ee 655, 168	1, 158, 162	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amou	int (see instructions)	490, 481	291, 921	35. 0
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		782, 402		36.00
, , , ,	Additional payment for high percentage of ESRD beneficiary dis	,	<del></del>		00.00
10.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68		0		40.00
	instructions)	•			
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33, 684 an 685. (see	0		41.00
	instructions)				
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-D	DRGs 652, 682, 683, 684	0		41.01
	an 685. (see instructions)				
12.00	Divide line 41 by line 40 (if less than 10%, you do not qualif		0.00		42.0
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	2, 683, 684 an 685. (see	0		43.00
4. 00	instructions) Ratio of average length of stay to one week (line 43 divided by	y line 41 divided by 7	0. 000000		44.0
14.00	days)	by Title 41 divided by 7	0.00000		44.00
45. 00	Average weekly cost for dialysis treatments (see instructions)	1	0. 00		45.00
46. 00	Total additional payment (line 45 times line 44 times line 41.		0		46.00
47. 00	Subtotal (see instructions)	,	58, 259, 570		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	70, 031, 474		48.00
	only. (see instructions)				
				Amount 1.00	
19. 00	Total payment for inpatient operating costs (see instructions)	1		70, 500, 924	49.00
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)		4, 246, 576	50.00
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
2. 00	Direct graduate medical education payment (from Wkst. E-4, lin	ne 49 see instructions).		486, 987	52.00
3.00	Nursing and Allied Health Managed Care payment			165, 142	
4.00	Special add-on payments for new technologies			180, 092	
4. 01	Islet isolation add-on payment			0	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69			0	55.00
6. 00 7. 00	Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II		hrough 25)	0	56. 00 57. 00
8. 00	Ancillary service other pass through costs from Wkst. D, Pt. I		ili ougii 33).	118, 831	
9. 00	Total (sum of amounts on lines 49 through 58)	v, coi. II IIIle 200)		75, 698, 552	
0.00	Primary payer payments			27, 983	
	Total amount payable for program beneficiaries (line 59 minus	line 60)		75, 670, 569	
1.00				5, 540, 744	
				160, 820	
2. 00	Coinsurance billed to program beneficiaries				
2. 00 3. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			1, 017, 709	64.0
2. 00 3. 00 4. 00 5. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			661, 511	65.0
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		661, 511 424, 062	65. 00 66. 00
62.00 63.00 64.00 65.00 66.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		661, 511 424, 062 70, 630, 516	65. 0 66. 0 67. 0
62.00 63.00 64.00 65.00 66.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (s		661, 511 424, 062 70, 630, 516	65. 0 66. 0 67. 0 68. 0

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

70.00

70.50

70.88

70.89

70.90 70.91

70. 93

0 70.95

0 70.87

0

0 70. 92

-57, 793 70. 94

-184, 922

70.87 70.88

70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

70.93 HVBP payment adjustment amount (see instructions)

70.94 | HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Demonstration payment adjustment amount before sequestration

70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

70.90 HSP bonus payment HVBP adjustment amount (see instructions)
70.91 HSP bonus payment HRR adjustment amount (see instructions)
70.92 Bundled Model 1 discount amount (see instructions)

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

Health Financial Systems REID HOSPITAL & HEALT	H CARE SERVI	CES	In Lieu	u of Form CMS-2	<u> 2552-1</u>
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Period: From 01/01/2020 To 12/31/2020		pared
	Ti +Lo	xVIII	Hocni tal	7/8/2021 10: 3 PPS	, / alli
	ı ııtıe		Hospi tal	Amount	
		FFT	(yyyy) 0	1. 00	$\vdash$
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column 0		0	1.00	70. 9
the corresponding federal year for the period prior to 10/1)	i ii coi aiiii c		Ĭ	Ü	, 0. ,
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter i	in column O		0	0	70.9
the corresponding federal year for the period ending on or a					
70.98 Low Volume Payment-3	,			0	70. 9
70.99 HAC adjustment amount (see instructions)				0	70. 9
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			70, 387, 801	71. C
71.01   Sequestration adjustment (see instructions)				464, 559	71.0
71.02 Demonstration payment adjustment amount after sequestration				0	
71.03   Sequestration adjustment-PARHM pass-throughs					71.0
72.00 Interim payments				69, 924, 439	
72.01   Interim payments-PARHM				_	72.0
73.00 Tentative settlement (for contractor use only)				0	
73.01 Tentative settlement-PARHM (for contractor use only)	00 70			4 407	73.0
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.0	02, 72, and			-1, 197	74.0
73) 74.01   Balance due provider/program-PARHM (see instructions)					74.0
75.00 Protested amounts (nonallowable cost report items) in accordance	ance with			0	1
CMS Pub. 15-2, chapter 1, §115.2	ance with			O	/ / 5. 0
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		l .			i
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.0
plus 2.04 (see instructions)					
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. (
92.00 Operating outlier reconciliation adjustment amount (see insti	ructions)			0	92. (
93.00  Capital outlier reconciliation adjustment amount (see instruc	ctions)			0	93.0
94.00 The rate used to calculate the time value of money (see inst	,			0. 00	
95.00 Time value of money for operating expenses (see instructions)	,			0	
96.00 Time value of money for capital related expenses (see instru	ctions)		D	0 (4.6) - 10.(1	96.0
			Prior to 10/1 1.00	2.00	1
HSP Bonus Payment Amount			1.00	2.00	
100.00 HSP bonus amount (see instructions)			0	0	100. c
HVBP Adjustment for HSP Bonus Payment					1
101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.0
102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0	0	102. (
HRR Adjustment for HSP Bonus Payment					
103.00 HRR adjustment factor (see instructions)			0.0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus payment (see instructions			0	0	104. 0
Rural Community Hospital Demonstration Project (§410A Demonst					
200.00 Is this the first year of the current 5-year demonstration po	eriod under	the 21st			200.0
Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement					-
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iii	ne 49)				201.
202.00 Medicare discharges (see instructions)	110 47)				202. (
203.00 Case-mix adjustment factor (see instructions)					203. (
Computation of Demonstration Target Amount Limitation (N/A ir	n first vear	of the currer	t 5-vear demons	tration	200.
period)	ii iii st yeur	or the curren	t o year demons	11 411 611	
204.00 Medicare target amount					204. (
205.00 Case-mix adjusted target amount (line 203 times line 204)					205.0
206.00 Medicare inpatient routine cost cap (line 202 times line 205)	)				206.0
Adjustment to Medicare Part A Inpatient Reimbursement					1
207.00 Program reimbursement under the §410A Demonstration (see ins	tructions)				207. (
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	, line 59)				208. (
09.00 Adjustment to Medicare IPPS payments (see instructions)					209. (
210.00 Reserved for future use					210. (
					211. (
	)				12 1 1 . (
Comparision of PPS versus Cost Reimbursement					
Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line					212. (
212.00 Total adjustment to Medicare Part A IPPS payments (from line 213.00 Low-volume adjustment (see instructions)	211)				212. ( 213. (
Comparision of PPS versus Cost Reimbursement 12.00 Total adjustment to Medicare Part A IPPS payments (from line	211)	mbursement)			212.

EALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
Provider CCN: 15-0048	Peri od: From 01/01/2020	
	Provider CCN: 15-0048	Provider CCN: 15-0048   Period:

7/8/2021 10:37 am Title XVIII Hospi tal PPS 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 14. 118 Medical and other services reimbursed under OPPS (see instructions) 46, 220, 725 2.00 2.00 51, 405, 984 3.00 OPPS payments 3 00 4.00 Outlier payment (see instructions) 58,034 4.00 4.01 Outlier reconciliation amount (see instructions) 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 0 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 245 452 9 00 9 00 10.00 Organ acquisitions Ω 10.00 14, 118 Total cost (sum of lines 1 and 10) (see instructions) 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 41, 167 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 13.00 Total reasonable charges (sum of lines 12 and 13) 41, 167 14.00 14.00 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 for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 0.000000 17.00 18.00 Total customary charges (see instructions) 41, 167 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 27,049 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21.00 Lesser of cost or charges (see instructions) 14, 118 21.00 22.00 Interns and residents (see instructions) 0 22.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 Λ 23.00 Total prospective payment (sum of lines 3, 51, 709, 470 24.00 4. 4.01. 8 and 9) 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 399 25.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 9, 020, 899 26.00 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 42, 702, 290 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 303, 660 28.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 0 43, 005, 950 30.00 Subtotal (sum of lines 27 through 29) 30.00 31.00 Primary payer payments 10, 212 31.00 Subtotal (line 30 minus line 31) 42, 9<u>95, 738</u> 32.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 33.00 34.00 Allowable bad debts (see instructions) 1, 647, 874 34.00 Adjusted reimbursable bad debts (see instructions) 1,071,118 35.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 36.00 1, 036, 889 36,00 37.00 Subtotal (see instructions) 44, 066, 856 37.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 -6 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39 00 39 00 0 39.50 Pioneer 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) 39.98 0 RECOVERY OF ACCELERATED DEPRECIATION 39 99 0 39 99 40.00 Subtotal (see instructions) 44, 066, 862 40.00 290, 841 40.01 Sequestration adjustment (see instructions) 40.01 Demonstration payment adjustment amount after sequestration 40.02 40.02 Sequestration adjustment-PARHM pass-throughs 40 03 40 03 41.00 Interim payments 43, 659, 802 41.00 41.01 Interim payments-PARHM 41.01 Tentative settlement (for contractors use only) 42.00 0 42.00 Tentative settlement-PARHM (for contractor use only) 42.01 42.01 116, 219 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 0 44.00 §115. 2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) n 90.00 91.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00 94.00 Total (sum of lines 91 and 93) 94.00 ol

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0		Worksheet E
	Component CCN: 15	From 01/01/2020 S048 To 12/31/2020	
	Component Con. 15-	3046 10 12/31/2020	7/8/2021 10:37 am
	Title XVIII	Subprovi der -	PPS

Material - Milicola, May Office (Inch.)   Septicis.			Title XVIII	Subprovi der  - I PF	PPS	
					1. 00	
Vertical and other services reinhursed under OWPS (see Instructions)   3, 267   2.00						
1.728   3.00   2.00		1				
0.01   0.01   1.07   2.07		,	tions)			
0.01   0.01   0.01   0.01   0.01   0.01   0.00		, ,				
Enter the hospit bil specific payment to cost ratio (see instructions)						
Sum of Tires 3. 4, and 4.01, divided by line 6   0.00 7.00			ctions)		0. 000	
Transitional corridor payment (see Instructions)   0   8.00   10.00						
10.00   Organ acquisitions   00   10.00   11			IV col 13 lino 200			
1.0   10   10   10   10   10   10   10			1 V, COI. 13, 1111e 200			
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   2,336   12,00   Ancil lary service charges   2,336   13,00   07gah acquist it on charges (Fron West D.4, Pt. III, col. 4, Iline 69)   2,30   13,00   13,00   07gah acquist it on charges (Fron West D.4, Pt. III, col. 4, Iline 69)   2,30   14,00   13,00						
12.00   Ancil I ary service charges   2,36   12.00   13.00   Organ acquist sit on charges (from West. D-4, Pt. III, col. 4, line 69)   2,36   14.00   13.00   Organ acquist sit on charges (sum of lines 12 and 13)   15.00						
13.00   Organ acquisition chargées (from Wist. D-4, Pt. III. col. 4, line 69)	10.00	9			0.00/	40.00
14.00			ine 60)			
Customary charges			THE 09)			
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis had been paged in accordance with 42 CFB \$413.13(e)   0.000000   17.000000   17.00000   17.000000   17.000000   17.000000   17.000000   17.000000   17.000000   17.0000000   17.00000000   17.00000000   17.0000000000   17.000000000000000000000000000000000000					_,	
had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   17.00	15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis		
17.00   Ratio of Line 15 to Line 16 (not to exceed 1.000000)   2.000000   17.00   2.036   18.00   18.00   Total customary charges (see instructions)   2.336   18.00   2.000   Excess of customary charges over reasonable cost (complete only if Line 18 exceeds Line 11) (see   1.534   19.00   1.534   19	16. 00			on a chargebasis	0	16. 00
18.00   Total customary charges (see instructions)   2.336   18.00   19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   20.00   21.00   22.00   22.00   23.00   25.00   25.00   25.00   26.	17 00		e)		0.00000	17 00
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   1.534   19.00		,				
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   802   21.00			ly if line 18 exceeds li	ne 11) (see		
Instructions		,		, ,		
21.00   Lesser of cost or charges (see instructions)   0.22.00	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0   22.00   0   23.00   0   23.00   0   23.00   0   23.00   0   23.00   0   23.00   0   23.00   0   23.00   0   23.00   2	21 00	,			902	21 00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0   23.00		,				
COMPUTATION OF RELIMBURSEMENT SETTLEMENT			ructi ons)			
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0   25.00	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			1, 301	24.00
26. 00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   1.8   26. 00   27. 00   28. 00   29. 00   29. 00   29. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00   28. 00   29. 00	05.00					
27. 00   Subtotal   [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,985   27. 00   1,985   1,9			•	cuctions)		
instructions						
28.00   Direct graduate medical education payments (From Wkst. E-4, line 50)   0   28.00   0   29.00   29.00   29.00   28.00   30.00	27.00		prus the sum of filles 22	ana 20] (300	1, 700	27.00
20. 00   Subtotal (sum of lines 27 through 29)   1,985   30. 00   Primary payer payments   0   31.00   31.00   31.00   Subtotal (line 30 minus line 31)   1,985   32.00   31.00   32.00   32.00   32.00   32.00   33.00   Composite rate ESRD (from West. I-5, line 11)   0   33.00   33.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   35.00   36.00   Allowable bad debts (see instructions)   0   35.00   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   0   36.00   37.00   Subtotal (see instructions)   0   36.00   37.00   Subtotal (see instructions)   0   38.00   39.00   3	28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
11.00   Primary payer payments   0   31.00   31.00   31.00   31.00   31.00   32.00						
Subtotain (i ine 30 minus line 31)   1,985   32.00		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   0   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   0   36.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   36.00   37.00   Subtotal (see instructions)   1,985   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   99.00   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.00   99.00   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   99.97   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   99.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   99.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   99.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   99.9						
33.00       Composite rate ESRD (from Wkst. I-5, line 11)       33.00         34.00       All owable bad debts (see instructions)       0 34.00         35.00       Adjusted reimbursable bad debts (see instructions)       0 35.00         36.00       All lowable bad debts for dual eligible beneficiaries (see instructions)       1,985         37.00       Subtotal (see instructions)       1,985         38.00       MSP-LCC reconciliation amount from PS&R       0 38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 39.00         39.01       Dioneer ACO demonstration payment adjustment (see instructions)       39.50         39.07       Demonstration payment adjustment amount before sequestration       0 39.97         39.99       Partial or full credits received from manufacturers for replaced devices (see instructions)       0 39.99         40.01       Sequestration adjustment amount after sequestration       1,985       40.01         40.02       Demonstration payment adjustment amount after sequestration       1,985       40.01         40.02       Sequestration adjustment (see instructions)       1,985       40.01         40.01       Interim payments       1,935       41.00         41.00       Interim payments-PARHM       42.01         42.01       Interim payments-PAR	02.00		CES)		1, 700	02.00
35.00	33.00	Composite rate ESRD (from Wkst. I-5, line 11)	•		0	33.00
36.00		,				
37.00   Subtotal (see instructions)   1,985   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   1,985   40.00   40.01   Sequestration adjustment (see instructions)   13   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.02   Demonstration payment adjustment amount after sequestration   40.02   Sequestration adjustment-PARHM pass-throughs   41.00   Interim payments   41.00   42.00   42.00   43.00   Bal ance due provi der/program (see instructions)   42.01   Tentative settlement (for contractor use only)   42.01   Tentative settlement (for contractor use only)   42.01   43.00   Bal ance due provi der/program (see instructions)   43.01   43.01   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, ,	rusti ana)			
38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.50   39.50   39.50   39.50   39.50   39.97   39.98   39.50   39.97   39.98   39.50   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   39.99   39.90   3			ructions)			
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.00   39.00   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.97   39.98   39.98   39.99   39.99   39.50   39.50   39.50   39.90   39.		MSP-LCC reconciliation amount from PS&R				
39. 97   Demonstration payment adjustment amount before sequestration   0   39. 97   39. 98   8   8   7   10   10   10   10   10   10   10	39. 00				0	
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. 00       Subtotal (see instructions)       1, 985       40. 00         40. 01       Sequestration adjustment (see instructions)       13 40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       1, 935       41. 00         41. 01       Interim payments       1, 935       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 01         43. 00       Bal ance due provider/program (see instructions)       37       43. 00         43. 01       Bal ance due provider/program-PARHM (see instructions)       37       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44. 00         90. 00       Original outlier amount (see instructions)       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 (see instructions)       0			s)		_	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   5ubtotal (see instructions)   1,985   40. 00   40. 01   40. 01   40. 02   40. 03   40. 01   40. 02   40. 03   40. 02   40. 03   4			and davious (see instru	stions)		
40.00       Subtotal (see instructions)       1,985       40.00         40.01       Sequestration adj ustment (see instructions)       13       40.01         40.02       Demonstration payment adj ustment amount after sequestration       0       40.02         40.03       Sequestration adj ustment-PARHM pass-throughs       0       40.03         41.00       Interim payments       1,935       41.00         41.01       Interim payments-PARHM       41.01         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Bal ance due provider/program (see instructions)       37       43.00         43.01       Bal ance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       0       44.00         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 (see instructions)       0       93.00		·	ced devices (see ilistiud	tions)		
40.01       Sequestration adjustment (see instructions)       13       40.01         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         40.03       Sequestration adjustment-PARHM pass-throughs       40.03         41.00       Interim payments       1,935       41.00         41.01       Interim payments-PARHM       41.01       41.01         42.00       Tentative settlement (for contractors use only)       0       42.01         43.00       Balance due provider/program (see instructions)       37       43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2       0       44.00         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       92.00         93.00       Time Value of Money (see instructions)       0       93.00						
40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   1 nterim payments   1, 935   41. 00   41. 01   1 nterim payments   1, 935   41. 00   42. 00   1 nterim payments   42. 00   42. 01   1 nterim payment   42. 00   43. 00   8al ance due provider/program (see instructions)   43. 01   8al ance due provider/program-PARHM (see instructions)   43. 01   44. 00   Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44. 00   91. 00   0   0   0   0   0   0   0   0   0	40. 01					
1, 935   41. 00   1					0	
41. 01   Interim payments-PARHM		1 '			1 005	
Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  §115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 utilier reconciliation adjustment amount (see instructions)  1 0 90.00 91.00 The rate used to calculate the Time Value of Money  1 0 93.00  1 ime Value of Money (see instructions)  0 42.00 42.01 42.00 43.01 43.00 43.01 44.00  91.00 91.00 92.00 93.00		1			1, 935	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)  94.00 Time Value of Money (see instructions)  95.00 Time Value of Money (see instructions)  97.00 Time Value of Money (see instructions)					0	
43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$115.2		,				•
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\text{\$\text{\$\text{\$\text{91.5.2}}}}{10 \text{ BE COMPLETED BY CONTRACTOR}}\$  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Time Value of Money (see instructions)					37	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 pl.00 70 The rate used to calculate the Time Value of Money 0 column 20 pl.00 71 me Value of Money (see instructions) 0 pl.00 72 00 73 00			noo with OMC Dut. 45 0	abants: 1	_	
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)	44.00		nce wrth CMS Pub. 15-2,	cnapter 1,	0	44.00
90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00						
7.1.00   1.01.00 /1 drid 70/						
	, 1. 00	1.11. (Sam. S. 1.1105 / Gild /S)		ļ	·	, , ,, ,,

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048		Worksheet E
	Component CCN: 15-T04	From 01/01/2020 To 12/31/2020	
	'		7/8/2021 10:37 am
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			642	
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		439	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			550 0	
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	
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)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acquisitions			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)  COMPUTATION OF LESSER OF COST OR CHARGES			642	11.00
	Reasonable charges				1
12. 00	Ancillary service charges			1.869	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	1
	Total reasonable charges (sum of lines 12 and 13)	,		1, 869	14.00
	Customary charges				
	Aggregate amount actually collected from patients liable for			0	
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(	e)		0.000000	17 00
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 1, 869	1
	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ine 11) (see	1, 227	1
17.00	instructions)	Ty TT TTHE TO EXCEEDS T	1110 11) (300	1, 22,	17.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	ly if line 11 exceeds l	ine 18) (see	0	20.00
21 00	Lesser of cost or charges (see instructions)			642	21.00
	Interns and residents (see instructions)			0 12	1
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		550	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instruction			0	
	Deductibles and Coinsurance amounts relating to amount on lin			0	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	1, 192	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		o	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	THE 30)		o o	
	Subtotal (sum of lines 27 through 29)			1, 192	
	Primary payer payments			, 0	
32.00	Subtotal (line 30 minus line 31)			1, 192	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			4
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
	Subtotal (see instructions)	ruetrons)		1, 192	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			1, 192 8	1
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			o o	1
	Sequestration adjustment-PARHM pass-throughs			ı Y	40.02
	Interim payments			1, 178	1
	Interim payments-PARHM				41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			6	
43.01	Balance due provider/program-PARHM (see instructions)		chanter 1	0	43. 01
	· · · · · · · · · · · · · · · · · · ·		CHADIEL	. ()]	44.00
	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	Chapter 1,		
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR	nce with CMS Pub. 15-2,	chapter 1,		1
<ul><li>44. 00</li><li>90. 00</li></ul>	Protested amounts (nonallowable cost report items) in accorda §115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)	nce with CMS Pub. 15-2,	onapter 1,	0	1
44. 00 90. 00 91. 00	Protested amounts (nonallowable cost report items) in accorda §115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)	nce with CMS Pub. 15-2,	chapter 1,	0	91.00
44. 00 90. 00 91. 00 92. 00	Protested amounts (nonallowable cost report items) in accorda §115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money	nce with CMS Pub. 15-2,	onapto. 1,	0 0 0.00	91.00 92.00
44. 00 90. 00 91. 00 92. 00 93. 00	Protested amounts (nonallowable cost report items) in accorda §115.2  TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  Outlier reconciliation adjustment amount (see instructions)	nce with CMS Pub. 15-2,	Graptor 1,	0	91.00 92.00 93.00

7.00

8.00

43, 776, 021

NPR Date

(Mo/Day/Yr)

2.00

In Lieu of Form CMS-2552-10 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0048 Peri od: Worksheet E-1 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/8/2021 10:37 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 69, 883, 639 43, 659, 802 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 07/08/2020 40, 800 3.01 3.02 0 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 40,800 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 69, 924, 439 43, 659, 802 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 116, 219 6.01

1, 197

Contractor

Number

1.00

69, 9<u>23, 242</u>

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

6.02

7.00

Health Financial Systems REID HOSPI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2020 Part |
To 12/31/2020 Date/Time Prepared: 7/8/2021 10: 37 am Provider CCN: 15-0048 Component CCN: 15-S048

		Title	XVIII	Subprovi der - I PF	PPS	
		I npati en	t Part A		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		4, 179, 13	7	1, 935	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2.00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER	07/08/2020	31, 80		1 0	3. 01
3. 02	ADSOSTMENTS TO TROVIDER	017 007 2020		Ö		3. 02
3. 03				Ö	l ol	3. 03
3. 04				O	0	3.04
3.05				0	0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54	Subtatal (sum of lines 2 01 2 40 minus sum of lines			0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		31, 80			3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4, 210, 93	7	1, 935	4. 00
	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			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Dec. 1 Leader December 1			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			0	1 0	5. 50
5. 50 5. 51	ILINIALIVE TO FROGRAM			0		5. 50 5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	Ö	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER				37	6. 01
6. 02	SETTLEMENT TO PROVIDER		6, 03	7	37	6. 01
7. 00	Total Medicare program liability (see instructions)		4, 204, 90		1, 972	7. 00
	,		., 20 1, 70	Contractor Number	NPR Date (Mo/Day/Yr)	,, 55
		(	)	1, 00	2. 00	
8. 00	Name of Contractor				2.00	8. 00
	ı i i i i i i i i i i i i i i i i i i i					

Health Financial Systems REID HOSPI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 7/8/2021 10: 37 am Provider CCN: 15-0048 Component CCN: 15-T048

		Title	· XVIII	Subprovi der -	PPS	<i>i</i> am
				I RF		
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		4, 824, 04	4	1, 178	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			O	0	3. 01
3. 02				O O	0	3. 02
3. 03 3. 04					0	3. 03 3. 04
3. 04					0	3. 04
3.03	Provider to Program			<u>J</u>	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51				o	o	3. 51
3. 52				O	0	3. 52
3. 53				O	0	3. 53
3. 54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			O	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		4, 824, 04	4	1, 178	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		4, 024, 044	+	1, 170	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		1		0	5. 01
5. 02	TENTATI VE TO TROVIDER			0		5. 02
5. 03				o O	l ol	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51				O	0	5. 51
5. 52	Cultural (			)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		1	ס	U	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		92, 68	4	6	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 916, 72		1, 184	7. 00
				Contractor	NPR Date	
		,		Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
5. 00	Name of contractor	l		1	ı	0.00

Heal th	Financial Systems REID HOSPITAL & HEALT	H CARE SERVICES	Inlie	u of Form CMS-	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0048	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part II	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I			7. 00	
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00					9.00
10.00					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	line 31) (see instructio	ns)		32.00
			•		•

Heal th	Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od:	Worksheet E-3	
				From 01/01/2020		
			Component CCN: 15-S048	To 12/31/2020	Date/Time Pre	
					7/8/2021 10: 3	7 am
			Title XVIII	Subprovi der -	PPS	
				I PF		
					1. 00	
	PART II - MEDICARE PART A SERVICES - IF	PF PPS				
1.00	Net Federal IPF PPS Payments (excluding	g outlier, ECT, and med	ical education payments)		4, 581, 011	1.00
2.00	Net IPF PPS Outlier Payments				12, 461	2.00
3.00	Net IPF PPS ECT Payments				0	3.00
4.00	Unweighted intern and resident FTE cour	nt in the most recent c	ost report filed on or b	oefore November	0. 00	4.00

		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4, 581, 011	1.00
2.00	Net IPF PPS Outlier Payments	12, 461	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	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)		
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 in the new program growth period of a "new	0. 00	6. 00
	teaching program" (see instuctions)		
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	7. 00
	teaching program" (see instuctions)		
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	8. 00
9. 00	Average Daily Census (see instructions)	23. 180328	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4, 593, 472	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16. 00	Subtotal (see instructions)	4, 593, 472	
17. 00	Pri mary payer payments		17. 00
18. 00	Subtotal (line 16 less line 17).	4, 593, 172	
19. 00	Deducti bl es	238, 920	
20.00	Subtotal (line 18 minus line 19)	4, 354, 252	
21. 00	Coi nsurance	180, 708	
22. 00	Subtotal (line 20 minus line 21)	4, 173, 544	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	88, 352	
24. 00	Adjusted reimbursable bad debts (see instructions)	57, 429	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53, 627	
26. 00	Subtotal (sum of lines 22 and 24)	4, 230, 973	
27. 00	Direct graduate medical education payments (see instructions)	0	27.00
28. 00	Other pass through costs (see instructions)	1, 864	
29. 00	Outlier payments reconciliation	0	29. 00
30. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Demonstration payment adjustment amount before sequestration	0	30. 99
31.00	Total amount payable to the provider (see instructions)	4, 232, 837	
31. 01	Sequestration adjustment (see instructions)	27, 937	
31. 02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	4, 210, 937	
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-6, 037	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	12, 461	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	
53. 00	Time Value of Money (see instructions)	0	53.00

Heal th	Financial Systems REID HOSPITAL	& HEALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0048	Peri od: From 01/01/2020	Worksheet E-3	
		Component CCN: 15-T048	To 12/31/2020		
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			4, 682, 087	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0175	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instruction	ns)		224, 740	3.00

		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4, 682, 087	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0175	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	224, 740	3.00
4.00	Outlier Payments	97, 712	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	5. 01
	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)	0. 00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7.00
	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	0. 00	8.00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9.00
10.00	Average Daily Census (see instructions)	14. 710383	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	5, 004, 539	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	5, 004, 539	17. 00
18.00	Primary payer payments	5, 000	18. 00
19.00	Subtotal (line 17 less line 18).	4, 999, 539	19.00
20.00	Deducti bl es	26, 752	20.00
21.00	Subtotal (line 19 minus line 20)	4, 972, 787	
22.00	Coinsurance	39, 314	
23.00	Subtotal (line 21 minus line 22)	4, 933, 473	23.00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23, 538	
	Adjusted reimbursable bad debts (see instructions)	15, 300	
26. 00		4, 092	
27. 00	Subtotal (sum of lines 23 and 25)	4, 948, 773	
	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	
		621	29. 00
30.00	Outlier payments reconciliation	0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
31. 99	Demonstration payment adjustment amount before sequestration	0	
32. 00		4, 949, 394	
32. 01	Sequestration adjustment (see instructions)	32, 666	
	Demonstration payment adjustment amount after sequestration	0	
33. 00	Interim payments	4, 824, 044	
34. 00	Tentative settlement (for contractor use only)	0	1
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	92, 684	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
00.00	\$115. 2	Ĭ	00.00
	TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	97, 712	50.00
51. 00	Outlier reconciliation adjustment amount (see instructions)	77, 712	
	The rate used to calculate the Time Value of Money	- 1	52.00
	Time Value of Money (see instructions)		53.00
	1	۰	

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

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E-3	
			From 01/01/2020 To 12/31/2020		narod:
			10 12/31/2020	7/8/2021 10: 3	7 am
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		3, 821, 862	1	1.00
2.00	Medical and other services			3, 655, 447	2.00
3.00	Organ acquisition (certified transplant centers only)		0 001 010	0 (55 447	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		3, 821, 862	3, 655, 447	4.00
5. 00 6. 00	Inpatient primary payer payments		0	o	5. 00 6. 00
7. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		3, 821, 862		7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		3, 021, 002	3, 033, 447	7.00
	Reasonable Charges				
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		9, 057, 145	14, 822, 688	•
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		9, 057, 145	14, 822, 688	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable for	1 3	0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	1	1
	Total customary charges (see instructions)	alvifling 14 avacada	9, 057, 145		1
17.00	Excess of customary charges over reasonable cost (complete or line 4) (see instructions)	if y if fine to exceeds	5, 235, 283	11, 167, 241	17. 00
18. 00	Excess of reasonable cost over customary charges (complete or	olv if line 1 evceeds line	,	o	18. 00
10.00	16) (see instructions)	if y it fille 4 exceeds fille			10.00
19. 00	Interns and Residents (see instructions)		0	ol	19.00
	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	20.00
	Cost of covered services (enter the lesser of line 4 or line		3, 821, 862	3, 655, 447	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	lers.		
	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0	_	25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0 001 000	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 821, 862	3, 655, 447	29. 00
30. 00	Excess of reasonable cost (from line 18)		1	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	.)	3, 821, 862		
32. 00	Deductibles	9)	3, 621, 602	3, 055, 447	1
	Coinsurance		0	0	1
	Allowable bad debts (see instructions)		0	l ől	34.00
	Utilization review		0	1	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	3, 821, 862	3, 655, 447	36.00
37.00	TO ZERO OUT MEDICALD	•	-3, 821, 862		
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	, , , , , , , , , , , , , , , , , , ,				39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)		0	1	
43. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1	1	l

Health Financial Systems REI	D HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048 Component CCN: 15-S048	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
	Title XIX	Subprovi der -	7/8/2021 10: 3 Cost	/ alli
		Inpatient	Outpati ent	
		1.00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT - A	ALL OTHER HEALTH SERVICES FOR TITLES V OR 2	KLX SERVICES		

		Inpatient	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	SERVICES		ł
1. 00	Inpatient hospital/SNF/NF services	305, 262		1.00
2. 00	Medical and other services	303, 202	0	2.00
3. 00		0	Ü	3.0
	Organ acquisition (certified transplant centers only)	205 242	0	4.00
4.00	Subtotal (sum of lines 1, 2 and 3)	305, 262	Ü	
5.00	Inpatient primary payer payments	U	0	5.00
6.00	Outpatient primary payer payments	205 242	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	305, 262	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0	0	8.00
9.00	Ancillary service charges	0	0	
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 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	17.0
	line 4) (see instructions)			
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	305, 262	0	18.00
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.0
	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)	o	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			ĺ
30.00	Excess of reasonable cost (from line 18)	305, 262	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.0
32. 00	Deductibles	o	0	32.0
33. 00	Coinsurance	o	0	33.0
34.00	Allowable bad debts (see instructions)	0	0	34.00
35. 00	Utilization review	o	O	35.0
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	o	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ő	0	37.0
38. 00	Subtotal (line 36 ± line 37)	0	0	38.0
	Direct graduate medical education payments (from Wkst. E-4)	0	U	39.00
			^	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.0
41.00	Interim payments	0	0	41.0
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
	Destructed and the Constitution of the control of t			
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.0

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E-3	
			From 01/01/2020		
		Component CCN: 15-T048	To 12/31/2020	Date/lime Pre	pared:
				7/8/2021 10: 3	<u>/ am</u>
		Title XIX	Subprovi der –	Cost	
			l RF		
·			I npati ent	Outpati ent	
			1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMEN	T - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	I X SERVICES		
COMPUTATION OF NET COST OF COVERED SER	VICES	<u> </u>			
1.00 Inpatient hospital/SNF/NF services			0		1.00

		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1. 00	Inpatient hospital/SNF/NF services	0		1.00
2. 00	Medical and other services	_	0	
3. 00	Organ acquisition (certified transplant centers only)	0	_	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			1
0 00	Reasonable Charges			0.00
8. 00 9. 00	Routine service charges	0	0	8. 00 9. 00
	Ancillary service charges	0	U	
10.00	Organ acquisition charges, net of revenue	0		10.00
	Incentive from target amount computation	0	_	11.00
12.00	Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES	0	0	12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
13.00	basis	U	U	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	U	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15.00
	Total customary charges (see instructions)	0.000000	0.000000	1
	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	
17.00	line 4) (see instructions)	U	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18.00
.0.00	16) (see instructions)	ŭ	, and the second	
19 00	Interns and Residents (see instructions)	0	0	19.00
	Cost of physicians' services in a teaching hospital (see instructions)	Ö	0	
	Cost of covered services (enter the lesser of line 4 or line 16)	Ö		
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			
22.00	Other than outlier payments	0	0	22.00
	Outlier payments	o	0	23.00
	Program capital payments	o		24.00
	Capital exception payments (see instructions)	0		25.00
		o	0	26.00
	Subtotal (sum of lines 22 through 26)	o	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)	o	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			1
30.00	Excess of reasonable cost (from line 18)	0	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	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	0	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		39.00
	Total amount payable to the provider (sum of lines 38 and 39)	o	0	40.00
	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2			

	Financial Systems REID HOSPITAL & HEALTI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C		In Lie	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	7/8/2021 10: 3° PPS	7 am
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	r cost reporti	ng periods	0. 00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see inst	ructions)	0.00	
3. 00 3. 01	Amount of reduction to Direct GME cap under section 422 of MN Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m)	(see	0. 00 0. 00	•
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0. 00	4.00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instantial straddling 7/1/2011)		r cost reporti	ng peri ods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see ins	tructions for	cost reporting	0. 00	4. 02
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	ines 4.01 and	0. 00	5.00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	16. 75	6. 00
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	
8. 00	Weighted FTE count for physicians in an allopathic and osteopprogram for the current year.	oathi c	15. 4	7 0.00	15. 47	8.00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherword multiply line 8 times the result of line 5 divided by the amount		0.0	0.00	0. 00	9. 00
10. 00	6.   Weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10.00
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	ırrent year	0.0	0. 00 0. 00		10. 01 11. 00
12. 00	Total weighted resident FTE count for the prior cost reportir instructions)	ng year (see				12.00
13. 00	Total weighted resident FTE count for the penultimate cost revear (see instructions)	eporti ng	0.0	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	l by 3).	0.0			14. 00 15. 00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs	programs	16. 7 16. 7			15.00
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	Adjusted rolling average FTE count Per resident amount		16.7			17. 00 18. 00
18. 00 19. 00	Approved amount for resident costs		85, 000. 0 1, 423, 75		1, 423, 750	
					1. 00	
20.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42		20.00
21 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	ıctions)			16. 75	21.00
	Allowable additional direct GME FTE Resident Count (see instr	,				22.00
23. 00	Enter the locality adjustment national average per resident a	mount (see	instructions)		85, 000. 00	23.00
	Multiply line 22 time line 23				1 422 750	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)		Inpati ent	Managed Care	1, 423, 750 Total	25.00
			Part A 1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	29, 55	0 6, 710		26. 00
27. 00	Total Inpatient Days (see instructions)		64, 44			27.00
28. 00 29. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 45850 652, 79		801, 023	28. 00 29. 00
29. 00 29. 01	Percent reduction for MA DGME		052, 79	7. 00	001, 023	29.00
30. 00				10, 376	10, 376	30.00
31. 00	Net Program direct GME amount				790, 647	31.00

	Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of the Country of the Coun					
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CCN: 15-0048	Peri od: From 01/01/2020	Worksheet E-4		
WEDI CF	LE EDUCATION COSTS		To 12/31/2020			
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING S	CHOOL AND PARAMED	OI 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)	1, 286, 781	33.00	
34.00	Ratio of direct medical education costs to total charges (lir		,	0. 000000	34.00	
35.00	Medicare outpatient ESRD charges (see instructions)	·		0	35.00	
36.00	Medicare outpatient ESRD direct medical education costs (line	e 34 x line 35)		0	36.00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
	Reasonable cost (see instructions)			74, 566, 947		
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0		
	Cost of physicians' services in a teaching hospital (see inst	tructi ons)		0		
	Primary payer payments (see instructions)			33, 283		
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	us line 40)		74, 533, 664	41.00	
	Part B Reasonable Cost					
42.00				46, 485, 468		
43.00	Primary payer payments (see instructions)			10, 212		
	Total Part B reasonable cost (line 42 minus line 43)			46, 475, 256		
	Total reasonable cost (sum of lines 41 and 44)	44 11 45		121, 008, 920		
	Ratio of Part A reasonable cost to total reasonable cost (lin			0. 615935		
47.00	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 384065	47. 00	
40.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	AK I B		700 / 47	48. 00	
	Total program GME payment (line 31)	(see instructions)		790, 647 486, 987		
	Part A Medicare GME payment (line 46 x 48) (title XVIII only) Part B Medicare GME payment (line 47 x 48) (title XVIII only)			486, 987 303, 660		
50.00	rait b wedicale owe payment (Tille 47 x 40) (title XVIII only)	(See HISH UCH OHS)		303, 660	30.00	

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

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/8/2021 10: 37 am

UIII y)					7/8/2021 10: 3	<u>7 am</u>
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1. 00	Cash on hand in banks	38, 552, 847	0	0	0	1.00
2.00	Temporary investments	420, 663, 653	1	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts recei vable	134, 894, 274	0	0	0	4.00
5.00	Other recei vabl e	512, 464, 495	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-66, 622, 834	0	0	0	6.00
7. 00	Inventory	8, 471, 964	1	0	0	7. 00
8. 00	Prepai d expenses	6, 050, 374	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	1, 054, 474, 873	0	0	0	11.00
12. 00	FIXED ASSETS Land	17, 227, 167	0	0	0	12.00
13. 00	Land improvements	12, 604, 071		0	_	13.00
14. 00	Accumul ated depreciation	12,004,071		0		14.00
15. 00	Bui I di ngs	321, 118, 905	- 1	0	1	15.00
16. 00	Accumulated depreciation	-170, 804, 939		0	Ö	16.00
17. 00	Leasehold improvements	13, 635, 060		0	Ö	17. 00
18.00	Accumul ated depreciation	-7, 143, 355	1	0	0	18.00
19.00	Fi xed equipment	2, 196, 200	0	0	0	19.00
20.00	Accumulated depreciation	-1, 752, 392	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	188, 844, 553		0	0	23. 00
24. 00	Accumulated depreciation	-146, 760, 930	0	0	0	24.00
25. 00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0		0	0	27.00
28. 00 29. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	229, 164, 340		0		30.00
30.00	OTHER ASSETS	227, 104, 340	0	<u> </u>	0	30.00
31. 00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0		32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	82, 832, 195	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	82, 832, 195	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 366, 471, 408	0	0	0	36.00
	CURRENT LIABILITIES					
37. 00	Accounts payable	36, 701, 381	1	0		37.00
38. 00	Salaries, wages, and fees payable	12, 456, 535	1	0		38.00
39.00	Payroll taxes payable (chart tarm)	10 544 210	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	10, 544, 319 63, 948, 026		0	0	40. 00 41. 00
42.00	Accel erated payments	03, 946, 020		U	ا	42.00
43. 00	Due to other funds			0	0	43.00
44. 00	Other current liabilities		0	0	Ö	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	123, 650, 261	0	0		45.00
	LONG TERM LIABILITIES	.,		-		
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	224, 029, 110	0	0	0	47.00
48.00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	3, 434, 596	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	227, 463, 706	0	0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	351, 113, 967	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	1, 015, 357, 441	1			52.00
53.00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	_	56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion	1 015 257 441	0	0	0	59.00
60.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	1, 015, 357, 441 1, 366, 471, 408		0		60.00
00.00	[59]	1, 300, 471, 400	ή	U		00.00
	1 * 7	1	1			1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

Peri od: Worksheet G-1 From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

							7/8/2021 10: 3	7 am
		Genera	l Fund	Speci al	Pur	rpose Fund	Endowment	
							Fund	
		1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		901, 029, 581			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		182, 680, 706					2.00
3.00	Total (sum of line 1 and line 2)		1, 083, 710, 287			0		3.00
4.00	Additions (credit adjustments) (specify)	0			0		0	4.00
5.00		0			0		0	5.00
6.00		0			0		0	6.00
7.00		0			0		0	7.00
8.00		0			0		0	8.00
9.00		0			0		0	9.00
10.00	Total additions (sum of line 4-9)		0	1		0		10.00
11.00	Subtotal (line 3 plus line 10)		1, 083, 710, 287			0		11.00
12.00	AMOUNTS INCLUDED ON HO COST REPORT	68, 352, 846			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	14.00
15.00		0			0		0	15.00
16.00		0			0		0	16.00
17.00		0			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		68, 352, 846			0		18.00
19.00	Fund balance at end of period per balance		1, 015, 357, 441			0		19.00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund						
	I <del></del>	6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3. 00	Total (sum of line 1 and line 2)	0	_		0			3.00
4.00	Additions (credit adjustments) (specify)		0	l .				4.00
5. 00			0					5.00
6. 00			0	1				6.00
7. 00			0					7.00
8. 00			0	1				8.00
9. 00			0	1				9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	AMOUNTS INCLUDED ON HO COST REPORT		0	1				12.00
13.00			0	1				13.00
14.00			0	1				14.00
15.00			0	1				15. 00
16. 00			0	1				16. 00
17. 00			0	1				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)			1				

40.00

41.00

42.00

43.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0048 Peri od: Worksheet G-2 From 01/01/2020 Parts I & II Date/Time Prepared: 12/31/2020 7/8/2021 10:37 am Cost Center Description Inpati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 71, 153, 560 71, 153, 560 1.00 2.00 SUBPROVIDER - IPF 9, 445, 240 9, 445, 240 2.00 SUBPROVIDER - IRF 5, 913, 649 5, 913, 649 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 Swing bed - SNF 0 0 5.00 Swing bed - NF 6.00 0 6.00 SKILLED NURSING FACILITY 7.00 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) 86, 512, 449 86, 512, 449 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 13, 958, 519 13, 958, 519 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16.00 13, 958, 519 13, 958, 519 16,00 11 - 15) 17.00 100, 470, 968 100, 470, 968 Total inpatient routine care services (sum of lines 10 and 16) 17.00 Ancillary services 286, 429, 380 519, 828, 869 806, 258, 249 18.00 18.00 26, 997, 543 68, 757, 365 95, 754, 908 19.00 Outpatient services 19.00 RURAL HEALTH CLINIC 20.00 C 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULANCE SERVICES 23.00 23.00 24.00 CMHC 24.00 25.00 AMBULATORY SURGICAL CENTER (D. P.) 25.00 26.00 HOSPI CE 5, 447, 047 5, 447, 047 26.00 2, 902, 605 4, 354, 113 27.00 OTHER 1, 451, 508 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 416, 800, 496 595, 484, 789 1, 012, 285, 285 28.00 G-3, line 1) PART II - OPERATING EXPENSES 29 00 Operating expenses (per Wkst. A, column 3, line 200) 314, 392, 387 29 00 30.00 ADD (SPECIFY) 0 30.00 31.00 0 31.00 0 32.00 32.00 0 33.00 33 00 34.00 0 34.00 35.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 0 DEDUCT (SPECIFY) 37.00 37.00 0 38.00 38.00

0

0

0

314, 392, 387

39.00

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

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

Heal th	Financial Systems REID HOSPITAL & HE	EALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0048	Peri od: From 01/01/2020 To 12/31/2020		pared:
				7/8/2021 10: 3	/ am
				1 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 20)		1. 00 1, 012, 285, 285	1. 00
2. 00	Less contractual allowances and discounts on patients' ac			569, 348, 232	2.00
3. 00	Net patient revenues (line 1 minus line 2)	Courts		442, 937, 053	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		314, 392, 387	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			128, 544, 666	5.00
0.00	OTHER I NCOME			120/011/000	0.00
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			38, 424, 437	7.00
8.00	Revenues from telephone and other miscellaneous communica	tion services		0	8. 00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			364, 409	13.00
	Revenue from meals sold to employees and guests			3, 386, 926	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16.00
	Revenue from sale of drugs to other than patients			8, 500	
	Revenue from sale of medical records and abstracts			349	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			61, 874	
	Revenue from gifts, flowers, coffee shops, and canteen			( 122	20.00
	Rental of vending machines			6, 132	
	Rental of hospital space			6, 748, 637 0	22. 00 23. 00
24. 00	Governmental appropriations			5, 134, 776	
	COVI D-19 PHE Fundi ng			5, 134, 776	24. 50
	Total other income (sum of lines 6-24)			54, 136, 040	
	Total (line 5 plus line 25)			182, 680, 706	
	OTHER EXPENSES (SPECIFY)			102, 000, 700	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 2	8)		182, 680, 706	

From 01/01/2020 Hospi ce CCN: 15-1524 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Hospi ce I SUBTOTAL SALARI ES OTHER RECLASSI FI -SUBTOTAL CATI ONS (col. 1 plus col. 2) 1.00 2.00 3.00 4.00 5.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT\* 1,800 1, 800 -1, 800 1.00 CAP REL COSTS-MVBLE EQUIP\* 2 00 2 00 864 864 864 3.00 EMPLOYEE BENEFITS DEPARTMENT\* 80, 202 80, 202 36, 130 116, 332 3.00 ADMINISTRATIVE & GENERAL\* 130, 893 4.00 31, 176 162, 069 15, 162 177, 231 4.00 5.00 PLANT OPERATION & MAINTENANCE\* 5.00 0 LAUNDRY & LINEN SERVICE\* 6.00 0 0 0 6.00 7.00 HOUSEKEEPI NG\* 0 0 0 7.00 8.00 DI FTARY\* 0 1,615 1,615 0 1,615 8.00 0 NURSING ADMINISTRATION\* 0 9.00 9.00 0 0 ROUTINE MEDICAL SUPPLIES\* 0 10.00 0 Λ 10.00 11.00 MEDICAL RECORDS\* 0 0 11.00 12.00 STAFF TRANSPORTATION\* 0 95, 841 95, 841 o 95, 841 12.00 0 0 VOLUNTEER SERVICE COORDINATION\* 13 00 0 13.00 14.00 PHARMACY\* 0 117, 788 117, 788 0 117, 788 14.00 PHYSICIAN ADMINISTRATIVE SERVICES\* 0 0 15.00 15.00 OTHER GENERAL SERVICE\* 0 16.00 16,00 0 0 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25 00 INPATIENT CARE-CONTRACTED\* 0 25.00 PHYSICIAN SERVICES\*\* 196, 819 26,00 0 196, 819 0 196, 819 26.00 27.00 NURSE PRACTITIONER\*\* 27.00 28.00 REGISTERED NURSE\*\* 761, 460 761, 460 375, 663 1, 137, 123 28.00 29.00 LPN/LVN\*\* 88, 818 107, 578 29.00 C 88.818 18,760 30.00 PHYSICAL THERAPY\*\* 0 C  $\cap$ 0 Λ 30.00 31.00 OCCUPATIONAL THERAPY\*\* 0 C 0 0 31.00 0 SPEECH/LANGUAGE PATHOLOGY\*\* 32.00 0 0 0 0 32.00 MEDICAL SOCIAL SERVICES\* 0 0 ol 33.00 0 0 33.00 SPIRITUAL COUNSELING\* 0 0 34.00 C 0 0 34.00 35.00 DI ETARY COUNSELING\*\* 0 0 0 0 35.00 36.00 COUNSELING - OTHER\*\* 0 0 0 36.00 37 00 HOSPICE AIDE & HOMEMAKER SERVICES\*\* 73 451 Ω 73, 451 85 344 158.795 37 00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN\*\* 0 C C 0 38.00 39.00 PATIENT TRANSPORTATION\*\* 0 C 0 0 0 39.00 40.00 IMAGING SERVICES\*\* 0 0 0 40.00 0 LABS & DLAGNOSTICS\*3 0 41 00 0 0 41 00 42.00 MEDICAL SUPPLIES-NON-ROUTINE\*\* 0 147, 417 147, 417 27,090 174, 507 42.00 DRUGS CHARGED TO PATIENTS\*\* 0 42.50 42.50 0 0 43 00 OUTPATIENT SERVICES\* 0 C O 0 Ω 43 00 PALLIATIVE RADIATION THERAPY\*\* 44.00 0 C 0 0 0 44.00 PALLIATIVE CHEMOTHERAPY\*\* 0 0 45.00 45.00 0 0 OTHER PATIENT CARE SERVICES (SPECIFY) \*\* 0 580, 368 580, 368 580, 368 46.00 46.00 0 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM \* 0 0 0 0 60.00 61.00 VOLUNTEER PROGRAM \* 0 0 0 0 61.00 FUNDRAI SI NG\* 0 0 0 62.00 62.00 0 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS\* 0 63.00 0 0 63.00 0 64.00 PALLIATIVE CARE PROGRAM\* C 0 0 0 64.00 OTHER PHYSICIAN SERVICES\* 0 0 0 65.00 65.00 0 0 RESIDENTIAL CARE\* 0 66, 00 0 0 66,00 67 00 ADVERTI SI NG\* C 0 0 0 67 00 TELEHEALTH/TELEMONI TORI NG\* 0 0 0 68.00 68.00 0 69 00 THRIFT STORE\* 0 0 0 0 0 69.00 0 NURSING FACILITY ROOM & BOARD\* 70.00 C 0 0 0 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY)\*  $\cap$ 0 71.00 2, 308, 512 2, 864, 861 100.00 100.00 TOTAL 1,054,622 1, 253, 556, 349

Provider CCN: 15-0048

Peri od:

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

<sup>\*\*</sup> 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 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/8/2021 10: 37 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			I	
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	•	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	864		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	-845	115, 487	•	3.00
4.00	ADMI NI STRATI VE & GENERAL*	-1, 525	175, 706	1	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	1 (15	1	7.00
8. 00 9. 00	DI ETARY* NURSI NG ADMI NI STRATI ON*	0	1, 615 0	1	8. 00 9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDICAL RECORDS*	0	0		11.00
12. 00	STAFF TRANSPORTATION*		95, 841	1	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*		75, 041 N		13.00
14. 00	PHARMACY*		117, 788		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		0 117, 700	1	15. 00
16. 00	OTHER GENERAL SERVICE*		0	•	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	o o	O	1	17.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				17.00
25. 00	I NPATI ENT CARE-CONTRACTED**	O	0		25. 00
26. 00	PHYSI CI AN SERVI CES**		196, 819		26.00
27. 00	NURSE PRACTITIONER**		170, 017		27.00
28. 00	REGI STERED NURSE**	o	1, 137, 123		28.00
29. 00	LPN/LVN**		107, 578		29.00
30.00	PHYSI CAL THERAPY**		0		30.00
31. 00	OCCUPATIONAL THERAPY**		0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**		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**	l ol	0		35. 00
36. 00	COUNSELING - OTHER**	o	0		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	o	158, 795		37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	o	0	1	38.00
39.00	PATI ENT TRANSPORTATI ON**	o	0	)	39.00
40.00	I MAGI NG SERVI CES**	o	0	ol .	40.00
41.00	LABS & DIAGNOSTICS**	o	0	o l	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	o	174, 507	,	42.00
42.50	DRUGS CHARGED TO PATIENTS**	o	0	1	42. 50
43.00	OUTPATIENT SERVICES**	o	0	ol .	43.00
44.00	PALLIATIVE RADIATION THERAPY**	o	0	)	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	o	0	)	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	o	580, 368		46.00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	0	0	)	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69.00	THRI FT STORE*	0	0		69.00
	NURSING FACILITY ROOM & BOARD*	0	0		70.00
	OTHER NONREI MBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-2, 370	2, 862, 491		100. 00
* Tran	sfer the amounts in column 7 to Wkst. 0-5. co	Jump 1 line of	annronri ata		

<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.

NALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE ROUTINE HOME	Provi der CC	N: 15-0048	Peri od:	Worksheet 0-2	
ARE		Hospi ce CCN		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/8/2021 10:3	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
5.00 INPATIENT CARE-CONTRACTED						25.00
6.00 PHYSICIAN SERVICES	0	196, 819	196, 81		196, 819	
7. 00 NURSE PRACTITIONER	0	0		0	0	
8. 00 REGI STERED NURSE	761, 460	0	761, 46		761, 460	
9. 00 LPN/LVN	88, 818	0	88, 81	0	88, 818	
0. 00 PHYSI CAL THERAPY	0	0		0	0	
1. 00 OCCUPATI ONAL THERAPY	0	0		0	0	31.00
2.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
3.00 MEDICAL SOCIAL SERVICES	0	0		0	0	33.00
4. 00   SPIRITUAL COUNSELING	0	0		0	0	34.00
5. 00 DIETARY COUNSELING	0	0		0	0	35.00
6. 00 COUNSELING - OTHER	0	0		0	0	36.00
7.00 HOSPICE AIDE & HOMEMAKER SERVICES	73, 451	0	73, 45	51 0	73, 451	37.00
8. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38.00
9. 00 PATIENT TRANSPORTATION	0	0		0	0	39.00
O. OO I MAGING SERVICES	0	o		0	0	40.00
1.00 LABS & DIAGNOSTICS	0	o		0	0	41.00
2. 00 MEDICAL SUPPLIES-NON-ROUTINE	O	147, 417	147, 41	7 0	147, 417	42.00
2.50 DRUGS CHARGED TO PATIENTS	O	o		0	0	42.50
3. 00 OUTPATIENT SERVICES	O	ol		0 0	0	43.00
4.00 PALLIATIVE RADIATION THERAPY	0	o		0 0	0	44.00
5. 00 PALLIATIVE CHEMOTHERAPY	0	o		0 0	0	45.00
6.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	580, 368	580, 36	0 8	580, 368	46.00
00. 00 TOTAL *	923, 729	924, 604	1, 848, 33	0	1, 848, 333	100.00
Transfer the amount in column 7 to Wkst. 0-5, co				•		•

		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	196, 819	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	761, 460	28. 00
29. 00	LPN/LVN	0	88, 818	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	73, 451	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	147, 417	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	580, 368	46.00
100.00	TOTAL *	0	1, 848, 333	100.00

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

Health Financial Systems REID HOSPITAL & FANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT Provider CCN: 15-0048 Peri od: Worksheet 0-3 From 01/01/2020 To 12/31/2020 RESPITE CARE Date/Time Prepared: 7/8/2021 10:37 am Hospi ce CCN: 15-1524

					77 O7 EGE 1 101 0	, u
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS		_	_	_1		
25. 00 I NPATI ENT CARE-CONTRACTED		0	0	0	0	0.00
26. 00 PHYSI CI AN SERVI CES	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	46, 582	46, 582	
29. 00 LPN/LVN	0	0	0	2, 326	2, 326	
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00   SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	10, 583	10, 583	37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00 PATI ENT TRANSPORTATI ON	0	0	0	0	0	39. 00
40.00   I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	3, 359	3, 359	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	62, 850	62, 850	100.00
* Transfer the amount in column 7 to West O.E. col	umn 1 line 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	C	0	25. 00
26. 00 PHYSI CI AN SERVI CES	C	0	26. 00
27. 00 NURSE PRACTITIONER	C	0	27. 00
28. 00 REGISTERED NURSE	C	46, 582	28.00
29. 00 LPN/LVN	C	2, 326	29. 00
30. 00 PHYSI CAL THERAPY	C	0	30.00
31. 00 OCCUPATIONAL THERAPY	C	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	C	0	33.00
34. 00 SPIRITUAL COUNSELING	C	0	34.00
35. 00 DI ETARY COUNSELING	C	0	35.00
36. 00 COUNSELING - OTHER	C	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	10, 583	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	3, 359	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	62, 850	100.00

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

Hospi ce CCN: 15-1524 12/31/2020 Date/Time Prepared: 7/8/2021 10:37 am Hospi ce I SALARI ES OTHER SUBTOTAL RECLASSI FI -SUBTOTAL (col . 1 + CATI ONS col. 4.00 1.00 2.00 3.00 5.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 0 25.00 0 PHYSICIAN SERVICES 26.00 0 Ω 0 26.00 0 0 27.00 NURSE PRACTITIONER 00000000000000000000 0 0 27.00 28.00 REGISTERED NURSE 329, 081 329, 081 28.00 29.00 LPN/LVN 0 0 16, 434 16, 434 29.00 PHYSI CAL THERAPY 0 30.00 0 0 30.00 31.00 OCCUPATIONAL THERAPY 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 32.00 MEDICAL SOCIAL SERVICES 0 0 33.00 0 33.00 0 SPIRITUAL COUNSELING 0 0 34.00 0 34.00 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 36.00 0 37.00 HOSPICE AIDE & HOMEMAKER SERVICES 0 74, 761 37.00 74, 761 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38.00 PATIENT TRANSPORTATION 39.00 39.00 0 0 IMAGING SERVICES 0 40.00 0 0 0 40.00 0 LABS & DIAGNOSTICS 0 41.00 Λ 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 23, 731 23, 731 42.00 DRUGS CHARGED TO PATIENTS 0 0 42.50 0 42.50 0 OUTPATIENT SERVICES 0 43.00 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 o 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00 0

0

444, 007

444, 007 100. 00

<sup>100.00|</sup>TOTAL \* 0|

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	329, 081	28. 00
29. 00	LPN/LVN	0	16, 434	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	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00		0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	74, 761	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	23, 731	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00		0	0	44.00
45.00		0	0	45.00
46.00		0	0	46.00
100.0	O TOTAL *	0	444, 007	100.00

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

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - DETERMINATION O	F HOSPITAL-BASED HOSPICE NET	Provider CCN: 15-0048	Peri od:	Worksheet 0-5
EVDENCES EOD ALLOCATION			From 01/01/2020	

EXPENSES FOR ALLOCATION	Trovider C		From 01/01/2020	WOLKSHEET 0-3		
EXPENSES FOR ALLOCATION	Hospi ce CC		Γο 12/31/2020	Date/Time Pre	pared:	
	'			7/8/2021 10: 37 am		
			Hospi ce I			
Descriptions		HOSPI CE	GENERAL	TOTAL		
		DI RECT	SERVI CE	EXPENSES (sum		
			EXPENSES FROM	of cols. 1 +		
		instructions)		2)		
			(see			
			instructions)			
		1. 00	2. 00	3. 00		
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FLXT				11, 114	1. 00	
2.00 CAP REL COSTS-MVBLE EQUIP		86		864	2.00	
3. 00 EMPLOYEE BENEFITS DEPARTMENT		115, 48		358, 378	3. 00	
4. 00 ADMINISTRATIVE & GENERAL		175, 70	716, 035	891, 741	4. 00	
5.00 PLANT OPERATION & MAINTENANCE			0	0	5.00	
6. 00 LAUNDRY & LINEN SERVICE				0	6. 00	
7. 00 HOUSEKEEPI NG			82, 290	82, 290	7. 00	
8. 00 DI ETARY		1, 61!	5 0	1, 615	8. 00	
9. 00 NURSING ADMINISTRATION			0	0	9. 00	
10.00 ROUTINE MEDICAL SUPPLIES			0	0	10.00	
11. 00 MEDI CAL RECORDS			712	712	11.00	
12. 00 STAFF TRANSPORTATION		95, 84	1	95, 841	12.00	
13. 00 VOLUNTEER SERVICE COORDINATION				0	13.00	
14. 00 PHARMACY		117, 78	0	117, 788	14.00	
15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES				0	15.00	
16. 00 OTHER GENERAL SERVICE			0	0	16.00	
17. 00 PATIENT/RESIDENTIAL CARE SERVICES			62, 110	62, 110	17.00	
LEVEL OF CARE						
50. 00 HOSPICE CONTINUOUS HOME CARE			D	0	50.00	
51.00 HOSPICE ROUTINE HOME CARE		1, 848, 33	3	1, 848, 333	51.00	
52. 00 HOSPICE INPATIENT RESPITE CARE		62, 850		62, 850	52.00	
53. 00 HOSPICE GENERAL INPATIENT CARE		444, 00	7	444, 007	53.00	
NONREI MBURSABLE COST CENTERS						
60. 00 BEREAVEMENT PROGRAM			D	0	60.00	
61.00 VOLUNTEER PROGRAM				0	61.00	
62. 00 FUNDRAI SI NG				0	62.00	
63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	63.00	
64. 00 PALLIATIVE CARE PROGRAM				0	64.00	
65. 00 OTHER PHYSI CI AN SERVI CES				0	65.00	
66. 00 RESIDENTI AL CARE				0	66.00	
67. 00 ADVERTI SI NG				0	67.00	
68. 00   TELEHEALTH/TELEMONI TORI NG				0	68. 00	
69. 00 THRI FT STORE				0	69.00	
70.00 NURSING FACILITY ROOM & BOARD				0	70.00	
71. 00 OTHER NONREIMBURSABLE (SPECIFY)				0	71.00	
99. 00 NEGATIVE COST CENTER				0	99. 00	
100. 00 TOTAL		2, 862, 49°	1, 115, 152	3, 977, 643	100.00	

358, 378

864

3, 977, 643 100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2020 Part I Hospi ce CCN: 15-1524 12/31/2020 Date/Time Prepared: To 7/8/2021 10:37 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 11, 114 1.00 CAP REL COSTS-BLDG & FIXT 11. 114 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 864 864 3.00 EMPLOYEE BENEFITS DEPARTMENT 358, 378 0 358, 378 3.00 ADMINISTRATIVE & GENERAL 891, 741 0 33, 199 936, 054 4.00 11, 114 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 5.00 0 LAUNDRY & LINEN SERVICE 0 6.00 0 C 0 0 6.00 7.00 HOUSEKEEPI NG 82, 290 0 82, 290 7.00 8.00 DI ETARY 1,615 0 0 0 1,615 8.00 NURSING ADMINISTRATION 0 0 9.00 0 9.00 0 0 ROUTINE MEDICAL SUPPLIES 0 10.00 0 Λ 10.00 11.00 MEDICAL RECORDS 712 0 0 0 712 11.00 12.00 STAFF TRANSPORTATION 95, 841 0 95, 841 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 14.00 PHARMACY 117, 788 0 0 0 117, 788 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 0 0 0 OTHER GENERAL SERVICE 0 16.00 16.00 0 0 0 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 62, 110 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 1,848,333 209, 968 2, 058, 301 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 62,850 C 107 14, 286 77, 243 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 444,007 0 757 100, 925 545, 689 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 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 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 0 0 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) 0 71 00 O 71.00 C 0 0 99.00 NEGATIVE COST CENTER 0 C 0 99.00

3, 977, 643

11, 114

0

2, 112 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2020 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2020 7/8/2021 10:37 am Hospi ce I ADMI NI STRATI V LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions PLANT E & GENERAL OPERATION & LINEN SERVICE MAI NTENANCE 4. 00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 936, 054 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 6.00 7.00 HOUSEKEEPI NG 25, 325 107, 615 7.00 8.00 DI ETARY 497 2, 112 8.00 NURSING ADMINISTRATION 9.00 0 9.00 0 0 ROUTINE MEDICAL SUPPLIES 0 0 10.00 0 10.00 11.00 MEDICAL RECORDS 219 0 11.00 0 12.00 STAFF TRANSPORTATION 29, 495 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 13.00 Ω 0 14.00 PHARMACY 36, 249 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 0 0 16.00 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 19, 114 C 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 633, 446 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 23, 772 C 0 13, 301 262 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 167, 937 0 0 94, 314 1,850 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 60.00 VOLUNTEER PROGRAM 0 61.00 0 0 61.00 FUNDRAI SI NG 0 62.00 0000000 0 0 0 62.00 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 PALLIATIVE CARE PROGRAM 0 64.00 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 0 0 0 66.00 67 00 ADVERTI SI NG 0 67 00 TELEHEALTH/TELEMONI TORI NG 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 0 0 0 0 71.00

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936, 054

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99.00 NEGATIVE COST CENTER

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2020 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2020 7/8/2021 10:37 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 10.00 C 10.00 11.00 MEDICAL RECORDS 931 11.00 12.00 STAFF TRANSPORTATION 125, 336 12.00 VOLUNTEER SERVICE COORDINATION 13.00 13.00 0 0 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 OTHER GENERAL SERVICE 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 125, 336 0 50.00 0 HOSPICE ROUTINE HOME CARE 868 51.00 51.00 0 0 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 8 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 55 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 0 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 FUNDRAI SI NG 62.00 62.00 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 66.00 0 0 0 66.00 67 00 ADVERTI SI NG 0 67 00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 Ω 71.00 0 0 0

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125, 336

0 99.00

0 100.00

99. 00 NEGATI VE COST CENTER

0 99.00

3, 977, 643 100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2020 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2020 To 7/8/2021 10:37 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 154, 037 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 OTHER GENERAL SERVICE 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 81, 224 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 125, 336 50.00 0 50.00 0 HOSPICE ROUTINE HOME CARE 143, 609 51.00 51.00 0 2, 836, 224 52.00 HOSPICE INPATIENT RESPITE CARE 1, 293 0 10,074 125, 953 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 9, 135 0 71, 150 890, 130 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 0 PALLIATIVE CARE PROGRAM 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

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81, 224

99. 00 NEGATI VE COST CENTER

Heal th Financial	Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2552-10
COCT ALLOCATION	LIOCOLTAL DACE	ED HOCDLOE CENEDAL CEDVICE COCTO	D	Da!!	W

Peri od: From 01/01/2020 To 12/31/2020 COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Part II
Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 15-1524 7/8/2021 10:37 am Hospi ce I CAP REL BLDG CAP REL MVBLE **EMPLOYEE** RECONCI LI ATI O ADMI NI STRATI V Cost Center Descriptions & FIX EQUI P **BENEFITS** E & GENERAL N (SQUARE FEET) (DOLLAR DEPARTMENT (ACCUMULATED VALUE) (GROSS COSTS) SALARI ES) 1. 00 2.00 4.00 3.00 4A GENERAL SERVICE COST CENTERS 1 00 400 1 00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 445 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 0 0 1, 576, 641 3.00 ADMINISTRATIVE & GENERAL 4.00 400 0 146,055 -936, 054 3, 041, 589 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 0 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 82, 290 7.00 0 8.00 DI FTARY 0 0 0 1, 615 8.00 NURSING ADMINISTRATION 0 9.00 0000 0 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 0 10.00 0 MEDICAL RECORDS 0 0 712 11.00 11.00 STAFF TRANSPORTATION 0 0 12.00 95, 841 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 13.00 0 0 14.00 **PHARMACY** 0 0 117, 788 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 15.00 C Ω 15.00 16.00 OTHER GENERAL SERVICE 0 C 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 62, 110 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 0 50.00 51.00 HOSPICE ROUTINE HOME CARE 923, 729 0 2,058,301 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 55 62,850 77, 243 52.00 53 00 HOSPICE GENERAL INPATIENT CARE 0 390 444,007 0 545, 689 53 00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 0 60.00 0 0 61.00 VOLUNTEER PROGRAM 0 0 0 0 61.00 0 0 62 00 FUNDRAI SI NG Ω 62 00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 0 0 63.00 PALLIATIVE CARE PROGRAM 0000 0 0 0 0 64.00 64.00 OTHER PHYSICIAN SERVICES 65.00 0 0 0 0 0 0 65.00 0 RESIDENTIAL CARE 0 66.00 0 66.00 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 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00 936, 054 100. 00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 11.114 358, 378 864

27. 785000

1.941573

0. 227305

0. 307752 101. 00

101.00 UNIT COST MULTIPLIER

Heal th 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

(IN-FACILITY

DAYS)

In Lieu of Form CMS-2552-10
Worksheet 0-6
Part II
Date/Time Prepared: 7/8/2021 10: 37 am

Hospice I

NURSING
ADMINISTRATIO
NAMINISTRATIO

						77 07 2021 10.0	7 GIII
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS. )	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			,			
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	445					5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPI NG	0		445			7. 00
8.00	DI ETARY	0		l 0	1, 290		8. 00
9.00	NURSI NG ADMI NI STRATI ON	0		l 0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		l 0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	1
14. 00	PHARMACY	0		0		0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		1 0		0	15.00
16. 00	OTHER GENERAL SERVICE	0		0		Ö	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					ő	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	55	0	55	160	ő	1
53. 00	HOSPICE GENERAL INPATIENT CARE	390			1, 130		
55.00	NONREI MBURSABLE COST CENTERS	370		370	1, 130	0	33.00
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62. 00	FUNDRAI SI NG	0				0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64. 00	PALLIATIVE CARE PROGRAM					0	
65.00	OTHER PHYSICIAN SERVICES					0	65.00
66.00	RESI DENTI AL CARE		_		0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	67.00
68.00		0				0	68.00
	TELEHEALTH/TELEMONI TORI NG	0		0		0	
69.00	THRIFT STORE	0		0		U	
70.00	NURSING FACILITY ROOM & BOARD					_	70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0	0	0	0	
	NEGATI VE COST CENTER			107 /15	2 442	_	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0 000000	1077010	2, 112		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	241. 831461	1. 637209	0. 000000	1101.00

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

Heal th	Financial Systems REID	TH CARE SERVI	CES	In Lie	u of Form CMS-2	<u> 2552-10</u>	
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	Provi der Co		Peri od:	Worksheet 0-6		
STATI STI CAL BASI S					From 01/01/2020	Part II	
			Hospi ce CCI	N: 15-1524 <sup>-</sup>	Γo 12/31/2020	Date/Time Pre	
						7/8/2021 10: 3	7 am
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	·	MEDI CAL	RECORDS	TRANSPORTATI O	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	l N	COORDI NATI ON	·	
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)	Ditio)	(IIII EE/TOE)	SERVICE)		
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1 00				I	1		1 00
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						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9.00
		10.054					
10.00	ROUTINE MEDICAL SUPPLIES	19, 054	10.054				10.00
11.00	MEDI CAL RECORDS		19, 054				11.00
12.00	STAFF TRANSPORTATION			1, 000			12.00
13.00	VOLUNTEER SERVICE COORDINATION			(	19, 054		13.00
14.00	PHARMACY			(		19, 054	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				ol ol	0	15.00
16.00	OTHER GENERAL SERVICE			1	ol ol	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					-	17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1, 000	ol ol	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	17, 764	17, 764		17, 764	17, 764	1
	y .						
52.00	HOSPICE INPATIENT RESPITE CARE	160	160		160	160	•
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 130	1, 130		1, 130	1, 130	53.00
	NONREI MBURSABLE COST CENTERS						,, ,,
60.00	BEREAVEMENT PROGRAM				0	0	60.00
61. 00	VOLUNTEER PROGRAM				이	0	61.00
62.00	FUNDRAI SI NG			(	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			(	o o	0	63.00
64.00	PALLIATIVE CARE PROGRAM				ol ol	0	64.00
65.00	OTHER PHYSICIAN SERVICES			1	ol ol	0	65.00
66. 00	RESI DENTI AL CARE			ĺ		0	66.00
67.00	ADVERTI SI NG					0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG			)		0	68.00
	ų .						
69. 00	THRI FT STORE				ال ال	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	71.00
99. 00	NEGATI VE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	931	125, 336	6 0	154, 037	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 048861	125. 336000	0. 000000	8. 084234	101. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

Hospi ce CCN: 15-1524

Peri od: Worksheet 0-6 From 01/01/2020 To 12/31/2020 Part II Date/Time Prepared:

7/8/2021 10:37 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 (SPECLEY CARE SERVICES (PATIENT BASIS) (IN-FACILITY DAYS) DAYS) 15. 00 16. 00 17.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DIFTARY 8.00 NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 11.00 MEDICAL RECORDS 11.00 STAFF TRANSPORTATION 12.00 12.00 13.00 VOLUNTEER SERVICE COORDINATION 13.00 14.00 **PHARMACY** 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 19,054 15.00 16.00 OTHER GENERAL SERVICE C 16.00 PATIENT/RESIDENTIAL CARE SERVICES 1, 290 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 51.00 HOSPICE ROUTINE HOME CARE 17, 764 0 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 160 0 160 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1, 130 0 1, 130 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 60.00 VOLUNTEER PROGRAM 0 61.00 61.00 62.00 FUNDRAI SI NG 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 64.00 OTHER PHYSICIAN SERVICES 65.00 0 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 68.00 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71.00 99.00 99. 00 NEGATI VE COST CENTER 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 100.00 81.224 101.00 UNIT COST MULTIPLIER 0.000000 0.000000 62.964341 101.00

LEVEL OF CARE

7/8/2021 10:  Hospi ce I  Charges by LOC (from Provi der Records)	
Charges by Loc (11011 Frovider Records)	
Cost Center Descriptions From Wkst. C, Cost to HCHC HRHC HIRC	
Part I, Col. Charge Ratio	
9 line	
0 1.00 2.00 3.00 4.00	
ANCILLARY SERVICE COST CENTERS	
1. 00 PHYSI CAL THERAPY 66. 00 0. 653218 0 0	1
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. 343525 0 0	
5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00 1. 489414 0 0 0	
6. 00 LABORATORY 60. 00 0. 185789 0 0	
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 00 0. 000000 0 0	
8. 00 FAMILY PRACTICE 93. 00 0. 570834 0 0	8.00
9. 00 RADI OLOGY-THERAPEUTI C 55. 00	9.00
10. 00   ANCI LLARY - OTHER   76. 00   0. 000000   0   0   0   0   0   0	
10. 97   CARDI AC REHABI LI TATI ON 76. 97   1. 063034   0   0   0	
11.00 Totals (sum of lines 1-11)	11.00
Charges by Shared Service Costs by LOC LOC (from	
Provi der	
Records)	
Cost Center Descriptions  HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1	
5.00 6.00 7.00 8.00 9.00	
ANCI LLARY SERVI CE COST CENTERS	
1.00 PHYSI CAL THERAPY 0 0 0 0 0	1.00
2. 00 OCCUPATIONAL THERAPY	2.00
3.00 SPEECH PATHOLOGY	3.00
4.00   DRUGS CHARGED TO PATIENTS   0   0   0   0	4. 00
5. 00   DURABLE MEDI CAL EQUI P-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 ANCILLARY - OTHER 0 0 0 0	
10. 97   CARDI AC REHABI LI TATI ON   O   O   O   O   O   O   O   O   O	
11.00 Totals (sum of lines 1-11) 0 0 0	11.00

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

Heal th	Financial Systems REID HOSPITAL & HEALTI	H CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der CC	N: 15-0048	Peri od:	Worksheet 0-8	
		Heeni ee CCN	l. 1E 1E04	From 01/01/2020 To 12/31/2020	Date/Time Pre	narad.
		Hospi ce CCN	1: 15-1524	10 12/31/2020	7/8/2021 10: 3	
				Hospi ce I	77072021 10.0	7 GIII
			TITLE XVIII		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,			125, 336	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	ne 10)		0		4.00
5.00	Program cost (line 3 times line 4)			0 0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7, col. 7,			2, 836, 224	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				17, 764	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				159. 66	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	15, 6	87 524		9.00
10.00	Program cost (line 8 times line 9)		2, 504, 5	86 83, 662		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,			125, 953	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)				787. 21	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)		54 0		14.00
15. 00	Program cost (line 13 times line 14)		121, 2	30 0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	-7, col. 9,			890, 130	16.00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				1, 130	
18. 00	Total average cost per diem (line 16 divided by line 17)				787. 73	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		64 20		19.00
20. 00	Program cost (line 18 times line 19)		759, 3	72 15, 755		20. 00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				3, 977, 643	
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				19, 054	
23. 00	Average cost per diem (line 21 divided by line 22)				208. 76	23.00

	Financial Systems	REID HOSPITAL & HEALT		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT		Provider CCN: 15-0048	Peri od: From 01/01/2020 To 12/31/2020		pared:
			Title XVIII	Hospi tal	PPS	<u>/ uiii                                 </u>
					1. 00	
	PART I - FULLY PROSPECTIVE METHOD					1
1 00	CAPITAL FEDERAL AMOUNT				4 044 007	1 00
1.00	Capital DRG other than outlier	and another and			4, 044, 987	1.00
1. 01	Model 4 BPCI Capital DRG other th	an outiler			(2, 027	1.01
2. 00 2. 01	Model 4 BPCI Capital DRG outlier	novmonts			62, 037 0	1
2. 01 3. 00	Total inpatient days divided by n		connecting pariod (see ins	tructions)	139. 43	3.00
3. 00 4. 00	Number of interns & residents (se		eporting perrod (see rns	structions)	16. 75	
5. 00	Indirect medical education percen				3. 45	
5. 00 6. 00	Indirect medical education percent		e sum of lines 1 and 1 (	11 columns 1 and	139, 552	6.00
0.00	1.01)(see instructions)	ment (martiply fine 3 by th	ic sam of fines f and f. c	71, COI anni 3 1 and	137, 332	0.00
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	10.00
11. 00					0	11.00
12.00	Total prospective capital payment	s (see instructions)			4, 246, 576	12.00
	I				1. 00	
	PART II - PAYMENT UNDER REASONABL					
1.00	Program inpatient routine capital				0	
2.00	Program inpatient ancillary capital cost (see instructions)  Total inpatient program capital cost (line 1 plus line 2)			0	2.00	
3.00					0	3.00
4. 00 5. 00	Capital cost payment factor (see				0	4. 00 5. 00
5.00	Total inpatient program capital c	ost (The 3 x The 4)			0	5.00
					1. 00	
	PART III - COMPUTATION OF EXCEPTI	ON PAYMENTS			1.00	
1. 00	Program inpatient capital costs (				0	1.00
2. 00	Program inpatient capital costs f		ces (see instructions)		0	2.00
3. 00	Net program inpatient capital cos		,		0	1
4. 00	Applicable exception percentage (				0.00	
5. 00	Capital cost for comparison to pa	yments (line 3 x line 4)			0	5.00
4 00	Dorcontago adjustment for extraor				0.00	4 00

Percentage adjustment for extraordinary circumstances (see instructions)

Current year allowable operating and capital payment (see instructions)

Current year capital payments (from Part I, line 12, as applicable)

Capital minimum payment level (line 5 plus line 7)

(if line 12 is negative, enter the amount on this line)

17.00 Current year exception offset amount (see instructions)

Current year operating and capital costs (see instructions)

Worksheet L, Part III, line 14)

Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)

Carryover of accumulated capital minimum payment level over capital payment (from prior year

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0.00

0

0

0

0

0

0

0

0 15.00

0 16.00

0 17.00

6.00

8.00

9.00

10.00

11.00

12.00

13.00

14.00

6.00

7.00

8.00

9 00

10.00

11.00

12.00

13.00

14.00

15.00

16.00