This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0048 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2024 2:00 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 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 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER	OR ADMINISTRATOR	CHECKBOX		
	1		2	SIGNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-552, 775	-987, 066	0	3, 371, 152	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	54, 069	13		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	-498, 706	-987, 053	0	3, 371, 152	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 REID HOSPITAL & HEALTH 150048 99915 07/01/1966 Ν 0 3.00 1 CARE SERVICES Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF REHAB UNIT 15T048 99915 01/01/2003 Р 0 N 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 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce HOSPI CE 14.00 151524 99915 11/03/1993 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) 01/01/2023 12/31/2023 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 UCPs, including supplemental UCPs, for 22.01 this 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) Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 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 October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν 22.03 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 yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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 yes 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e 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 1 007 363 206 218 7, 738 120 24.00 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. 25.00 If this provider is an IRF, enter the in-state 0 40 0 21 642 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 01/01/2023 12/31/2023 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N Ν N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reporting Y 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Υ 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0048 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA Ν 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 N "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COM	ATA	Provider CCN: 15-0048 Period: Worksheet S-2					
					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	nared:
					10 12/31/2023	5/31/2024 2: 0	
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der	FTEs in	1/ (col . 1 +	
				Si te	Hospi tal	col. 2))	
				1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Ye	ar FTE Residents in N	lonprovi de	r Settings				
period that begins on or after							
64.00 Enter in column 1, if line 63 i				0.0	0.00	0. 000000	64. 00
in the base year period, the nure resident FTEs attributable to r							
settings. Enter in column 2 th							
resident FTEs that trained in y	our hospital. Enter i	n column 3	3 the ratio				
of (column 1 divided by (column				Harris alaka d	Harris alaka d	D-+: - (I	
	Program Name	Progr	am Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
				Nonprovi der		col . 4))	
				Si te	'	, ,	
	1. 00	2	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63				0.0	0.00	0. 000000	65.00
is yes, or your facility trained residents in the base							
year period, the program name							
associated with primary care							
FTEs for each primary care							
program in which you trained							
residents. Enter in column 2, the program code. Enter in							
column 3, the number of							
unweighted primary care FTE							
residents attributable to							
rotations occurring in all							
non-provider settings. Enter ir 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)							
(See Tristi de trons)				Unwei ghted	Unwei ghted	Ratio (col.	
				FTĔs	FTEs in	1/ (col. 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Si te	2.00	2.00	
Section 5504 of the ACA Current	Year FTF Residents i	n Nonnrov	ider Settino	1.00	for cost report	3.00	
beginning on or after July 1, 2	010				Tor cost report	ing perrous	
66.00 Enter in column 1 the number of				0.0	0. 00	0. 000000	66. 00
FTEs attributable to rotations							
Enter in column 2 the number of FTEs that trained in your hospi							
(column 1 divided by (column 1							
-	Program Name	Progr	am Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTES	FTEs in	3/ (col. 3 +	
				Nonprovider Site	Hospi tal	col. 4))	
	1. 00	2	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program	FAMILY MED	1350		0.0			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		I	I		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pro	ovider CCN: 15-		eriod: rom 01/01/2 o 12/31/2		Workshee Part I Date/Tir 5/31/202	me Pre	pared:
					1. 0	0	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 68.00 For a cost reporting period beginning prior to October 1, 2022, d MAC to apply the new DGME formula in accordance with the FY 2023 (August 10, 2022)?	lid you obtain	permi ssi	on from you				68. 00
			-	1. 00	2.00	3. 00	
Inpatient Psychiatric Facility PPS					1 2.00	0.00	
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does Enter "Y" for yes or "N" for no.	it contain a	n IPF sub	provi der?	N			70.00
71.00 If line 70 is yes: Column 1: Did the facility have an approved GM recent cost report filed on or before November 15, 2004? Enter " 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train r. program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter " Column 3: If column 2 is Y, indicate which program year began dur (see instructions)	Y" for yes or esidents in a Y" for yes or	"N" for new teac "N" for	no. (see hi ng no.	N	N	0	71.00
Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or d	loes it contai	n an IRF		Υ	Т		75.00
subprovider? Enter "Y" for yes and "N" for no.							
76.00 If line 75 is yes: Column 1: Did the facility have an approved GM recent cost reporting period ending on or before November 15, 200 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Columindicate which program year began during this cost reporting periods.	04? Enter "Y" program in ad umn 3: If colud	for yes o ccordance mn 2 is Y	r "N" for with 42	N	N	0	76. 00
				-	1. 0	0	
Long Term Care Hospital PPS						J	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 81.00 Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no. TEFRA Providers	nter	N N		80. 00 81. 00			
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR. 86.00 Did this facility establish a new Other subprovider (excluded uni §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	no.	N		85. 00 86. 00			
87.00 Is this hospital an extended neoplastic disease care hospital cla 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ssified under	section	Approved	for	Number	o.f	87. 00
			Permaner Adjustme (Y/N)	nt	Appro Permar Adjustm	ved nent ments	
88.00 Column 1: Is this hospital approved for a permanent adjustment to amount per discharge? Enter "Y" for yes or "N" for no. If yes, co. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N		2.0	0	88. 00
		. A Line	Effectiv	ve	Appro		
		No.	Date		Permar Adjusti Amount Discha	ment Per arge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line n		0.00	2. 00		3. 0		89. 00
on which the per discharge permanent adjustment approval was base Column 2: Enter the effective date (i.e., the cost reporting peribeginning date) for the permanent adjustment to the TEFRA target per discharge. Column 3: Enter the amount of the approved permanent adjustment to TEFRA target amount per discharge.	ed. od amount	0.00					3 7. 33
			1. 00		2. 0		
Title V and XIX Services							
 90.00 Does this facility have title V and/or XIX inpatient hospital serves or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the content of the conten	st report eitl		N N		Y Y		90.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.						92.00
instructions) Enter "Y" for yes or "N" for no in the applicable composes this facility operate an ICF/IID facility for purposes of ti	ol umn.	•	N		N		93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "			N		N		94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicab			0.00		0. 0	0	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "		the	0.00 N		N. O.		96.00

|--|

	Provider C	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet S- Part I Date/Time Pr 5/31/2024 2:	epared:
			V	XI X	J DIII
98.00 Does title V or XIX follow Medicare (title XVIII) for the	interns and res	sidents nost	1. 00 Y	2. 00 Y	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y' column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in			
98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.	title V, and ir	narges on wkst n column 2 for	. Y	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a creimbursed 101% of inpatient services cost? Enter "Y" for for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a C/outpatient services cost? Enter "Y" for yes or "N" for no			N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in column 2 for title XIX.		Y	Y	98.06	
column 2 for title XIX. Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the al for outpatient services? (see instructions)	I-inclusive met	thod of paymen	t N		105. 00 106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colucolumn 2: If column 1 is Y and line 70 or line 75 is Y, approved medical education program in the CAH's excluded	N		107.00		
Enter "Y" for yes or "N" for no in column 2. (see instruction of this facility is a REH (line 3, column 4, is "12"), is reimbursement for I&R training programs? Enter "Y" for yes			107. 0		
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00		
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 f this hospital qualifies as a CAH or a cost provider, a	1.00 re N	2. 00 N	3. 00 N	4.00	100.00
	9			I IV	1109 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				N	109.00
				1.00	109.00
for yes or "N" for no for each therapy.	"Y" for yes or	"N" for no.	410A If yes,		
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and N	"Y" for yes or	"N" for no.	410A If yes, ugh 215, as	1. 00 N	
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and N	Ty" for yes or worksheet E-2, I to the Frontier (cost reporting column 1 is Y, participating ir	Community period? Enter the column 2.	410A If yes, ugh 215, as	1.00	110.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for	Ty" for yes or worksheet E-2, I to the Frontier (cost reporting column 1 is Y, participating ir	Community period? Enter enter the column 2. s; and/or "C"	410A If yes, ugh 215, as	1. 00 N	110.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services.	the Frontier (cost reporting column 1 is Y, articipating beds	Community period? Enter the column 2.	410A If yes, ugh 215, as	1. 00 N	110.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable.	n the Frontier (cost reporting column 1 is Y, additional bedsealth Model reporting column 1 is the first t	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	1. 00 N	110.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital oparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes	T'Y" for yes or Worksheet E-2, I the Frontier (cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased	Community period? Enter enter the n column 2. s; and/or "C"	410A If yes, ugh 215, as	1. 00 N	110.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is participate in the Pennsylvania Rural Health that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital content of the participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	a the Frontier (cost reporting column 1 is Y, participating ir additional beds ealth Model reporting column 1 is cipating in the ceased or "N" for no B, or E only) "93" percent e (includes	Community period? Enter enter the column 2. s; and/or "C"	410A If yes, ugh 215, as	1. 00 N	111.00
for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wapplicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is penter all that apply: "A" for Ambulance services; "B" for for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural He (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital constration. In column 3, enter the date the hospital oparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care	a the Frontier (cost reporting column 1 is y, participating ir additional beds ealth Model reporting column 1 is ipating in the ceased or "N" for no B, or E only) "93" percent e (includes ders) based on	Community period? Enter enter the column 2. s; and/or "C"	410A If yes, ugh 215, as	1. 00 N	110.00

143.00 Ci ty: RI CHMOND 47374 143.00 State: ΙN Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146. 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.

Contractor's Number: 08101

141.00

142.00

Contractor's Name: WPS

office and enter the home office contractor name and contractor number.

PO Box:

141.00 Name: REID HOME OFFICE

142.00 Street: 1100 REID PARKWAY

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	REID HOSPITAL & HEA		Provider CCN: 15-0048 Pe		: 01/01/2023	w of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/31/2024 2:0	pared:
						5/31/2024 2:0	JO pili
						1. 00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	yes or "N" for	no.			N	147. 00
148.00 Was there a change in the order of				£		N N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? E	Part A	es or "N" Part E		itle V	Title XIX	149.00
		1. 00	2.00		3.00	4.00	-
Does this facility contain a prov	der that qualifies for ar						
or charges? Enter "Y" for yes or							
155. 00 Hospi tal	·	N	N		N	N	155. 00
156.00 Subprovi der - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157. 00
158. 00 SUBPROVI DER							158.00
159. 00 SNF		N	N		N	N N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N		N N	N N	160. 00 161. 00
101. 00 CMITC			IV		IN	IV	101.00
						1. 00	1
Mul ti campus							
165.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	BSAs?	N	165. 00				
	Name	County	State	Zi p Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4. 00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 00	166. 00
						1. 00	-
Health Information Technology (HI	T) incentive in the Americ	can Recovery as	nd Rei nyest	tment Act		1.00	
167.00 Is this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10					er the	·	168.00
reasonable cost incurred for the H				. ,,			
168.01 If this provider is a CAH and is					dshi p		168. 01
exception under §413.70(a)(6)(ii)						0.00	11/0 00
169.00 If this provider is a meaningful transition factor. (see instruction		I IS NOT A CAH	(11 ne 105	IS "N"),	enter the	9. 99	169. 00
1 212 1 21 22 22 22 22 22 22 22 22 22 22				Be	gi nni ng	Endi ng	
					1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and ending	date for the r	eporti ng				170. 00
perrou respectivery (mm/dd/yyyy)							

171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)

1.00

N

2.00

0171.00

	Financial Systems REID HOSPITAL & HEALT TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2023		2		
				To 12/31/2023	Date/Time Pro 5/31/2024 2:0			
				Y/N	Date	JO PIII		
				1. 00	2. 00			
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEM	IENT QUESTI ONI	NAI RE					
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. En	ter all dates in	the			
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	boginning of	the cost	N		۱,		
00	reporting period? If yes, enter the date of the change in co					1.		
	Treporting perrou? IT yes, enter the date or the change IT co	nullin 2. (See	Y/N	Date	V/I			
			1.00	2.00	3. 00	_		
00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	2.00	0.00	2.				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)			3.				
			Y/N	Type	Date			
			1.00	2. 00	3. 00			
	Financial Data and Reports							
	Column 1: Were the financial statements prepared by a Certi-Accountant? Column 2: If yes, enter "A" for Audited, "C" fo or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different contents.	or Compiled, lable in	Y N	A	04/20/2023	5.		
	those on the filed financial statements? If yes, submit reco	nciliation.		\/ /NI	1 1 0			
				Y/N 1. 00	Legal Oper. 2.00	-		
	Approved Educational Activities			1.00	2.00			
	Column 1: Are costs claimed for a nursing program? Column 2 the legal operator of the program?		s the provide	er N		6		
00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		wed during t	he Y		8		
00	Are costs claimed for Interns and Residents in an approved g program in the current cost report? If yes, see instructions	, S.				9		
	Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.			Y		10		
	0 Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.							
					1. 00			
	Bad Debts					12		
00	O If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting							
00	i nstructi ons.							
00	instructions. Bed Complement							
. 00	i nstructi ons.			structions.	N	15.		
. 00	instructions. Bed Complement	Par	t A	Par	t B	15.		
. 00	instructions. Bed Complement	Par Y/N	t A Date	Par Y/N	t B Date	15		
. 00	instructions. Bed Complement	Par	t A	Par	t B	15		

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Y	04/02/2024	Υ	04/02/2024	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
10.00	cost report? If yes, see instructions.					40.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	IN IN		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.				l	l

Heal th	Financial Systems REID HOSPITAL & HEA	ALTH CARE SERVI	CES	In Lie	u of Form CMS	5-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0048 F	eri od:	Worksheet S			
				rom 01/01/2023 o 12/31/2023		repared:		
					5/31/2024 2:			
			iption O	Y/N 1.00	Y/N 3. 00			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	'	0	N N	3.00 N	20.00		
	Report data for Other? Describe the other adjustments:							
		Y/N 1.00	2. 00	Y/N 3. 00	Date			
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4. 00	21. 00		
	records? If yes, see instructions.							
					1 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1. 00			
	Capital Related Cost		,					
22.00	Have assets been relifed for Medicare purposes? If yes, se				N	22.00		
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	N	23. 00				
24.00	Were new leases and/or amendments to existing leases enter	orting period?	N	24. 00				
05.00	If yes, see instructions			1.6	.,	05.00		
25. 00	Have there been new capitalized leases entered into during instructions.	, the cost repo	rting period?	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? If	yes, see	N	26. 00		
07.00	i nstructi ons.					07.00		
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng perioa? it	yes, submiτ	N	27. 00		
	Interest Expense							
28. 00	. 33 3	reporti ng	N	28. 00				
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Υ	29. 00					
27.00	treated as a funded depreciation account? If yes, see inst		27.00					
30. 00	Has existing debt been replaced prior to its scheduled mat	see	Υ	30. 00				
31. 00	instructions. Has debt been recalled before scheduled maturity without i	See	N	31.00				
01.00	instructions.	Soddinee of fiew	debt. 11 yes,	300	.,,			
	Purchased Services				.,			
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Υ	32.00		
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If	Y	33.00		
	no, see instructions.							
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an	arrangement wi	th provider-ba	sed physicians?	N	34.00		
34.00	If yes, see instructions.	arrangement wi	in provider ba	seu priysi er aris:	14	34.00		
35. 00	If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date			
				1.00	2. 00			
24 22	Home Office Costs					0/ 00		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		36. 00 37. 00		
37.00	If yes, see instructions.	repared by the	nome office:	'		37.00		
38. 00	If line 36 is yes , was the fiscal year end of the home of			N		38. 00		
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			N		39. 00		
37.00	see instructions.	ioi charri compo	nonts: 11 yes,	1.4		37.00		
40.00	'			40. 00				
	i nstructi ons.							
		2.	00					
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KERRY		BEJARANO		41.00		
	respectively.							
42.00	Enter the employer/company name of the cost report	FORVI S				42.00		
43. 00	preparer. Enter the telephone number and email address of the cost	3173834000		KERRY. BEJARANO	@FORVIS COM	43.00		
4 3.00	report preparer in columns 1 and 2, respectively.	0173034000		REINT. DESARANO	-1 3KV1 3. COW	13.00		
		•		•				

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0048 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 44.00	Heal th	Financial Systems	REID HOSPITAL & HE	ALTH	CARE SERVI	CES		In Lieu	u of Form CMS-	2552-10
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. DIRECTOR 41.00 42.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEM	ENT QUESTIONNAIRE		Provi der C	CCN: 15-0048				2
2.00 pm Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.										
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 42.00							10	12/31/2023	Date/IIMe Pre	eparea:
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 42.00									3/31/2024 2.0) piii
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 42.00					2	00				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 41.00		Ta			ა.	. 00				_
held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 42.00		Cost Report Preparer Contact Informati	on							
respectively. 42.00 Enter the employer/company name of the cost report preparer. 42.00	41.00	Enter the first name, last name and the	ne title/position	DI R	ECTOR					41.00
42.00 Enter the employer/company name of the cost report preparer.		held by the cost report preparer in co	olumns 1, 2, and 3,							
preparer.		respecti vel y.								
	42.00	Enter the employer/company name of the	e cost report							42.00
40.00 5 1 1 1 1 1 1 1 1 1		preparer.								
43.00 Enter the telephone number and email address of the cost 43.00	43.00	Enter the telephone number and email	address of the cost							43.00
report preparer in columns 1 and 2, respectively.		report preparer in columns 1 and 2, re	especti vel y.							

34.00

0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm I/P Days / 0/P Visits / Tri ps Bed Days CAH/REH Hours Component Worksheet A No. of Beds Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 55, 845 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 153 0.00 0 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 153 55, 845 7.00 0.00 0 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 31.00 30 10, 950 0.00 0 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 43.00 13.00 14.00 Total (see instructions) 183 66, 795 0.00 0 14.00 15.00 CAH visits 0 15.00 15. 10 REH hours and visits 0.00 0 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 41.00 20 7,300 0 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 116.00 0 0 24.00 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 26 00 26 00 FEDERALLY QUALIFIED HEALTH CENTER 89.00 26. 25 0 26. 25 27.00 Total (sum of lines 14-26) 203 27.00 28.00 Observation Bed Days 28.00 Ambulance Trips 29 00 29 00 Employee discount days (see instruction) 30.00 30.00 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions)
Total ancillary labor & delivery room 32.00 0 0 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

30.00

0

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0048

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 2:00 pm

			1 2 15 111 1 1			5/31/2024 2:0	O pm
		1/P Days	o/P Visits	/ Irips	Full lime	Equi val ents	
	Companent	Title XVIII	T: +Lo VIV	Total All	Total Intorno	Employees Op	
	Component	litte xviii	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 825	772	32, 888		I	1.00
1.00	8 exclude Swing Bed, Observation Bed and	12, 025	112	32,000			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	8, 574	8, 525				2.00
3.00	HMO IPF Subprovi der	0,0,1	0, 020				3.00
4. 00	HMO IRF Subprovider	757	703				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	1	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7. 00	Total Adults and Peds. (exclude observation	12, 825	772				7.00
7.00	beds) (see instructions)	12,020	,,,	02,000			7.00
8. 00	INTENSIVE CARE UNIT	1, 550	156	4, 214			8.00
9. 00	CORONARY CARE UNIT	1, 000	.00	.,			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		79	1, 274			13.00
14. 00	Total (see instructions)	14, 375	1, 007	38, 376		1, 245. 80	14.00
15. 00	CAH vi si ts	0	0	0		1, = 101 00	15.00
15. 10	REH hours and visits	o	0	0			15. 10
16.00	SUBPROVIDER - IPF		-	_			16.00
17. 00	SUBPROVI DER - I RF	1, 691	0	3, 964	0.00	22. 75	
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	1, 053	27	1, 211	0.00	26. 32	24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				17. 93	1, 294. 87	27.00
28.00	Observation Bed Days		390	10, 256			28. 00
29.00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			429			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	120	161			32.00
32.01	Total ancillary labor & delivery room			0			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
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Heal th Fi nancialSystemsREID HOSPITALHOSPITALAND HOSPITAL HEALTH CARE COMPLEXSTATISTICAL DATA Provi der CCN: 15-0048

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				10) 12/31/2023	Date/IIMe Pre 5/31/2024 2:0	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 106	274	10, 457	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			2 027	2 222		2 00
2.00	HMO and other (see instructions)			2, 037	2, 323		2.00
3. 00 4. 00	HMO I PF Subprovi der				49		3. 00 4. 00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				49		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						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						13.00
14.00	Total (see instructions)	0.00	0	4, 106	274	10, 457	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	138	0	276	1
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.)	0.00					23.00
24. 00	HOSPI CE	0.00					24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					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)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			О			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0048

					To	12/31/2023	Date/Time Pre 5/31/2024 2:0	
		Wkst. A Line Number	Amount Reported	Reclassificat	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage	
		Number	керог геа	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col . 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	101, 153, 220	0	101, 153, 220	2, 730, 630. 63	37. 04	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
	Α		_	_				
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A -		0	О	0	0. 00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0. 00	4. 01
5.00	Physician and Non		0	0	0	0. 00	0. 00	
6. 00	Physician-Part B Non-physician-Part B for		0	0	0	0. 00	0. 00	6.00
	hospi tal-based RHC and FQHC services			_				
7. 00	Interns & residents (in an approved program)	21. 00	0	1, 803, 728	1, 803, 728	37, 285. 65	48. 38	7.00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44. 00	0	О	0	0. 00	0. 00	
10. 00	Excluded area salaries (see instructions)		5, 465, 794	333, 125	5, 798, 919	169, 159. 95	34. 28	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		11, 450, 239	0	11, 450, 239	182, 143. 90	62. 86	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		459, 288	0	459, 288	3, 083. 75	148. 94	13.00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0. 00	14.00
14. 01	Home office salaries		39, 003, 421	О	39, 003, 421	1, 059, 195. 66	36. 82	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	1	0	0. 00 0. 00	0.00	14. 02 15. 00
15.00	- Administrative		0	٥		0.00	0.00	15.00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A		0	О	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0	0	0. 00	0.00	16. 02
	Physicians Part A - Teaching			_				
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		30, 837, 175	0	30, 837, 175			17. 00
10 00	instructions)							10 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		1, 910, 333	0	1, 910, 333			19.00 20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21.00
22 00	B Physician Part A -		0	0				22. 00
	Administrative		U					
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	Ö	·			24.00
25. 00	Interns & residents (in an approved program)		421, 069	0	421, 069			25.00
25. 50	Home office wage-related (core)		5, 686, 569	0	5, 686, 569			25. 50
25. 51	Related organization		0	О	О			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)							

Social Service

43.00 Other General Service

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 (col. 2 ± col. Sal ari es 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 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 106, 548 106, 548 3, 214. 96 33. 14 26.00 27.00 Administrative & General 5.00 2, 897, 097 295, 984 3, 193, 081 109, 528. 35 29. 15 27.00 28.00 6, 263, 854 6, 263, 854 88, 691. 25 70. 63 28.00 Administrative & General under contract (see inst.) 29.00 29.00 Maintenance & Repairs 6.00 0.00 0.00 30.00 Operation of Plant 7.00 0 0 0.00 0.00 30.00 0 0 31.00 . Laundry & Linen Service 8.00 0 0.00 0.00 31.00 0 0 32.00 Housekeepi ng 0.00 9.00 C 0.00 32.00 33.00 Housekeeping under contract 0 0 0.00 0.00 33.00 (see instructions) 56, 300. 26 34.00 Dietary 10.00 3, 425, 600 -2, 256, 865 1, 168, 735 20. 76 34.00 Dietary under contract (see 35.00 392, 148 392, 148 5, 556. 00 70. 58 35.00 instructions) 36.00 Cafeteri a 11.00 2, 256, 865 2, 256, 865 108, 717. 65 20. 76 36.00 0.00 37.00 Maintenance of Personnel 12.00 0 0.00 37.00 Nursing Administration 13.00 383, 496 2, 080. 00 184. 37 38.00 38.00 0 383, 496 39.00 Central Services and Supply 14.00 0.00 0.00 39.00 126, 350. 78 38. 44 40.00 Pharmacy 15.00 4, 857, 435 0 4, 857, 435 40.00 Medical Records & Medical Records Library 41.00 16.00 0 0 00 0.00 41.00

4, 261, 295

0

4, 261, 295

100, 465. 87

0.00

42. 42. 40. 00

0.00 43.00

17.00

18.00

(see inst.)

instructions)

Total (sum of lines 3 thru 5)

Total overhead cost (see

6.00

7.00

48. 58

38. 08

6.00

7.00

REID HOSPITAL & HEALTH CARE SERVICES HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/31/2024 2:00 pm 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, 803, 728 1.00 107, 809, 222 106, 005, 494 2, 787, 592. 23 38. 03 1.00 instructions) 2.00 Excluded area salaries (see 5, 465, 794 333, 125 5, 798, 919 169, 159. 95 34. 28 2.00 instructions) 3.00 Subtotal salaries (line 1 102, 343, 428 -2, 136, 853 100, 206, 575 2, 618, 432. 28 38. 27 3.00 minus line 2) 4.00 50, 912, 948 50, 912, 948 1, 244, 423. 31 40.91 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs 36, 523, 744 36, 523, 744 0.00 36. 45 5.00

189, 780, 120

22, 203, 977

-2, 136, 853

679, 480

187, 643, 267

22, 883, 457

3, 862, 855. 59

600, 905. 12

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 HOSPITAL WAGE RELATED COSTS Provi der CCN: 15-0048 Peri od: Worksheet S-3 From 01/01/2023 Part IV Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm Amount Reported 1. 00 PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST 401K Employer Contributions 1 00 233, 361 1 00 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 4, 133, 619 2.00 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 3.00 0 Qualified Defined Benefit Plan Cost (see instructions) 4.00 0 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 401K/TSA Plan Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 0 8.01 Health Insurance (Self Funded without a Third Party Administrator) 0 Health Insurance (Self Funded with a Third Party Administrator) 18, 775, 281 8.02 Heal th Insurance (Purchased) 8.03 0 9.00 Prescription Drug Plan 74,664 10.00 Dental, Hearing and Vision Plan 652, 574

17.00 0

0 18.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Worksheet S-3 Part V Provi der CCN: 15-0048 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm 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 1.00 0 Hospi tal 0 2.00 0 2.00 HOSPITAI SUBPROVIDER - IPF SUBPROVIDER - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF 3.00 3.00 4.00 0 4.00 5.00 0 0 5.00 6.00 0 6.00 0 7.00 0 0 7.00 SKILLED NURSING FACILITY 8.00 8.00 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 10.00 10.00 11.00 Hospi tal -Based HHA 11.00 12.00 AMBULATORY SURGICAL CENTER (D. P.) I 12.00 13.00 Hospi tal -Based Hospi ce 0 13.00 0 14.00 Hospital-Based Health Clinic RHC 14.00 15.00 Hospital-Based Health Clinic FQHC 15.00

16.00 Hospi tal -Based-CMHC

17.00 RENAL DIALYSIS I

18.00 Other

Heal th	ı Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
	TAL-BASED HOSPICE IDENTIFICATION	N DATA		Provi der C	CN: 15-0048	Peri od:	Worksheet S-9	
				Hospi ce CC	N: 15-1524	From 01/01/2023 To 12/31/2023		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	4.00	Г 00	/ 00	
	PART I - ENROLLMENT DAYS FOR C	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
1. 00	Hospice Continuous Home Care	I REPORTING	PERIODS BEGINN	ING BEFORE OCT	T 2015			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	Unduplicated census count							9.00

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	TER OCTOBER 1,	2015			
10.00	Hospice Continuous Home Care	0	0	0	0	10.00	
11.00	Hospice Routine Home Care	17, 341	369	2, 167	19, 877	11.00	
12.00	Hospice Inpatient Respite Care	169	0	36	205	12.00	
13.00	Hospice General Inpatient Care	884	27	95	1, 006	13.00	
14.00	Total Hospice Days	18, 394	396	2, 298	21, 088	14.00	
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015							
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00	
16.00	Hospice General Inpatient Care	0	0	0	o	16.00	

Health Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CCN: 15-0048	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Pre 5/31/2024 2:0	pared:
				1. 00	
PART I - HOSPITAL AND HOSPITAL COMPLEX	DATA				
Uncompensated and Indigent Care Cost-to	o-Charge Ratio				
1 00 0+ +	`			0 070001	1 00

				1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA						
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
1. 00	Cost to charge ratio (see instructions)			0. 270221	1.00		
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			88, 520, 329			
3. 00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment		d?		4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d		0	5.00		
6.00	Medi cai d charges			263, 689, 250	6.00		
7.00	Medicaid cost (line 1 times line 6)			71, 254, 373			
8. 00	Difference between net revenue and costs for Medicaid program (see instru			0	8. 00		
	Children's Health Insurance Program (CHIP) (see instructions for each lin	ne)					
9. 00	Net revenue from stand-alone CHIP			0			
10.00				0			
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (see instru			0	12.00		
	Other state or local government indigent care program (see instructions f						
13. 00	Net revenue from state or local indigent care program (Not included on li				13.00		
14. 00		(Not included i	n lines 6 or	0	14.00		
	10)			0	15. 00		
15. 00							
16. 00	16.00 Difference between net revenue and costs for state or local indigent care program (see instructions)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
	instructions for each line)						
	Private grants, donations, or endowment income restricted to funding char				17.00		
18. 00				0	18.00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs	(sum of lines	0	19. 00		
	8, 12 and 16)						
		Uni nsured	Insured	Total (col. 1			
		pati ents	pati ents	+ col . 2)			
		1. 00	2. 00	3. 00			
20.00	Uncompensated care cost (see instructions for each line)	F 0/7 0/0	0 (4(400	14 (14 071	20.00		
20.00	, , , , , , , , , , , , , , , , , , , ,	5, 967, 862	8, 646, 409				
21. 00	Cost of patients approved for charity care and uninsured discounts (see	1, 612, 642	8, 646, 409	10, 259, 051	21. 00		
22. 00	instructions)	0	0	0	22. 00		
22.00	Payments received from patients for amounts previously written off as charity care	U	U	0	22.00		
22 00		10, 259, 051	22.00				
23. 00	cost of charity care (see first uctions)	1, 612, 642	8, 646, 409	10, 239, 031	23.00		
				1. 00			
24 00	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a Length of	stav limit	N 1.00	24. 00		
24.00	imposed on patients covered by Medicaid or other indigent care program?	ia a rengtii oi	July IIIII L	I V	24.00		
25 00		t care nrogram'	s Lenath of	0	25. 00		
23.00	25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of 0						

Payments received from patients for amounts previously written off as U U U				22.00		
charity care						
Cost of charity care (see instructions)	1, 612, 642	8, 646, 409	10, 259, 051	23.00		
			1. 00			
24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit						
imposed on patients covered by Medicaid or other indigent care program?						
If line 24 is yes, enter the charges for patient days beyond the indigen-	s length of	0	25.00			
stay limit						
Charges for insured patients' liability (see instructions)		0	25. 01			
Bad debt amount (see instructions)			12, 361, 935	26.00		
Medicare reimbursable bad debts (see instructions)			937, 488	27.00		
Medicare allowable bad debts (see instructions)			1, 442, 289	27. 01		
Non-Medicare bad debt amount (see instructions)			10, 919, 646	28.00		
Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see		3, 455, 519	29.00			
Cost of uncompensated care (line 23, col. 3, plus line 29)		13, 714, 570	30.00			
Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13, 714, 570	31.00		
	Charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	Does the amount on line 20 col. 2, include charges for patient days beyond a length of imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care program' stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions) Cost of uncompensated care (line 23, col. 3, plus line 29)	charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions) Cost of uncompensated care (line 23, col. 3, plus line 29)	charity care Cost of charity care (see instructions) 1,612,642 8,646,409 10,259,051 1.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions) 3,455,519 Cost of uncompensated care (line 23, col. 3, plus line 29)		

позет	AL UNCOMPENSATED AND INDIGENT CARE DATA PTO	JVI del CCN.	F	rom 01/01/2023 o 12/31/2023		pared:		
					1. 00			
	PART II - HOSPITAL DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 264927	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?					3.00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		rom Medica	d?		4.00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	n Medicaid				5.00		
6. 00	Medicaid charges					6.00		
7.00	Medicaid cost (line 1 times line 6)	a l matruati	000)			7.00		
8. 00	Difference between net revenue and costs for Medicaid program (se Children's Health Insurance Program (CHIP) (see instructions for		OHS)			8. 00		
9. 00	Net revenue from stand-alone CHIP	each file)				9.00		
10. 00	Stand-alone CHIP charges					10.00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (se	ee instructi	ons)			12.00		
	Other state or local government indigent care program (see instru							
13.00	Net revenue from state or local indigent care program (Not includ)		13.00		
14. 00	CO Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)							
15.00	00 State or local indigent care program cost (line 1 times line 14)							
16.00	00 Difference between net revenue and costs for state or local indigent care program (see instructions)							
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17.00	Private grants, donations, or endowment income restricted to fund	ding charity	care			17. 00		
18. 00	Government grants, appropriations or transfers for support of hos					18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i	ndi gent car	e programs	(sum of lines		19. 00		
	8, 12 and 16)	1.			T			
			Ini nsured	Insured	Total (col. 1			
			oati ents 1.00	pati ents 2.00	+ col . 2) 3.00			
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts (see instructions)		5, 967, 862	8, 646, 409	14, 614, 271	20.00		
21. 00	Cost of patients approved for charity care and uninsured discount	ts (see	1, 581, 048			21.00		
	instructions)	(.,,	2, 2, 12, 121	, ,			
22. 00	Payments received from patients for amounts previously written of charity care	ff as	O	0	0	22. 00		
23.00	Cost of charity care (see instructions)		1, 581, 048	8, 646, 409	10, 227, 457	23.00		
					1. 00			
24.00	Does the amount on line 20 col. 2, include charges for patient da		length of	stay limit	N	24.00		
05.00	imposed on patients covered by Medicaid or other indigent care pr					05.00		
25. 00	If line 24 is yes, enter the charges for patient days beyond the	indigent ca	ire program	s rength of	0	25. 00		
25. 01	stay limit .01 Charges for insured patients' liability (see instructions) 0.25.							
26. 00	Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)				12, 361, 935			
27. 00	Medicare reimbursable bad debts (see instructions)				935, 726	1		
27. 00	Medicare allowable bad debts (see instructions)				1, 439, 578	1		
28. 00	Non-Medicare bad debt amount (see instructions)				10, 922, 357	1		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amoun	nts (see ins	structions)		3, 397, 479	1		
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	(13, 624, 936	•		
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			13, 624, 936			
		•			•	•		

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			CN: 15-0048 F	Period: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepar		
					5/31/2024 2: 0	0 pm
Cost Center Description	Sal ari es	0ther	lotal (col. 1 + col. 2)	Reclassificat ions (See	Reclassified Trial Balance	
				A-6)	(col. 3 +-	
	1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS				10 700 070	10 700 070	1
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP BLDG & FLXT - OFFSLTE		0		, , , , , , , , , , , , , , , , , , , ,	19, 723, 079 11, 112, 825	1. 00 1. 01
2.00 00200 CAP REL COSTS-MVBLE EQUIP		0	C	0	0	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATIENT TELEPHONES	106, 548	21, 408	127, 956	-1, 816	126, 140 0	4. 00 5. 01
5. 02 00550 DATA PROCESSING	Ö	0	ď	O	0	5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING	0 77, 081	0 1, 705, 650	1, 782, 731	0	0 1, 782, 731	5. 03 5. 04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	106, 709			85, 140	5. 05
5. 06 00590 OTHER A&G 7. 00 00700 OPERATION OF PLANT	2, 820, 016	27, 037, 006	29, 857, 022	413	29, 857, 435 0	5. 06 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	o o	0		o o	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0 3, 425, 600	0 4, 375, 715	7, 801, 315	0 5 -5, 139, 952	0 2, 661, 363	9. 00 10. 00
11. 00 01100 DI ETARY 11. 00 01100 CAFETERI A	3, 425, 600	4, 373, 713	7, 601, 315	5, 139, 179	5, 139, 179	
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	383, 496	383, 496	
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	4, 857, 435	44, 894, 167	49, 751, 602	-6, 822	0 49, 744, 780	14. 00 15. 00
16. 00 O1600 MEDICAL RECORDS & LIBRARY	0	0	C	o	0	16.00
17. 00 01700 SOCI AL SERVI CE 17. 01 01701 INSERVI CE EDUCATI ON	3, 962, 065 299, 230	602, 637 1, 708, 350			4, 564, 702 2, 007, 580	17. 00 17. 01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	C	1, 886, 075	1, 886, 075	21.00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM	1, 932, 026 191, 622	692, 514 21, 409			738, 465 213, 031	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	27, 980, 440 4, 571, 700	14, 726, 073 2, 581, 027			42, 270, 616 7, 152, 727	
41. 00 04100 SUBPROVI DER - RF	1, 871, 963	416, 605	2, 288, 568	o	2, 288, 568	
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	458, 695	133, 793	592, 488	0	592, 488	43.00
50. 00 05000 OPERATING ROOM	2, 067, 913	54, 833, 587	56, 901, 500	-17, 661, 891	39, 239, 609	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	630, 813 9, 015, 620	258, 532 13, 558, 483			887, 693 22, 518, 427	52. 00 54. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 128, 470	13, 918, 287			6, 550, 244	•
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	5, 417, 333	9, 330, 556			14, 702, 134	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 902, 445 9, 190, 229	855, 110 3, 150, 364			2, 756, 592 12, 079, 798	65. 00 66. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 591, 460	1, 268, 413			2, 859, 873	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	516, 954 0	142, 552 0	659, 506	-646 0	658, 860 0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	27, 179, 455	27, 179, 455	
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSI S	95, 503	0 714, 646	810, 149	1	0 810, 149	73. 00 74. 00
76. 00 03950 ANCILLARY - OTHER	0	0	C	o	0	76.00
76.97 07697 CARDIAC REHABILITATION 77.00 07700 ALLOGENEIC HSCT ACQUISITION	551, 658	82, 057 0	633, 715	-64	633, 651 0	76. 97 77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	Ö	0		o o	0	78. 00
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY	9, 691, 492	5, 596, 986	15, 288, 478	-1, 008, 159	14, 280, 319	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	2, 076, 529	481, 592	2, 558, 121	-59, 984	2, 498, 137	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	320, 171	526, 492	846, 663		846, 663	96.00
102.00 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0	0	102.00
113. 00 11300 I NTEREST EXPENSE		9, 836, 425	9, 836, 425	-9, 836, 425	0	113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 659, 327 99, 410, 338	1, 358, 584 214, 935, 729	3, 017, 911 314, 346, 067		3, 414, 586 334, 246, 610	
NONREI MBURSABLE COST CENTERS	77, 410, 336	214, 733, 727	314, 340, 007	17, 700, 543	334, 240, 010	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12 707 490	12 707 496	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07950 RENTAL SPACE	0	12, 707, 680 14, 763, 310			4, 993, 112 5, 969, 123	
194. 01 07951 FOUNDATION	268, 804	123, 207			392, 011	
194. 02 07952 RETAI L SERVI CES 194. 03 07953 REI D CONTRACTED SERVI CES	179, 031 0	34, 872 0	213, 903 (213, 903 0	194. 02
194.04 07954 REID PHYSICIAN ASSOC.	0	0	(0	0	194. 04
194. 05 07955 CONNERSVILLE LOCATION 194. 06 07956 VACANT SPACE	0 0	4, 113, 743 721, 570			1, 245, 603 203, 391	
194.07 07957 HOME OFFICE	0	0	, 5,6	0	0	194. 07
194.08 07958 CAMBRIDGE RHC 194.09 07959 REID HEALTH PAVILION - RES	0 1, 295, 047	0 206, 788	1, 501, 835	0 5 -5, 469	0 1, 496, 366	194. 08 194. 09
The state of the s	1 ., 2, 5, 5 //	200, 700	., 551, 550	3, 107	., 170, 000	1.707

Health Financial Systems REII	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2023 Fo 12/31/2023		narod:
					5/31/2024 2:0	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
200.00 TOTAL (SUM OF LINES 118 through 199)	101, 153, 220	247, 606, 899	348, 760, 119	0	348, 760, 119	200. 00

Health Financial Sy			LTH CARE SERVICE	ES	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AN	ID ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CCN	I: 15-0048	Peri od: From 01/01/2023	Worksheet A	
						Date/Time Prep	
Cost Ce	enter Description	Adjustments	Net Expenses			5/31/2024 2: 00	O pm
		(See A-8)	For				
		6. 00	Allocation 7.00				
GENERAL SERVI	CE COST CENTERS	0.00	7.00				
	COSTS-BLDG & FIXT	-4, 328, 837					1.00
	PBLDG & FIXT - OFFSITE COSTS-MVBLE EQUIP	0					1. 01 2. 00
	E BENEFITS DEPARTMENT	19, 975, 686	1				4.00
	ENT TELEPHONES	0	0				5. 01
5. 02 00550 DATA PR		22, 438, 447	22, 438, 447				5. 02
5. 03 00560 PURCHAS 5. 04 00570 ADMITTI	SING RECEIVING AND STORES	0 -10	1, 782, 721				5. 03 5. 04
	RING/ACCOUNTS RECEIVABLE	0	85, 140				5. 05
5. 06 00590 OTHER A		10, 813, 819	1				5.06
7. 00 00700 OPERATI 8. 00 00800 LAUNDRY	ON OF PLANT ′& LINEN SERVICE	0	0				7. 00 8. 00
9. 00 00900 HOUSEKE		0	0				9.00
10. 00 01000 DI ETARY		-399					10.00
11. 00 01100 CAFETER		-4, 097, 816					11.00
	G ADMINISTRATION SERVICES & SUPPLY	0	383, 496				13. 00 14. 00
15. 00 01500 PHARMAC		-741, 710					15.00
1 1	RECORDS & LIBRARY	0	0				16.00
17. 00 01700 SOCI AL 17. 01 01701 I NSERVI		-602, 391	4, 564, 702 1, 405, 189				17. 00 17. 01
	RVICES-SALARY & FRINGES APPRV	-602, 391	1				21.00
22.00 02200 I &R SER	RVICES-OTHER PRGM COSTS APPRV	-976					22.00
23. 00 02300 PARAMED		-54, 281	158, 750				23.00
30. 00 03000 ADULTS	JTINE SERVICE COST CENTERS & PEDIATRICS	-7, 087, 889	35, 182, 727				30.00
31. 00 03100 NTENSI		0	1				31.00
41. 00 04100 SUBPROV		-151, 660					41.00
43. 00 04300 NURSERY	RVICE COST CENTERS	-762	591, 726				43.00
50. 00 05000 OPERATI		-12, 375, 983	26, 863, 626				50.00
	RY ROOM & LABOR ROOM	-148					52.00
	OGY-DI AGNOSTI C C CATHETERI ZATI ON	-1, 489, 960 -1, 010	1				54. 00 59. 00
60. 00 06000 LABORAT		-488, 357					60.00
65. 00 06500 RESPIRA		0	_,				65.00
66. 00 06600 PHYSI CA 69. 00 06900 ELECTRO		-147, 011	11, 932, 787				66.00
	DENCEPHALOGRAPHY	-20, 244 -2, 052					69. 00 70. 00
	SUPPLIES CHARGED TO PATIENT	0	1				71.00
	DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS C 74. 00 07400 RENAL D	CHARGED TO PATIENTS	0					73. 00 74. 00
76. 00 03950 ANCILLA		0					76.00
	REHABILITATION	-5, 780	1				76. 97
	IEIC HSCT ACQUISITION CELL IMMUNOTHERAPY	0	0				77. 00 78. 00
	ERVICE COST CENTERS	J	<u> </u>				70.00
91. 00 09100 EMERGEN	ICY	-2, 601, 075	11, 679, 244				91.00
92. 00 09200 0BSERVA 93. 00 04040 FAMI LY	ATION BEDS (NON-DISTINCT PART	-34, 559	2, 463, 578				92. 00 93. 00
	RSABLE COST CENTERS	- 34, 009	2,403,370				, , 3. 00
	MEDICAL EQUIP-RENTED	-493, 290					96. 00
102. 00 10200 0PI 0I D	TREATMENT PROGRAM DSE COST CENTERS	0	0				102. 00
113. 00 11300 I NTERES		0	0				113. 00
116. 00 11600 HOSPI CE		-6, 196					116. 00
	ALS (SUM OF LINES 1 through 117)	18, 495, 556	352, 742, 166				118. 00
	BLE COST CENTERS FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	ANS' PRIVATE OFFICES	0	4, 993, 112				192.00
194. 00 07950 RENTAL		0	5, 969, 123				194. 00
194. 01 07951 FOUNDAT 194. 02 07952 RETAI L		0	392, 011 213, 903				194. 01 194. 02
194. 03 07953 REID CO		0	213, 903				194. 02
194. 04 07954 REID PH	IYSICIAN ASSOC.	o	0				194. 04
194. 05 07955 CONNERS		0	1, 245, 603			•	194.05
194. 06 07956 VACANT 194. 07 07957 HOME OF		0	203, 391			•	194. 06 194. 07
194. 08 07958 CAMBRI D	OGE RHC	0					194. 07
194. 09 07959 REID HE	EALTH PAVILION - RES	0	1, 496, 366			•	194. 09
200. 00 TOTAL ((SUM OF LINES 118 through 199)	18, 495, 556	367, 255, 675				200. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/31/2024 2:00 pm

		Lnoroooo			5/31/2024 2:00 pm
	0+ 0+	Increases	C-1	0+6	
	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4. 00	5. 00	
1 00	A - CAPITAL EXPENSE RECLASS	1 00	ما	0 571 504	1.00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 571, 584	
2. 00	NEW CAP BLDG & FIXT -	1. 01	0	10, 655, 555	2.00
2 00	OFFSITE	1 00		00.004	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98, 084	
4. 00	NEW CAP BLDG & FIXT -	1. 01	0	457, 270	4.00
F 00	OFFSITE	1 00		21/ 00/	F 00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	216, 986	
6.00		0.00	0	0	6.00
7.00		0.00	0	0	
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	1
11.00		0.00	0	0	
12.00		0.00	0	0	
13.00		0.00	0	0	1.5.55
14.00		0.00	0	0	
15.00		0.00	0	0	1
16.00		0.00	0	0	16.00
17.00		0.00	0	0	
18.00		0.00	0	0	1.5.55
19.00		0.00	0	0	
20.00		0.00	0	0	
21.00		0.00	0	0	
22. 00		0.00	0	0	22. 00
23. 00		0.00	0	0	23.00
24. 00		0.00	0	0	24.00
25. 00		0.00	0	0	25. 00
26. 00		0.00	0	0	26.00
27. 00		0.00	0	0	27. 00
28. 00		0.00	0	0	
29. 00		0.00	0	0	29.00
	U DA CAFETERI A REGILACO		0	20, 999, 479	
1 00	B - CAFETERIA RECLASS	44.00	0.054.045	0.000.014	1.00
1. 00	CAFETERI A	1100	<u>2, 256, 865</u>	2, 882, 314	
	C - NURSING VP RECLASS		2, 256, 865	2, 882, 314	
1 00		12.00	202 404	0	1.00
1. 00	NURSING ADMINISTRATION	1300	383, 496	$\frac{0}{0}$	1.00
	D - OCCUPATIONAL MEDICINE RE	L 100	383, 496	U	
1 00	OTHER A&G	5. 06	679, 480	321, 410	1.00
1. 00	OTHER AGG	3.00	679, 480	321, 410	
	E - IMPLANTABLE DEVICES RECL	ACC	079, 400	321, 410	
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	27, 179, 455	1.00
1.00	PATIENTS	/2.00	٩	21, 117, 400	1.00
2. 00	INTENIS	0.00	o	0	2.00
3. 00		0.00	ő	0	3.00
4. 00		0.00	0	0	4.00
4.00			0	<u>27,</u> 179, 455	4.00
	F - INTEREST RECLASS		<u> </u>	27, 177, 433	
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 836, 425	1.00
1.00	0	— ·····	— — "	9, 836, 425	
	G - INTERN AND RESIDENT		9	7,000,120	
1. 00	I &R SERVI CES-SALARY &	21.00	1, 803, 728	82, 347	1.00
1.00	FRI NGES APPRV	21.00	1,000,720	02,017	1.00
	0	+	1, 803, 728	82, 347	
	H - HOSPI CE		., 500, 720	02, 047	
1. 00	HOSPI CE	116. 00	333, 125	65, 350	1.00
1.00	0	 	333, 125	65, 350	
500 00	Grand Total: Increases		5, 456, 694	61, 366, 780	
220.00	12. 2	ı I	3, .00, 074	3., 300, 700	300: 00

Heal th	Financial Systems	REI D	HOSPITAL & HEA	ALTH CARE SERV	'I CES	In Lieu	of Form CMS-	-2552-10
RECLAS	SI FI CATI ONS			Provi der (Peri od:	Worksheet A-	6
						From 01/01/2023 To 12/31/2023	Date/Time Pr	epared:
							5/31/2024 2:	OO pm
	Cost Center	Decreases Li ne #	Sal ary	Other	_ Wkst. A-7 Ref.	I		
	6. 00	7. 00	8. 00	9. 00	10. 00	-		
	A - CAPITAL EXPENSE RECLASS	71.00	0.00	7. 00	10.00			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1, 816	9			1.00
2.00	DATA PROCESSING	5. 02	0	0		,		2.00
3.00	PURCHASING RECEIVING AND	5. 03	O	0	13			3.00
	STORES							
4.00	ADMI TTI NG	5. 04	0	0	13			4.00
5. 00	CASHI ERI NG/ACCOUNTS	5. 05	0	21, 569	10			5. 00
	RECEI VABLE	5.04		(4/ 004				, 00
6.00	OTHER A&G	5. 06	0	616, 981		•		6.00
7. 00 8. 00	OPERATION OF PLANT	7. 00	0	773	1	1		7.00
9. 00	DI ETARY PHARMACY	10. 00 15. 00	0	6, 822		1		8. 00 9. 00
10.00	MEDICAL RECORDS & LIBRARY	16. 00	0	0, 622	-	1		10.00
11. 00	ADULTS & PEDIATRICS	30. 00	o	37, 422		l .		11.00
12. 00	OPERATING ROOM	50.00	Ö	17, 911	-			12.00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	18, 366				13.00
14. 00	LABORATORY	60.00	0	45, 755		1		14.00
15. 00	RESPI RATORY THERAPY	65. 00	o	963		l .		15.00
16.00	PHYSI CAL THERAPY	66. 00	0	260, 795	0			16.00
17.00	ELECTROCARDI OLOGY	69. 00	0	0	0			17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	O	646	0			18.00
19.00	CARDIAC REHABILITATION	76. 97	0	64	0			19.00
20.00	EMERGENCY	91. 00	0	7, 269	0			20.00
21.00	FAMILY PRACTICE	93. 00	0	59, 984		l .		21.00
22.00	DURABLE MEDICAL EQUIP-RENTED	96. 00	0	0	_	l .		22. 00
23. 00	HOSPI CE	116. 00	0	1, 800				23. 00
24. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	7, 714, 568				24.00
25. 00	RENTAL SPACE	194. 00	0	8, 794, 187				25.00
26.00	FOUNDATION	194. 01	0	0	_			26.00
27. 00 28. 00	CONNERSVILLE LOCATION VACANT SPACE	194. 05 194. 06	0	2, 868, 140 518, 179				27. 00 28. 00
29. 00	REID HEALTH PAVILION - RES	194. 09	0	5, 469		1		29.00
29.00	O TILALTII FAVILION - KES _	194.09	— — —			<u>'</u>		29.00
	B - CAFETERIA RECLASS		<u> </u>	20, 777, 477		<u> </u>		
1.00	DI ETARY	10.00	2, 256, 865	2, 882, 314	0			1.00
	0		2, 256, 865	2, 882, 314				
	C - NURSING VP RECLASS	<u>'</u>	· · · · · ·			'		
1.00	OTHER A&G	5. 06	383, 496	0	0)		1.00
	0		383, 496	0)			
	D - OCCUPATIONAL MEDICINE RE							
1. 00	EMERGENCY	<u>91.</u> 00	<u>679, 4</u> 80	32 <u>1, 4</u> 10)		1.00
	0		679, 480	321, 410)			_
4 00	E - IMPLANTABLE DEVICES RECLA			47 / 40 000		.i		1
1.00	OPERATING ROOM	50.00	0	17, 643, 980				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1, 652		•		2.00
3. 00 4. 00	RADI OLOGY-DI AGNOSTI C CARDI AC CATHETERI ZATI ON	54. 00 59. 00	0	37, 310 9, 496, 513		1		3. 00 4. 00
4.00	O CATHETERIZATION		— —	<u>9, 496, 513</u> 27, 179, 455		<u>'</u>		4.00
	F - INTEREST RECLASS		<u> </u>	27, 177, 455	,			-
1. 00	INTEREST EXPENSE	113. 00	0	9, 836, 425	11			1.00
00	0		— — ö l	9, 836, 425		†		
	G - INTERN AND RESIDENT		51	, 555, 120		<u> </u>		1
1.00	I&R SERVICES-OTHER PRGM	22. 00	1, 803, 728	82, 347	0			1.00
	COSTS APPRV				L			
	0		1, 803, 728	82, 347	1]
	H - HOSPICE							
1.00	ADULTS & PEDIATRICS	30.00	333, 125	6 <u>5, 3</u> 50		1		1.00
F00 0-	0		333, 125	65, 350		1		F00 05
500.00	Grand Total: Decreases	l	5, 456, 694	61, 366, 780	ין	I		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS | Peri od: | Worksheet A-7 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0048

				''	0 12/31/2023	5/31/2024 2:0	
				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	18, 717, 396	0	0	0	234, 987	1.00
2.00	Land Improvements	10, 883, 356	0	0	0	534, 441	2.00
3. 00	Buildings and Fixtures	344, 604, 749	12, 096, 845	0	12, 096, 845	0	3.00
4.00	Building Improvements	13, 645, 110	0	0	0	0	4.00
5.00	Fixed Equipment	2, 237, 098	0	0	0	27, 739	5.00
6.00	Movable Equipment	220, 799, 729	9, 887, 802	0	9, 887, 802	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	610, 887, 438	21, 984, 647	0	21, 984, 647	797, 167	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	610, 887, 438	21, 984, 647	0	21, 984, 647	797, 167	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	18, 482, 409	0				1.00
2.00	Land Improvements	10, 348, 915	0				2.00
3.00	Buildings and Fixtures	356, 701, 594	0				3.00
4.00	Building Improvements	13, 645, 110	0				4.00
5.00	Fixed Equipment	2, 209, 359	0				5.00
6.00	Movable Equipment	230, 687, 531	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	632, 074, 918	0				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	632, 074, 918	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-0048 Peri od: Worksheet A-7 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE 1.00 0 0 1.00 0 0 1.01 0 0 1.01 0 2.00 CAP REL COSTS-MVBLE EQUIP 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 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 NEW CAP BLDG & FIXT - OFFSITE 1.01 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 0 2.00

0

3.00

Total (sum of lines 1-2)

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2

Heal th	n Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 2:00	pared:	
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance		
			Leases	(col. 1 -	THS (Tuctions)			
				col . 2)				
		1. 00	2. 00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	401, 387, 387	0	401, 387, 387		0	1.00	
1. 01	NEW CAP BLDG & FIXT - OFFSITE	230, 687, 531	0	230, 687, 531			1. 01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0			2.00	
3.00	Total (sum of lines 1-2)	632, 074, 918		632, 074, 918			3.00	
		ALLOCA	FION OF OTHER (CAPITAL	SUMMARY C			
	Cost Center Description		0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)				
	DART LLL DECONOLLLATION OF CARLEY COOTS	6. 00	7. 00	8. 00	9. 00	10.00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C		0		15 070 170	217 007	1 00	
1.00	CAP REL COSTS-BLDG & FIXT NEW CAP BLDG & FIXT - OFFSITE	0	0	0			1.00	
1. 01 2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10, 655, 555	0	1. 01 2. 00	
3.00	Total (sum of lines 1-2)	0	0		25, 734, 727	216, 986	3. 00	
3.00	Total (Suil of Titles 1-2)	U	SI	JMMARY OF CAPIT		210, 700	3.00	
				JUNIOR OF CALL				
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)				
			instructions)			9 through 14)		
		11.00	12. 00	13.00	instructions) 14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12.00	13.00	14.00	15. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	LNTERS 0	0	98, 084	0	15, 394, 242	1. 00	
1. 01	NEW CAP BLDG & FIXT - OFFSITE	0	0	457, 270			1. 01	
2. 00	CAP REL COSTS-MVBLE EQUIP			437, 270			2. 00	
3.00	Total (sum of lines 1-2)	ا	ĺ	555, 354	1	- 1	3.00	
		-			-	, ,		

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

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0048 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					To 12/31/2023		
				Expense Classification or		5/31/2024 2: 0	O pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1.00
1. 01	Investment income - NEW CAP BLDG & FIXT - OFFSITE (chapter		0	NEW CAP BLDG & FIXT - OFFSITE	1. 01	0	1. 01
2. 00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	0	PURCHASING RECEIVING AND	5. 03	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0	STORES	0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -16, 932, 529		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	84, 604, 621			0	12. 00
13. 00	Laundry and linen service		0		0.00		13. 00
14. 00 15. 00	Rental of quarters to employee		-4, 097, 816 0	CAFETERIA	11. 00 0. 00		14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than	В	0	PURCHASING RECEIVING AND STORES	5. 03	O	16. 00
17. 00	patients Sale of drugs to other than	В	-736, 048	PHARMACY	15. 00	0	17. 00
18. 00		В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)	5		DI ETADY	10.00		
20. 00 21. 00	interest, finance or penalty	В	0	DI ETARY	10. 00 0. 00		20.00
22. 00	overpayments and borrowings to		О		0.00	O	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP BLDG &			NEW CAP BLDG & FIXT -	1. 01	0	26. 01
27. 00	Depreciation - CAP REL			OFFSITE CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***			28.00
29. 00	Physi ci ans' assi stant		0	1	0.00	0	29. 00

Provider CCN: 15-0048 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Wkst. A-7 Cost Center Description Amount Line # (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 30.99 Hospice (non-distinct) (see 30.00 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 -50, 449 EMPLOYEE BENEFITS DEPARTMENT 33.00 33. 01 MISCELLANEOUS INCOME -10 ADMITTING 5.04 33.01 В MISCELLANEOUS INCOME -37, 754 OTHER A&G 33.02 33 02 R 5.06 0 MISCELLANEOUS INCOME 33.03 В -42, 050 I NSERVI CE EDUCATI ON 17.01 33.03 MISCELLANEOUS INCOME -54, 281 PARAMED ED PRGM 33.04 В 23.00 33.04 -5, 792 ADULTS & PEDIATRICS 33.05 MISCELLANEOUS INCOME В 30.00 33.05 MISCELLANEOUS INCOME ONURSERY 43.00 0 33.06 В 33.06 33.07 MISCELLANEOUS INCOME В -11, 704 OPERATING ROOM 50.00 33.07 MISCELLANEOUS INCOME -225, 394 RADI OLOGY-DI AGNOSTI C 33.08 В 54.00 33.08 MISCELLANEOUS INCOME -29, 066 LABORATORY ol 33 09 В 60 00 33 09 -119, 506 PHYSI CAL THERAPY MISCELLANEOUS INCOME 33.10 В 66.00 33.10 -46, 633 EMERGENCY MISCELLANEOUS INCOME В 91.00 33.11 33.11 33. 12 MISCELLANEOUS INCOME В -15 FAMILY PRACTICE 93.00 33.12 MISCELLANEOUS INCOME -491, 154 DURABLE MEDICAL EQUIP-RENTED 33 13 В 96.00 33 13 33.14 INTEREST INCOME В -4, 283, 763 CAP REL COSTS-BLDG & FIXT 1.00 11 33.14 33.15 UNNECESSARY BORROWING Α -5, 552, 662 CAP REL COSTS-BLDG & FIXT 1.00 11 33.15 33 16 SELF INSURANCE ADJUSTMENT -8, 903, 833 EMPLOYEE BENEFITS DEPARTMENT 0 33 16 Α 4 00 -69, 713 OTHER A&G MARKETI NG/ADVERTI SI NG 0 33.17 Α 5.06 33.17 33. 18 MARKETI NG/ADVERTI SI NG Α -260 DI ETARY 10.00 0 33.18 MARKETI NG/ADVERTI SI NG -1, 155 INSERVICE EDUCATION 33.19 17.01 0 33.19 Α MARKETI NG/ADVERTI SI NG -963 &R SERVICES-OTHER PRGM 33 20 22.00 33. 20 Α COSTS APPRV 33. 21 MARKETI NG/ADVERTI SI NG -3, 128 ADULTS & PEDIATRICS 30.00 0 33.21 Α MARKETI NG/ADVERTI SI NG -4, 468 SUBPROVI DER - I RF 33 22 Α 41.00 0 33.22 MARKETI NG/ADVERTI SI NG -762 NURSERY 33. 23 33, 23 Α 43.00 0 33 24 MARKETI NG/ADVERTI SI NG Α -386 OPERATING ROOM 50.00 0 33 24 33. 25 MARKETI NG/ADVERTI SI NG -1, 010 CARDIAC CATHETERIZATION 59.00 33.25 Α MARKETI NG/ADVERTI SI NG -18, 865 PHYSI CAL THERAPY 33. 26 66.00 33. 26 Α MARKETI NG/ADVERTI SI NG -2, 052 ELECTROENCEPHALOGRAPHY 33.27 70.00 0 33.27 Α MARKETI NG/ADVERTI SI NG 33.28 Α -5. 749 CARDIAC REHABILITATION 76.97 33.28 MARKETI NG/ADVERTI SI NG -34, 544 FAMILY PRACTICE 93.00 33.29 33. 29 33.30 MARKETI NG/ADVERTI SI NG -2, 136 DURABLE MEDICAL EQUIP-RENTED 96.00 0 33.30 Α 33. 31 MARKETI NG/ADVERTI SI NG -6, 121 HOSPI CE 0 Δ 116.00 33.31 33.32 NON-ALLOWABLE EXPENSES Α -773, 478 OTHER A&G 5.06 ol 33.32 NON-ALLOWABLE EXPENSES -139 DI ETARY 33.33 33.33 Α 10.00 0 -456, 403 I NSERVI CE EDUCATION 33.34 NON-ALLOWABLE EXPENSES 17.01 0 33.34 Α NON-ALLOWABLE EXPENSES -13 &R SERVICES-OTHER PRGM 33.35 Α 22.00 33.35 COSTS APPRV 33.36 NON-ALLOWABLE EXPENSES -705 ADULTS & PEDIATRICS 30.00 33.36 Α ol 33.37 NON-ALLOWABLE EXPENSES Α -388 OPERATING ROOM 50.00 0 33.37 NON-ALLOWABLE EXPENSES -148 DELIVERY ROOM & LABOR ROOM 33 38 52.00 33.38 Α 33. 39 NON-ALLOWABLE EXPENSES Α -147 RADI OLOGY-DI AGNOSTI C 54.00 0 33.39 33.40 NON-ALLOWABLE EXPENSES Α -8, 640 PHYSI CAL THERAPY 66.00 33.40 NON-ALLOWABLE EXPENSES -31 CARDIAC REHABILITATION 33.41 76.97 0 33.41 Α NON-ALLOWABLE EXPENSES -3, 710 EMERGENCY 91.00 ol 33.42 Α 33.42 33. 43 NON-ALLOWABLE EXPENSES Α -75 HOSPI CE 116.00 0 33.43 -22, 323, 215 OTHER A&G 33 44 HAF EXPENSE Α 5.06 33.44 BOND REFUNDING - 2015 BONDS BOND REFUNDING - 2016 BONDS -401, 531 OTHER A&G 33. 45 5.06 0 33.45 Α -7, 737 OTHER A&G 33.46 Α 5.06 33.46 OCC MED - EMPLOYEE COST -82, 341 OTHER A&G 33.47 Α 5.06 33.47 OCC MED - EMPLOYEE COST -266, 787 LABORATORY 33.48 60.00 0 33.48 Α OCC MED - EMPLOYEE COST 33.49 Α -6. 144 RADI OLOGY-DI AGNOSTI C 54.00 0 33.49 33.50 OCC MED - EMPLOYEE COST -5, 662 PHARMACY 15.00 0 33.50 Α OTHER ADJUSTMENTS (SPECIFY) 33 51 0.00 33.51 (3)

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0048 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm 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 33.52 OTHER ADJUSTMENTS (SPECIFY) 0. 00 33. 52 OTHER ADJUSTMENTS (SPECIFY) 33.53 0 0.00 33.53 33.54 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.54 OTHER ADJUSTMENTS (SPECIFY) 33.55 0.00 33.55 (3)OTHER ADJUSTMENTS (SPECIFY) 33.56 33.56 0.00 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.57 33.57 (3)33 58 OTHER ADJUSTMENTS (SPECIFY) 0 00 33 58 33.59 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.59 33.60 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.60 (3) OTHER ADJUSTMENTS (SPECIFY) 33.61 33.61 0.00 33.62 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.62 OTHER ADJUSTMENTS (SPECIFY) 33.63 0.00 33.63 OTHER ADJUSTMENTS (SPECIFY) 33. 64 0.00 33.64 33. 65 OTHER ADJUSTMENTS (SPECIFY) 0.00 33.65

18, 495, 556

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

(3)

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

Provider CCN: 15-0048

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm

					5/31/2024 2:0	JU PIII
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	R CLAIMED HOME	
	OFFICE COSTS:					l
1.00	50.00	OPERATING ROOM	REID OUTPATIENT SURGERY	26, 256, 664	33, 064, 601	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL	5, 507, 588	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS & HR	28, 929, 968	0	3.00
4.00	5. 02	DATA PROCESSING	INFORMATION SYSTEMS	22, 438, 447	0	4.00
4. 01	5. 06	OTHER A&G	A&G	34, 536, 555	0	4. 01
5.00	TOTALS (sum of lines 1-4).			117, 669, 222	33, 064, 601	5.00
	Transfer column 6, line 5 to					l
	Worksheet A-8, column 2,					l
	line 12.					L

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 RELAT	TED ORGANIZATION(S) AND/OR HO	OME 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		O.OO 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 S	Systems	S	RE	ID HOS	SPITAL &	HEA	ALTH CARE SER\	/I CES			In I	_i eu	u of For	n CM	IS-2552-1
STATEMENT OF COST	S OF S	ERVICES FROM	RELATED ORGA	NI ZAT	ONS AND	HON	ME Provi der	CCN: 1	15-0048	Perio			Workshe	et A	A-8-1
OFFICE COSTS											01/01/20			_	
										lo	12/31/20)23			Prepared:
													5/31/20	24 2	2:00 pm_
Net	Wk	st. A-7 Ref.													
Adjustmer	its														
(col. 4 mi	nus														
col. 5)	*														
6. 00		7.00													
A. COSTS I	NCURRE	D AND ADJUSTN	MENTS REQUIRE	D AS	A RESULT	0F	TRANSACTI ONS	WI TH	RELATED	ORGANI	ZATI ONS	OR	CLAI MED	HON	IE

5.00 84,604,621 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

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

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

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

i ei iiibui	Terribut Seiliert under titte XVIII.									
6.00		6.0	00							
	HOME OFFICE	7.0)()							
8.00		8.0)()							
9.00		9.0)()							
10.00		10.0)()							
100.00		100.0	00							

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

OFFICE COSTS:

-6, 807, 937

5, 507, 588

28, 929, 968

22, 438, 447

34, 536, 555

9

0

0

1.00

2.00

3.00

4.00

4.01

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0048

						10 12/31/2023	5/31/2024 2:0	
	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	5. 06	OTHER A&G	26, 967	26, 967	0	179, 000	0	1.00
2.00	17. 01	INSERVICE EDUCATION	102, 783	102, 783	0	179, 000	0	2.00
3.00	30. 00	ADULTS & PEDIATRICS	7, 078, 264	7, 078, 264	0	179, 000	0	3. 00
4.00		SUBPROVI DER - I RF	147, 192	147, 192	2 0	179, 000	0	4.00
5.00	50. 00	OPERATING ROOM	5, 555, 568	5, 555, 568	0	246, 400	0	5.00
6.00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 258, 275	1, 258, 275	0	260, 300	0	6. 00
7.00	60. 00	LABORATORY	192, 504	192, 504	0	260, 300	0	7.00
8.00	69. 00	ELECTROCARDI OLOGY	20, 244		0	179, 000	0	8. 00
9. 00	91. 00	EMERGENCY	2, 550, 732	2, 550, 732	2 0	179, 000	0	9. 00
10.00	0. 00		0	C	0	0	0	1
200.00			16, 932, 529		0			200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		OTHER A&G	0		-	1	0	
2. 00		I NSERVI CE EDUCATI ON	0	· ·	ή	0	0	
3. 00		ADULTS & PEDIATRICS	0	C	0	0	0	
4. 00		SUBPROVI DER - I RF	0		0	0	0	
5. 00		OPERATING ROOM	0	(0	0	0	
6. 00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	0.00
7. 00		LABORATORY	0	(0	0	0	
8. 00		ELECTROCARDI OLOGY	0	(0	0	0	8. 00
9. 00		EMERGENCY	0	(0	0	0	7.00
10.00	0. 00		0	9	0	0	0	1
200.00		0 1 0 1 (8)	0	(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.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		OTHER A&G	15.00					1. 00
2. 00		INSERVICE EDUCATION			-	1		2.00
3. 00		ADULTS & PEDIATRICS				7, 078, 264		3.00
4. 00		SUBPROVI DER - I RF	0			147, 192		4. 00
5. 00		OPERATING ROOM	0			5, 555, 568		5. 00
6. 00		RADI OLOGY-DI AGNOSTI C	1 0		ή	1, 258, 275		6.00
7. 00		LABORATORY	1 0		-	192, 504		7.00
8. 00		ELECTROCARDI OLOGY	1 0		1	l '		8.00
9. 00		EMERGENCY		1	-			9.00
10. 00	0.00			`	-	1		10.00
200.00	3.00				-	1		200.00
	'			1		1	ı	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0048 Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				T-	0 12/31/2023	Date/Time Pre 5/31/2024 2:0	
			CAP	TAL RELATED CO	STS		
	Cost Center Description	Net Expenses	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	EMPLOYEE	
		for Cost		& FIXT -		BENEFITS	
		Allocation (from Wkst A		OFFSI TE		DEPARTMENT	
		col. 7)	1.00				
	GENERAL SERVICE COST CENTERS	0	1. 00	1.01	2. 00	4. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	15, 394, 242	15, 394, 242	1			1. 00
1. 01 2. 00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP	11, 112, 825	0	11, 112, 825	0		1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	20, 101, 826	0	19, 365	0	20, 121, 191	4.00
5. 01	00540 NONPATI ENT TELEPHONES	0	0	0	O	0	5. 01
5. 02 5. 03	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	22, 438, 447	0 243, 316	0	0	0	5. 02 5. 03
5. 04	00570 ADMITTING	1, 782, 721	12, 672	1	Ö	15, 349	5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	85, 140	105 105	,	0	0	5.05
5. 06 7. 00	00590 OTHER A&G 00700 OPERATION OF PLANT	40, 671, 254 0	105, 105 301, 821		0	620, 483 0	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0		Ö	0	8.00
9.00	00900 HOUSEKEEPI NG	0	0	0	0	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 660, 964 1, 041, 363	502, 212 263, 696		0	232, 728 449, 405	
13. 00	I I	383, 496	53, 622		Ö	76, 365	
14.00	I I	0	0	_	0	0(7.351	
15. 00 16. 00	I I	49, 003, 070 0	270, 745 0	1	0	967, 251 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	4, 564, 702	34, 039		Ö	788, 958	17. 00
17. 01	I I	1, 405, 189	285, 501	1	0	59, 585	
21. 00 22. 00	+ I	1, 886, 075 737, 489	0	0	0 0	359, 173 25, 548	
23. 00	02300 PARAMED ED PRGM	158, 750	29, 101	_	Ö	38, 157	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	25 102 727	2 (12 022	1 0	ol	E EOE 22E	20.00
30. 00 31. 00	+ +	35, 182, 727 7, 152, 727	3, 612, 033 673, 420	1	0	5, 505, 325 910, 353	
41.00	04100 SUBPROVI DER - I RF	2, 136, 908	490, 912	0	o	372, 760	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	591, 726	73, 535	0	0	91, 339	43.00
50. 00		26, 863, 626	1, 252, 431	633, 758	0	411, 779	50.00
52.00	· · · · · · · · · · · · · · · · · · ·	887, 545	228, 094		o	125, 613	
54. 00 59. 00	+ I	21, 028, 467 6, 549, 234	1, 918, 390 372, 449		0	1, 795, 262 423, 838	
60.00	06000 LABORATORY	14, 213, 777	798, 026		0	1, 078, 743	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 756, 592	45, 174		o	378, 830	65.00
66. 00 69. 00		11, 932, 787 2, 839, 629	221, 730 214, 188		0	1, 830, 032 316, 904	66. 00 69. 00
70.00		656, 808	214, 100		Ö	102, 940	
71. 00		0	0	0	0	0	71.00
72. 00 73. 00	1	27, 179, 455	0	0	0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	810, 149	40, 868	ő	Ö	19, 017	
76.00		0	0	0	0	0	76.00
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	627, 871 0	224, 501 0	0	0	109, 851 0	76. 97 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
01 00	OUTPATIENT SERVICE COST CENTERS	11 (70 044	0.40, 225	1	ما	1 704 544	01 00
91. 00 92. 00	1	11, 679, 244	849, 235	0	0	1, 794, 544	91. 00 92. 00
93. 00	1 1	2, 463, 578	0	41, 005	0	413, 495	
07.00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	252 272	40.750	120,020	ما	/2.755	0, 00
	010200 OPI OI D TREATMENT PROGRAM	353, 373 0	48, 658 0		l	63, 755 0	102.00
.02.0	SPECIAL PURPOSE COST CENTERS				9	<u> </u>	
	0 11300 INTEREST EXPENSE	2 400 200	12 20/			20/ 752	113.00
118.0	011600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	3, 408, 390 352, 742, 166	12, 206 13, 177, 680		0	396, 753 19, 774, 135	
	NONREI MBURSABLE COST CENTERS	002//12/100		1,7001,7201	5	. , , , , , , , , , ,	
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	D 19200 PHYSICIANS' PRIVATE OFFICES D 07950 RENTAL SPACE	4, 993, 112 5, 969, 123	0	5, 236, 845 945, 482	0		192. 00 194. 00
194. 0	1 07951 FOUNDATI ON	392, 011	5, 650	0	Ö	53, 526	194. 01
	2 07952 RETAIL SERVICES	213, 903	64, 182		0		194.02
	3 07953 REID CONTRACTED SERVICES 4 07954 REID PHYSICIAN ASSOC.	0	0	15, 104	0		194. 03 194. 04
194.0	5 07955 CONNERSVILLE LOCATION	1, 245, 603	0	0	o	0	194. 05
194. 0	6 07956 VACANT SPACE	203, 391	1, 940, 634	831, 133	0	0	194. 06

Į	Heal th Financial	Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
	COST ALLOCATION -	- GENERAL SERVICE COSTS		Provider CCN: 15-0048	From 01/01/2023	Worksheet B Part I Date/Time Prepared

					5/31/2024 2:0	O pm
		CAPI	TAL RELATED CO	OSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	EMPLOYEE	
	for Cost		& FIXT -		BENEFITS	
	Allocation		OFFSI TE		DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1.00	1. 01	2. 00	4. 00	
194. 07 07957 HOME OFFICE	0	0	0	0	0	194. 07
194. 08 07958 CAMBRI DGE RHC	0	0	0	0	0	194. 08
194.09 07959 REID HEALTH PAVILION - RES	1, 496, 366	206, 096	0	0	257, 880	194. 09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	367, 255, 675	15, 394, 242	11, 112, 825	О	20, 121, 191	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/31/2024 2:00 pm Cost Center Description NONPATI ENT DATA PURCHASI NG ADMI TTI NG CASHI ERI NG/AC TELEPHONES RECEIVING AND COUNTS PROCESSI NG **STORES** RECEI VABLE 5. 01 5. 02 5. 04 5 03 5 05 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 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 000000000000000000 22, 438, 447 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 28, 260 271, 576 5.03 5.04 00570 ADMITTING 226, 080 2, 128, 213 5.04 183 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE C 463, 720 5.05 00590 OTHER A&G 4, 069, 443 5.06 2.438 5.06 0 0 00700 OPERATION OF PLANT 7 00 C 0 0 7.00 28, 260 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 8.00 9.00 00900 HOUSEKEEPI NG 84, 780 0 0 9.00 0 01000 DI ETARY 10.00 10.00 0 664, 110 4.030 0 11.00 01100 CAFETERI A 0 0 11.00 01300 NURSING ADMINISTRATION 0 13 00 141, 300 0 0 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 0 0 01500 PHARMACY 15.00 904, 320 35,008 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 409, 770 784 0 0 0 17.00 01701 INSERVICE EDUCATION 17.01 579, 330 332 0 17.01 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 508, 680 63 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 197, 820 50 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 1, 723, 861 43, 468 150, 367 32, 791 30.00 03100 INTENSIVE CARE UNIT 0 31.00 310,860 12, 153 16, 887 3,683 31.00 0 1, 779 04100 SUBPROVI DER - I RF 8. 158 41.00 41.00 240, 210 2.157 04300 NURSERY 43.00 0 2, 279 2, 372 517 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 953, 171 39, 259 357, 402 77, 941 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0000000 268 470 4 062 12, 998 2,835 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 119, 501 35, 592 364, 671 79, 133 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 324, 990 22, 230 224, 966 49,060 59.00 60.00 06000 LABORATORY 1, 158, 660 5,899 213, 089 46, 470 60.00 45, 900 06500 RESPIRATORY THERAPY 12, 488 10,010 65 00 169, 560 65 00 06600 PHYSI CAL THERAPY 2, 190, 151 52, 949 11, 547 66.00 2,744 66.00 1, 532 06900 ELECTROCARDI OLOGY 565, 200 60, 569 13, 209 69.00 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 254, 340 1,068 11, 776 2,568 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 C 71.00 16, 775 07200 IMPL. DEV. CHARGED TO PATIENTS 76, 923 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 296, 748 64,714 73.00 07400 RENAL DIALYSIS 2,080 74 00 56, 520 314 74 00 454 76.00 03950 ANCILLARY - OTHER 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0 84, 780 453 4.077 889 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 C 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 0 91.00 09100 EMERGENCY 1, 271, 700 24,834 200, 359 43,693 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93.00 0 211, 950 3, 309 15, 129 3, 299 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 197, 820 4, 770 896 195 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 367, 380 8, 163 9, 897 2, 158 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 22, 311, 277 269, 662 2, 128, 213 463, 720 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 C 0 0 194.00 07950 RENTAL SPACE 170 0 194, 00 194. 01 07951 FOUNDATI ON 70,650 276 0 194. 01 194. 02 07952 RETAIL SERVICES 0 194.02 0 0 42, 390 171 0 0 194. 03 07953 REID CONTRACTED SERVICES 0 194, 03 C 0 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. C 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 194.05 0 0 C 764 194.06 07956 VACANT SPACE 0 194.06 C 0 194. 07 07957 HOME OFFICE 0 0 194.07 C 0 194. 08 07958 CAMBRI DGE RHC 0 0 0 0 194.08 194.09 07959 REID HEALTH PAVILION - RES 0 194.09 14, 130 533 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0048	From 01/01/2023	Worksheet B Part I Date/Time Prepared:

						5/31/2024 2:0	0 pm
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		TELEPHONES	PROCESSI NG	RECEIVING AND		COUNTS	
				STORES		RECEI VABLE	
		5. 01	5. 02	5. 03	5. 04	5. 05	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum Lines 118 through 201)	ol	22, 438, 447	271, 576	2, 128, 213	463.720	202 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm

						5/31/2024 2:0	0 pm
Cc	ost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
				PLANT	LINEN SERVICE		
OFNEDAL	OFFICE OF STATES	5A. 05	5. 06	7. 00	8. 00	9. 00	
	SERVI CE COST CENTERS						4 00
	AP REL COSTS-BLDG & FIXT						1.00
	EW CAP BLDG & FIXT - OFFSITE						1. 01
1 1	AP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EN	MPLOYEE BENEFITS DEPARTMENT						4.00
	ONPATI ENT TELEPHONES						5. 01
5. 02 00550 DA	ATA PROCESSING						5.02
5. 03 00560 PL	URCHASING RECEIVING AND STORES						5.03
	DMI TTI NG						5. 04
	ASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
1 1	THER A&G	45, 501, 837	45, 501, 837				5. 06
	PERATION OF PLANT	377, 247	53, 350				7. 00
1 1	AUNDRY & LINEN SERVICE	28, 260	3, 996		32, 256		8. 00
1 1					32, 230	04 740	
1 1	OUSEKEEPI NG	84, 780	11, 989		U	96, 769	9.00
10. 00 01000 DI		4, 064, 044	574, 729		O ₁	2, 747	10.00
	AFETERI A	1, 754, 464	248, 113		0	0	11.00
	URSING ADMINISTRATION	654, 783	92, 598	1, 228	0	0	13.00
	ENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PH	HARMACY	51, 180, 394	7, 237, 885	6, 056	0	0	15.00
16.00 01600 ME	EDICAL RECORDS & LIBRARY	228, 552	32, 321	0	0	0	16.00
17. 00 01700 SC	OCIAL SERVICE	5, 798, 253	819, 977	275	o	481	17.00
	NSERVICE EDUCATION	2, 329, 937	329, 495	5, 857	ol	421	17. 01
	&R SERVICES-SALARY & FRINGES APPRV	2, 245, 248	317, 518		0	0	21.00
1 1	&R SERVICES-OTHER PRGM COSTS APPRV	1, 271, 780	179, 853		ام	0	22. 00
1 1	ARAMED ED PRGM	553, 622	78, 292		ol	0	23. 00
	NT ROUTINE SERVICE COST CENTERS	333, 022	10, 272	1, 704	<u> </u>	0	23.00
	DULTS & PEDIATRICS	44 250 572	/ E40 //2	83, 428	10 (70	40.205	20.00
		46, 250, 572	6, 540, 663	· ·	·	48, 385	30.00
	NTENSI VE CARE UNI T	9, 080, 083	1, 284, 087			5, 280	31.00
	UBPROVI DER - I RF	3, 252, 884	460, 016			0	41. 00
43. 00 04300 NL		761, 768	107, 728	1, 684	0	0	43.00
	RY SERVICE COST CENTERS						
50. 00 05000 0F	PERATING ROOM	32, 589, 367	4, 608, 723	25, 522	2, 589	15, 253	50.00
52. 00 05200 DE	ELIVERY ROOM & LABOR ROOM	1, 529, 617	216, 315	5, 225	1, 533	1, 571	52.00
54.00 05400 RA	ADI OLOGY-DI AGNOSTI C	27, 418, 475	3, 877, 466	33, 850	3, 294	2, 707	54.00
59. 00 05900 CA	ARDI AC CATHETERI ZATI ON	7, 966, 767	1, 126, 644	2, 886	1, 556	1, 036	59.00
	ABORATORY	17, 514, 664	2, 476, 889		20	2, 025	60.00
1 1	ESPI RATORY THERAPY	3, 418, 554	483, 445		0	334	65. 00
1 1	HYSI CAL THERAPY	18, 290, 532	2, 586, 610		287	789	66.00
	LECTROCARDI OLOGY	4, 011, 231	567, 260		0	902	69.00
	LECTROENCEPHALOGRAPHY	1, 217, 919	172, 236		131	0	70.00
1 1		1, 217, 919	172, 230		131	0	70.00
1 1	EDICAL SUPPLIES CHARGED TO PATIENT	-1	2 05/ 015	0	U		
	MPL. DEV. CHARGED TO PATIENTS	27, 273, 153	3, 856, 915		U	0	72.00
	RUGS CHARGED TO PATIENTS	361, 462	51, 117		0	0	73. 00
	ENAL DIALYSIS	929, 402	131, 434		0	762	74.00
	NCILLARY - OTHER	0	0	0	0	0	76. 00
76. 97 07697 CA	ARDIAC REHABILITATION	1, 052, 422	148, 831	2, 301	0	267	76. 97
77. 00 07700 AL	LLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78. 00 07800 CA	AR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATI E	ENT SERVICE COST CENTERS						
91. 00 09100 EN		15, 863, 609	2, 243, 400	19, 452	4, 597	5, 661	91.00
	BSERVATION BEDS (NON-DISTINCT PART	0	_, ,	,	.,	-,	92.00
	AMILY PRACTICE	3, 151, 765	445, 716	0	1, 015	1, 343	93. 00
	EIMBURSABLE COST CENTERS	3, 131, 703	443, 710	0	1,013	1, 343	73.00
	URABLE MEDICAL EQUIP-RENTED	808, 506	114, 337	2, 357	ol		04 00
					-	67	96.00
	PIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	PURPOSE COST CENTERS						
	NTEREST EXPENSE						113. 00
116. 00 11600 HC		4, 204, 947	594, 655		0		116. 00
	UBTOTALS (SUM OF LINES 1 through 117)	343, 020, 900	42, 074, 603	284, 507	31, 090	93, 587	118. 00
NONREI ME	BURSABLE COST CENTERS						
	IFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192. 00 19200 PH	HYSICIANS' PRIVATE OFFICES	10, 229, 957	1, 446, 700	67, 960	1, 063	535	192.00
194. 00 07950 RE	ENTAL SPACE	6, 914, 775	977, 874	14, 400			194. 00
194. 01 07951 FC		522, 113	73, 836		o		194. 01
194. 02 07952 RE		356, 296	50, 387	430	n n		194. 02
	EID CONTRACTED SERVICES	030, 270	0, 307	0	0		194. 03
	ELD PHYSICIAN ASSOC.	1E 104	-		Š		194. 03
		15, 104	2, 136		O		
	ONNERSVILLE LOCATION	1, 246, 367	176, 259		ا ا		194. 05
194. 06 07956 VA		2, 975, 158	420, 741	58, 450	이		194. 06
194. 07 07957 HC		0	0	0	0		194. 07
194. 08 07958 CA		0	0	0	0		194. 08
	EID HEALTH PAVILION - RES	1, 975, 005	279, 301	4, 721	103		194. 09
200. 00 Cr	ross Foot Adjustments	o					200. 00
201. 00 Ne	egative Cost Centers	0	0	0	0	0	201. 00
		'	'		,		

Health Financial Systems R	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		eri od:	Worksheet B	
			F	rom 01/01/2023	Part I	
			T	o 12/31/2023	Date/Time Pre	pared:
					5/31/2024 2:0	
Cost Center Description	Subtotal	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			PLANT	LINEN SERVICE		
	5A. 05	5. 06	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	367, 255, 675	45, 501, 837	430, 597	32, 256	96, 769	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0048

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/31/2024 2:00 pm 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 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 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 10.00 4, 653, 023 10 00 11.00 01100 CAFETERI A 2,008,617 11.00 01300 NURSING ADMINISTRATION 13 00 0 1,703 750, 312 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 0 01500 PHARMACY 0 58, 527, 802 15 00 0 103, 467 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 16.00 01700 SOCIAL SERVICE 17.00 0 0 77, 662 0 0 0 0 17.00 01701 INSERVICE EDUCATION 4,608 17.01 0 0 17.01 οĺ 21.00 |02100|| &R SERVICES-SALARY & FRINGES APPRV 30, 533 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 4, 415 0 0 0 22.00 0 02300 PARAMED ED PRGM 4, 045 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 726, 407 558, 245 348.844 0 8, 483 30.00 03100 INTENSIVE CARE UNIT 84, 911 31.00 477, 471 53,060 0 646 31.00 04100 SUBPROVI DER - I RF 449, 145 38.755 24, 218 ol 41.00 41.00 22 04300 NURSERY 43.00 0 7, 322 4, 576 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50, 001 31, 245 0 188, 356 50.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 10, 979 6.861 0 2,800 52 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 188, 982 118, 094 1, 208, 430 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 43, 927 27, 450 0 4, 999 59.00 ol 60.00 06000 LABORATORY 0 0 0 154, 329 60.00 0 ō 06500 RESPIRATORY THERAPY 65 00 39.343 24, 585 220 65 00 0 66.00 06600 PHYSI CAL THERAPY 205, 590 0 12 66.00 06900 ELECTROCARDI OLOGY 35, 273 331, 347 69.00 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 0 14, 798 0 0 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 56, 397, 443 73.00 07400 RENAL DIALYSIS 992 74 00 1,588 74 00 0 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0 15, 582 9.737 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 ol 77.00 77.00 0 C 07800 CAR T-CELL IMMUNOTHERAPY 0 O 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 0 91.00 161,066 100, 650 0 165, 362 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 17, 255 93 00 0 62,876 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 0 12, 894 n 0 3, 902 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 167, 939 116. 00 116. 00 11600 HOSPI CE 44, 835 0 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 1<u>, 957, 729</u> 118.00 4, 653, 023 750, 312 0 58, 497, 223 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 C 0 194.00 07950 RENTAL SPACE 0 0 0 194, 00 0 194. 01 07951 FOUNDATI ON 6,513 0 194. 01 194. 02 07952 RETAIL SERVICES 0 0 0 0 0 0 194.02 6.171 194. 03 07953 REID CONTRACTED SERVICES 0 0 194, 03 C 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. 0 C 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 194.05 C 194.06 07956 VACANT SPACE 0 0 194.06 C 0 194. 07 07957 HOME OFFICE 0 01194 07 0 C 194. 08 07958 CAMBRI DGE RHC 0 0 0 0 194.08 30, 579 194. 09 194.09 07959 REID HEALTH PAVILION - RES 38, 204 0 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0048	From 01/01/2023	Worksheet B Part I Date/Time Prepared:

						5/31/2024 2:0	00 pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	·			ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	4, 653, 023	2, 008, 617	750, 312	0	58, 527, 802	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0048

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

			'	0 12/31/2023	Date/lime Pre 5/31/2024 2:0	
		·		INTERNS &	RESI DENTS	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	SERVI CES-SALA RY & FRI NGES APPRV	SERVI CES-OTHE R PRGM COSTS APPRV	
	16. 00	17. 00	17. 01	21.00	22. 00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP BLDG & FIXT - OFFSITE						1. 00 1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATIENT TELEPHONES						5. 01
5. 02 00550 DATA PROCESSI NG 5. 03 00560 PURCHASI NG RECEI VI NG 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 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 O1300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	260, 873					15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0	6, 696, 648				17. 00
17. 01 01701 I NSERVI CE EDUCATI ON	0	0	2, 670, 318]		17. 01
21. 00 02100 1&R SERVI CES-SALARY & FRINGES APPRV	0	0	C	2, 593, 299	4 454 040	21.00
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM	0	ol Ol	5, 527)	1, 456, 048	22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	١	U _I	5, 527			23.00
30. 00 03000 ADULTS & PEDI ATRI CS	18, 412	4, 421, 591	796, 214	2, 159, 338	1, 212, 392	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 068	538, 524	118, 286		75, 617	31.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	999 290	0	53, 414		0	41. 00 43. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	290	<u> </u>	10, 126	o <u>l</u> Ol	0	43.00
50. 00 05000 OPERATI NG ROOM	43, 763	0	204, 500	86, 792	48, 731	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 592	168, 871	15, 209		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	44, 927	0	274, 657		6, 722	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	27, 547 26, 093	0	60, 031 215, 756		0 0	59. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	5, 620	Ö	55, 512		Ö	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 484	0	296, 926		0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 417	0	48, 694			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 442	0	20, 172 0	1	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 419	o	C	o o	ő	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	36, 337	0	C	0	0	73. 00
74. 00 07400 RENAL DIALYSIS	255	0	2, 219	1	0	74.00
76. 00 03950 ANCI LLARY - OTHER 76. 97 07697 CARDI AC REHABI LI TATI ON	0 499	0	21, 382	_	0	76. 00 76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	477	0	21, 302		0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	24 524	1 5/7 //2	247 425	100 2/0	F/ 202	01 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 534	1, 567, 662	247, 425	100, 260	56, 293	91. 00 92. 00
93. 00 04040 FAMILY PRACTICE	1, 853	0	85, 971	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 102.00 10200 OPI OI D TREATMENT PROGRAM	110	0	17, 590	0		96. 00 102. 00
SPECIAL PURPOSE COST CENTERS	ı o	υ _l) O	0	102.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 212	0	47, 363			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	260, 873	6, 696, 648	2, 596, 974	2, 593, 299	1, 456, 048	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O		ol ol	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	O	Č	0		192.00
194.00 07950 RENTAL SPACE	0	0	C	0		194. 00
194. 01 07951 FOUNDATION	0	0	8, 916			194. 01 194. 02
194. 02 07952 RETAI L SERVI CES 194. 03 07953 REI D CONTRACTED SERVI CES		0	8, 674 C			194. 02
194. 04 07954 REID PHYSICIAN ASSOC.		o	C	ol ol		194. 03
194. 05 07955 CONNERSVILLE LOCATION	0	ō	C	o	0	194. 05
194. 06 07956 VACANT SPACE	0	O	C	0		194.06
194. 07 07957 HOME OFFI CE 194. 08 07958 CAMBRI DGE RHC	0	0	C			194. 07 194. 08
sojovivoj orimotit boli titio	<u>.</u> 역	Ч		. ₁	<u> </u>	1. / 1. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10 Provider CCN: 15-0048

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: | 5/31/2024 2:00 pm |

						3/31/2024 2.0	o piii
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
		RECORDS &	SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM COSTS	
		LI BRARY			APPRV	APPRV	
		16. 00	17. 00	17. 01	21. 00	22. 00	
194. 09 07959	REID HEALTH PAVILION - RES	0	0	55, 754	0	0	194.09
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	260, 873	6, 696, 648	2, 670, 318	2, 593, 299	1, 456, 048	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS REID HOSPITAL & HEALTH CARE SERVICES Provi der CCN: 15-0048

			To	12/31/2023	Date/Time Prepared:
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	5/31/2024 2: 00 pm
	PRGM		Residents Cost & Post		
			Stepdown		
	23. 00	24. 00	Adjustments 25.00	26. 00	
GENERAL SERVI CE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP BLDG & FIXT - OFFSITE					1.00
2. 00 00200 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					5. 01 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 OO700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13. 00 14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE 17. 01 01701 INSERVICE EDUCATION					17. 00 17. 01
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRV					21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	(40,050				22.00
23. 00 02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	643, 250				23. 00
30. 00 03000 ADULTS & PEDIATRICS	0	66, 185, 647	-3, 371, 730	62, 813, 917	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	11, 872, 486		11, 662, 191	31.00
41. 00 04100 SUBPROVI DER - IRF 43. 00 04300 NURSERY	0	4, 291, 742 893, 494	0	4, 291, 742 893, 494	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	37, 894, 842 1, 960, 573		37, 759, 319 1, 960, 573	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	643, 250	33, 832, 825		33, 814, 132	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	9, 262, 843		9, 262, 843	59.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	20, 402, 463 4, 028, 363		20, 402, 463 4, 028, 363	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	Ö	21, 417, 524		21, 417, 524	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	5, 159, 027	-156, 553	5, 002, 474	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1, 430, 091 0	0	1, 430, 091 0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	31, 139, 487	O	31, 139, 487	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	56, 846, 359		56, 846, 359	73.00
74.00 07400 RENAL DI ALYSI S 76.00 03950 ANCI LLARY - OTHER		1, 067, 588 0	0	1, 067, 588 0	74. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1, 251, 028	0	1, 251, 028	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	ĭ	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	O _I	<u> </u>	70.00
91. 00 09100 EMERGENCY	0	20, 559, 971		20, 403, 418	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04040 FAMILY PRACTICE	0	3, 767, 794	0	3, 767, 794	92. 00 93. 00
OTHER REIMBURSABLE COST CENTERS	5				
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	959, 763 0		959, 763	96.00
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	ı o	0	0	0	102. 00
113.00 11300 INTEREST EXPENSE					113. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 643, 250	5, 064, 507 339, 288, 417		5, 064, 507 335, 239, 070	116. 00 118. 00
NONREIMBURSABLE COST CENTERS	043, 230	557, 200, 417	-4, 047, 347	333, 239, 070	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE	0	11, 746, 215 7, 907, 049		11, 746, 215 7, 907, 049	192. 00 194. 00
194. 01 07951 FOUNDATI ON		611, 507	0	611, 507	194. 01
194. 02 07952 RETAIL SERVICES	0	422, 025	0	422, 025	194. 02
194. 03 07953 REID CONTRACTED SERVICES 194. 04 07954 REID PHYSICIAN ASSOC.	0	0 17, 240	0	0 17, 240	194. 03 194. 04
194.05 07955 CONNERSVILLE LOCATION		1, 422, 626		1, 422, 626	194. 05
194. 06 07956 VACANT SPACE	0	3, 454, 349		3, 454, 349	194.06
194. 07 07957 HOME OFFICE 194. 08 07958 CAMBRIDGE RHC	0	0		0	194. 07 194. 08
411 1111 2 2 2 1012	, 9		. 9	٥١	130

Health Financial Systems	REID HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2023	Worksheet B Part I
				To 12/31/2023	Date/Time Prepared:
					5/31/2024 2:00 pm
Cost Center Description	PARAMED ED	Subtotal	Intern &	Total	
	PRGM		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
	23. 00	24. 00	25.00	26.00	
194.09 07959 REID HEALTH PAVILION - RES	0	2, 386, 247		0 2, 386, 247	194. 09
200.00 Cross Foot Adjustments	0	0		0 0	200.00
201.00 Negative Cost Centers	o	0		0 0	201. 00
202.00 TOTAL (sum lines 118 through 201) 643, 250	367, 255, 675	-4, 049, 34	7 363, 206, 328	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 2007 | Prepared: | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0048

			10	12/31/2023	Date/lime Pre 5/31/2024 2:0	
		CAP	TAL RELATED CO	STS	,	
		DI DO A FINT	LUEW OAR RURO	10/01 5 50/11 5		
Cost Center Description	Directly	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	Subtotal	
	Assigned New Capital		& FLXT - OFFSLTE			
	Related Costs		OITSITE			
	0	1.00	1. 01	2. 00	2A	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		0	10.2/5		10 2/5	2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.01 O0540 NONPATIENT TELEPHONES		0	19, 365	0	19, 365 0	4. 00 5. 01
5. 02 00550 DATA PROCESSING		0	0	0	0	5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	Ö	243, 316	0	Ö	243, 316	5. 03
5. 04 00570 ADMI TTI NG	o	12, 672	91, 208	o	103, 880	5.04
5. 05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	378, 580	0	378, 580	5.05
5. 06 00590 OTHER A&G	0	105, 105		0	138, 219	5.06
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	301, 821 0	75, 426 0	0	377, 247 0	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG		0	0	0	0	9. 00
10. 00 01000 DI ETARY	l o	502, 212	i o	o	502, 212	10.00
11. 00 01100 CAFETERI A	o	263, 696	0	o	263, 696	11.00
13.00 O1300 NURSING ADMINISTRATION	0	53, 622	0	0	53, 622	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	270, 745	0 228, 552	0	270, 745 228, 552	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE		34, 039		0	34, 039	17. 00
17. 01 01701 I NSERVI CE EDUCATI ON		285, 501	0	ő	285, 501	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	o	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22.00
23. 00 02300 PARAMED ED PRGM	0	29, 101	129, 744	0	158, 845	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		2 (12 022		ام	2 (12 022	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0	3, 612, 033 673, 420		0	3, 612, 033 673, 420	30. 00 31. 00
41. 00 04100 SUBPROVI DER - RF		490, 912		o	490, 912	41. 00
43. 00 04300 NURSERY	o	73, 535		o	73, 535	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	1, 252, 431	633, 758	0	1, 886, 189	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	228, 094 1, 918, 390		0	228, 094 1, 995, 849	52. 00 54. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		372, 449		0	372, 449	59.00
60. 00 06000 LABORATORY	Ö	798, 026		Ö	798, 026	60.00
65. 00 06500 RESPIRATORY THERAPY	0	45, 174	0	o	45, 174	65.00
66. 00 06600 PHYSI CAL THERAPY	0	221, 730		0	2, 270, 322	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	214, 188		0	214, 188	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	188, 419	0	188, 419 0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	0	Ö	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	40, 868	0	o	40, 868	74.00
76. 00 03950 ANCI LLARY - OTHER	0	0	0	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	224, 501	0	0	224, 501	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	٩		0	<u> </u>		70.00
91. 00 09100 EMERGENCY	0	849, 235	0	0	849, 235	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93. 00 04040 FAMILY PRACTICE	0	0	41, 005	0	41, 005	93.00
OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	48, 658	139, 039	ol	187, 697	96. 00
102.00 10200 OPLOLD TREATMENT PROGRAM		40, 030	134, 034	ol		102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		102.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	12, 206		0	12, 206	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	13, 177, 680	4, 084, 261	0	17, 261, 941	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	٥	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o o	0	5, 236, 845	Ö	5, 236, 845	
194.00 07950 RENTAL SPACE	o	0	945, 482	o	945, 482	
194. 01 07951 FOUNDATI ON		5, 650		o		194. 01
194. 02 07952 RETAIL SERVICES	0	64, 182	0	0	64, 182	
194. 03 07953 REID CONTRACTED SERVICES	0	0	15 104	O		194. 03
194. 04 07954 RELD_PHYSICIAN_ASSOC. 194. 05 07955 CONNERSVILLE_LOCATION		0	15, 104 0	٥	15, 104 0	194. 04 194. 05
194. 06 07956 VACANT SPACE		1, 940, 634	831, 133	ol O	2, 771, 767	
194. 07 07957 HOME OFFICE	o	0	0	ō		194. 07
	•					

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0048	From 01/01/2023	Worksheet B Part II Date/Time Prepared: 5/31/2024 2:00 pm

						5/31/2024 2:0	O pm
			CAPI	TAL RELATED CO	STS		
	Cost Center Description	Di rectly	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	Subtotal	
	'	Assigned New		& FLXT -			
		Capi tal		OFFSI TE			
		Related Costs					
		0	1. 00	1. 01	2. 00	2A	
194. 08 07958	CAMBRI DGE RHC	0	0	0	0	0	194. 08
194. 09 07959	REID HEALTH PAVILION - RES	0	206, 096	0	0	206, 096	194. 09
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)	0	15, 394, 242	11, 112, 825	0	26, 507, 067	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/31/2024 2:00 pm 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 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 19, 365 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 5.02 00550 DATA PROCESSING 0 0 5.02 00560 PURCHASING RECEIVING AND STORES 0 0 5.03 0 243, 316 5.03 5.04 00570 ADMITTING 15 104, 059 5.04 164 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 0 0 0 0 5.05 00590 OTHER A&G 598 0 0 5.06 2, 184 5.06 0 00700 OPERATION OF PLANT 0 7 00 0 Ω Ω 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 0 8.00 9.00 00900 HOUSEKEEPI NG 0 0 9.00 01000 DI ETARY 0 10.00 10.00 0 224 3, 611 0 11.00 01100 CAFETERI A 433 0 0 0 11.00 01300 NURSING ADMINISTRATION 13 00 74 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 0 14.00 0 0 01500 PHARMACY 0 15 00 933 C 31, 365 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 761 0 0 703 0 17.00 01701 INSERVICE EDUCATION 0 17.01 57 0 298 0 17.01 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 346 0 0 0 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 25 0 0 57 0 22.00 02300 PARAMED ED PRGM 0 0 23.00 23.00 37 45 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 272 0 0 38, 946 7, 365 30.00 03100 INTENSIVE CARE UNIT 31.00 878 0 0 10, 888 827 31.00 0 04100 SUBPROVI DER - I RF 0 1.932 400 41.00 41.00 359 04300 NURSERY 0 43.00 88 C 2,042 116 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 397 0 35, 174 17, 505 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 121 0 0 3, 639 637 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 1, 731 54.00 0 31, 888 17,679 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 409 0 0 19, 917 11, 019 59.00 60.00 06000 LABORATORY 1,040 0 0 5, 285 10, 437 60.00 06500 RESPIRATORY THERAPY 0 0 11, 188 65 00 2.248 65 00 365 0 66.00 06600 PHYSI CAL THERAPY 1,765 0 2, 459 2, 593 66.00 1, 372 2, 967 06900 ELECTROCARDI OLOGY 69.00 306 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 99 0 0 957 577 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 768 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 14,535 73.00 07400 RENAL DIALYSIS 0 74 00 18 Ω 281 102 74 00 76.00 03950 ANCILLARY - OTHER 0 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 106 0 0 406 200 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 0 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 9, 814 91.00 1,730 0 22, 250 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 04040 FAMILY PRACTICE 93 00 399 Ω 0 2,964 741 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 61 0 4, 274 44 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 383 0 0 7, 313 485 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 0 118.00 19,030 0 241, 602 104, 059 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 194.00 07950 RENTAL SPACE 0 0 0 194, 00 0 152 194. 01 07951 FOUNDATI ON 52 0 247 0 194. 01 194. 02 07952 RETAIL SERVICES 0 34 0 153 0 194.02 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 0 194, 03 0 0 194.04 194.04 07954 REID PHYSICIAN ASSOC. 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 194.05 0 684 0 194.06 07956 VACANT SPACE 0 0 0 194.06 0 194. 07 07957 HOME OFFICE 0 0 194.07 0 C 0 194. 08 07958 CAMBRI DGE RHC 0 C 0 0 0 194.08 194.09 07959 REID HEALTH PAVILION - RES 0 194.09 249 478 200.00 200.00 Cross Foot Adjustments

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/31/2024 2:0	
Cost Center Description	EMPLOYEE	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	

						5/31/2024 2:0	00 pm
	Cost Center Description	EMPLOYEE	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	
		BENEFITS	TELEPHONES	PROCESSI NG	RECEIVING AND		
		DEPARTMENT			STORES		
		4. 00	5. 01	5. 02	5. 03	5. 04	
201.00	Negative Cost Centers	0	0	(0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	19, 365	0	(243, 316	104, 059	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

						5/31/2024 2:0	
	Cost Center Description	CASHI ERI NG/AC COUNTS	OTHER A&G	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		RECEI VABLE 5. 05	5. 06	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	5.05	5.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2.00	00200 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 5. 05	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	378, 580					5. 04 5. 05
5. 06	00590 OTHER A&G	378, 380	141, 001				5.06
7. 00	00700 OPERATION OF PLANT	0	141, 001	377, 412			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	12	0,,,,,,	l .		8.00
9. 00	00900 HOUSEKEEPI NG	0	37	Ō		37	9. 00
10.00	01000 DI ETARY	0	1, 780	10, 082	0	1	10.00
11.00	01100 CAFETERI A	0	768	5, 294	0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	287	1, 077	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	_	0	14. 00
15. 00	01500 PHARMACY	0	22, 492	5, 308		0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	100	0	0	0	16.00
	01700 SOCIAL SERVICE	0	2, 540	241	0	0	17.00
17. 01 21. 00	O1701 INSERVICE EDUCATION O2100 I&R SERVICES-SALARY & FRINGES APPRV	0	1, 021 983	5, 133 0		0	17. 01 21. 00
22. 00		0	557		· ·	0	1
23. 00	1 1	0	242	1, 546	· ·	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		., 0.0	<u> </u>		20.00
30.00	03000 ADULTS & PEDIATRICS	26, 742	20, 258	73, 125	5	20	30.00
31.00	03100 INTENSIVE CARE UNIT	3, 003	3, 977	13, 520	1	2	31.00
41.00	04100 SUBPROVI DER - I RF	1, 451	1, 425			0	
43.00	04300 NURSERY	422	334	1, 476	0	0	43.00
	ANCILLARY SERVICE COST CENTERS	(0.5/4	44.074	00.070		,	
50.00	05000 OPERATING ROOM	63, 561	14, 274	22, 370		6	
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 312	670	4, 579		1	52.00
54. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	64, 948 40, 008	12, 009 3, 489	29, 669 2, 529		0	54. 00 59. 00
60.00	06000 LABORATORY	37, 896	7, 671	11, 120		1	60.00
65. 00	06500 RESPIRATORY THERAPY	8, 163	1, 497	657	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	9, 417	8, 011	26, 552	o	Ö	66.00
69.00	06900 ELECTROCARDI OLOGY	10, 772	1, 757	307	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 094	533	2, 974	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	13, 680	11, 946	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	52, 774	158	0	0	0	73. 00
	07400 RENAL DIALYSIS	370	407	820	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	2 01/	0	0	76.00
	07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON	725	461 0	2, 016 0	l .	0	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	_	· ·		
70.00	OUTPATIENT SERVICE COST CENTERS	9	0	0	<u> </u>	0	70.00
91. 00		35, 632	6, 948	17, 049	2	2	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART			,			92.00
93.00	04040 FAMILY PRACTICE	2, 691	1, 380	0	0	1	93.00
	OTHER REIMBURSABLE COST CENTERS						
	l l	159	354				96. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	1, 760	1, 842	0	o	1	113. 00 116. 00
118.00		378, 580	130, 385				118.00
110.00	NONREI MBURSABLE COST CENTERS	370, 300	130, 303	247,300	1.2	30	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	4, 481	59, 566			192.00
194.00	07950 RENTAL SPACE	0	3, 029	12, 621	0	0	194.00
	07951 FOUNDATI ON	0	229	113	0	0	194. 01
	07952 RETAIL SERVICES	0	156	377	0		194. 02
	07953 REID CONTRACTED SERVICES	0	0	0	0		194. 03
	07954 REID PHYSICIAN ASSOC.	0	7	0	이		194. 04
	07955 CONNERSVILLE LOCATION	0	546	0	0		194.05
	07956 VACANT SPACE	0	1, 303	51, 231	0		194.06
	707957 HOME OFFICE	0	0				194. 07 194. 08
	307958 CAMBRIDGE RHC 07959 REID HEALTH PAVILION - RES		865	4, 138	0		194. 08
200.00		"	003	4, 138		'	200.00
	1 12.222 . 222 . 103 40 51101150	1 <u> </u>		1	<u> </u>	I	

Health Financial Systems	REID HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		eri od:	Worksheet B	
				rom 01/01/2023 o 12/31/2023		sparad.
			'	0 12/31/2023	Date/Time Pre 5/31/2024 2:0	
Cost Center Description	CASHI ERI NG/AC	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	COUNTS		PLANT	LINEN SERVICE		
	RECEI VABLE					
	5. 05	5. 06	7. 00	8. 00	9. 00	
201.00 Negative Cost Centers	0	0	0	0	C	201.00
202.00 TOTAL (sum lines 118 through 201) 378, 580	141, 001	377, 412	12	37	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0048

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 2007 | Prepared: | Pre

			10	12/31/2023	Date/lime Pre 5/31/2024 2:0	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	
	10.00	11. 00	N 13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 OO100 CAP REL COSTS-BLDG & FIXT 1.01 OO101 NEW CAP BLDG & FIXT - OFFSITE 2.00 OO200 CAP REL COSTS-MVBLE EQUIP 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT 5.01 OO540 NONPATIENT TELEPHONES 5.02 OO550 DATA PROCESSING 5.03 OO560 PURCHASING RECEIVING AND STORES 5.04 OO570 ADMITTING 5.05 OO580 CASHIERING/ACCOUNTS RECEIVABLE 5.06 OO590 OTHER A&G 7.00 OO700 OPERATION OF PLANT						1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	517, 910 0 0	270, 191 229	55, 289			8. 00 9. 00 10. 00 11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	Ö	0	00, 20,	o		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 17. 01 01701 INSERVI CE EDUCATI ON 21. 00 02100 I&R SERVI CES-SALARY & FRINGES APPRV 22. 00 02200 I&R SERVI CES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMED ED PROVIDENCE COST, CENTERS	0 0 0 0 0 0	13, 918 0 10, 447 620 4, 107 594	0 0 0 0 0 0	0 0 0 0 0 0	344, 761 0 0 0 0 0 0	15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	414, 772	75, 092	25, 705	ol	50	30.00
31.00 03100 INTENSIVE CARE UNIT	53, 145	11, 422	3, 910	o	4	31.00
41. 00 04100 SUBPROVI DER - 1 RF 43. 00 04300 NURSERY	49, 993	5, 213 985	1, 785 337	0	0	41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	ı y	900	337	υ _l	0	43.00
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 726 1, 477	2, 302 506	0	1, 110 16	50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	25, 421 5, 909	8, 702 2, 023	0	7, 119 29	54. 00 59. 00
60. 00 06000 LABORATORY	O	20, 760	0	ō	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	5, 292	1, 812	0	1	65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0	27, 655 4, 745	0	0	0 1, 952	66. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		1, 991		0	1, 732	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	. 0	0	o	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0 214	0 73	0	332, 212 0	73. 00 74. 00
76. 00 03950 ANCI LLARY - OTHER	0	0	0	o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 096	717	o	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
91. 00 09100 EMERGENCY	0	21, 666	7, 417	0	974	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0	8, 458	0	0	102	93.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 734	0	ol	23	96.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	. 0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS				T		110.00
113. 00 11300 NTEREST EXPENSE 116. 00 11600 HOSPI CE	0	6, 031	0	o	989	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	517, 910	263, 346	55, 289	Ö	344, 581	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 RENTAL SPACE	0	0	0	0		192. 00 194. 00
194. 01 07951 FOUNDATI ON	0	876	0	ō		194. 01
194. 02 07952 RETAIL SERVICES	0	830	0	0		194. 02
194. 03 07953 RELD CONTRACTED SERVICES 194. 04 07954 RELD PHYSICIAN ASSOC.	0	0	0	0		194. 03 194. 04
194. 05 07955 CONNERSVILLE LOCATION		0		ol		194. 04
194. 06 07956 VACANT SPACE	o	0	o	ō	0	194. 06
194. 07 07957 HOME OFFICE	0	0	0	O		194. 07
194. 08 07958 CAMBRIDGE RHC 194. 09 07959 REID HEALTH PAVILION - RES	0	0 5, 139		0		194. 08 194. 09
200.00 Cross Foot Adjustments		5, 157		Ĭ		200.00
·						

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0048	From 01/01/2023	Worksheet B Part II Date/Time Prepared:

						5/31/2024 2:0	O pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	517, 910	270, 191	55, 289	0	344, 761	202.00

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

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/31/2024 | 2:00 pm |

COUNT COUNTY PROMETRY THE PROMETRY				'	0 12/31/2023	5/31/2024 2:0	
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
DEBERAL SERVICE COST CENTERS		RECORDS &			RY & FRINGES	R PRGM COSTS	
Cherent Service OST CENTERS			17.00	17.01			
1.00	GENERAL SERVICE COST CENTERS	16.00	17.00	17.01	21.00	22.00	
2.00 00000 CAP REL DOSTS-AMPLE EQUIP 4.00 00000 PRUPUTUSE BEREIT IS EPRAFIMENT 5.01 000000 PRUPUTUSE BEREIT IS EPRAFIMENT 5.01 000000 PRUPUTUSE BEREIT IN SERVING SERV							1.00
4.00 DOGOGIER PLOYEE BINEFIT IS DEPARTWENT 4.00 5.00 COSCO, DOTA PROCESS NG 5.00 5.00 COSCO, DOTA PROCESS NG 5.00 5.0	· · · · · · · · · · · · · · · · · · ·						
5. 01 0.0050 MONNATIENT TELEPHONES 5. 0.0 0.0050 CATA PROCESSING 5. 0.0050 C	1 I						
5.02 000500 PARCHASTING RECEIVING AND STORES 5.02 5.02 5.02 5.02 5.02 5.02 5.03 5.03 5.04 5.02 5.04 5.05 5.04 5.05 5.04 5.05 5.	• • • • • • • • • • • • • • • • • • •						
5.04 0.0570 ASMITTING	• • • • • • • • • • • • • • • • • • •						
5. 06 0.00580 CASH LER INCACCOUNTS RECET VABLE 5. 06 7. 00 0.00590 OTHER AGE 7. 00 0.0050 OTHER AGE 7. 00 OTHER AGE							
5.06 0.0500 OTHER AMS							
2.00 00700 00FRATION OF PLANT							
8. 00 00800 LANDRY & LINEN SERVICE 9.00 00900 DUSCREPTINO 10.00 10.00 11.00							
10.00 10.000 DETARY							
11.00 11.00 CAFTERIA							
13.00							1
14.00 10400 PARMACY							
15.00 01500 PHARMACY 115.00 115.00 117.00 1							
17.00 01700 SOCIAL SERVICE 0 48,731 17.00 1701 101701 101701 101701 1018SERVICE EDUCATION 0 0 0 0 292,630 17.01 17.01 1701 1018SERVICE EDUCATION 0 0 0 0 0 5,436 21.00 2020 2020 18R SERVICES-SALARY & FRINGES APRIV 0 0 0 0 0 0 0 1,233 22.00 2020 20200 18R SERVICES-SOTHER PROBLOSTS APRIV 0 0 0 0 0 0 0 0 0							
17.0 0700 INSERVICE EDUCATION 0 0 292,630 17.0 17.0 02100 IRS SERVICES SALARY & FRINCES APPRV 0 0 0 0 5,436 21.00 22.0 0300 IRS SERVICES SALARY & FRINCES APPRV 0 0 0 0 0 0 1,233 22.0 0 23.0 0300 03000 ARMED ED PRIGM 0 0 0 0 0 0 0 23.0 0		1					
21.00		1		202 (20			
22.00 02200 RAY SERVICES-OTHER PROM COSTS APPRV 0 0 0 606 23.3 22.0 02300 PARAMED ED PROM 0 0 0 606 23.0 02300 PARAMED ED PROM 0 0 0 606 23.0 02300 PARAMED ED PROM 0 0 0 0 0 0 0 0 0	• • • • • • • • • • • • • • • • • • •	1 -1					
INPATI ENT ROUTH NE SERVICE COST CENTERS 30.00		1 -1	71			1, 233	
30.00		0	0	606			23. 00
31.00 03100 INTERSIVE CARE UNIT 1,812 3,919 12,903 31.00		1/ 122	22 175	07 252			20.00
11.00							
ANCILLARY SERVICE COST CENTERS 50.00 50.		1					
50.00		255	0	1, 110			43.00
S2.00 05200 05200 DELIVERY ROOM & LABOR ROOM 1, 395 1, 229 1, 667 52.00 54.00 5500 RADIO RADIO LOOF COLD ACMOSTIC 39, 444 60.00 59.00 05900 CARDIA C CATHETERI ZATI ON 24, 136 0 6, 579 59.00 60.00 06000 LABORATORY 22, 862 0 23, 444 60.00 65.00 06500 RESPIRATORY THERAPY 4, 925 0 6, 083 65.00 66.00 06500 RESPIRATORY THERAPY 5, 661 0 32, 539 66.00 60.00 60.00 06000 LECETROCARDIO LOGRAPHY 1, 263 0 2, 211 70.00 70.00 70.00 70.00 07000 ELECTROCARDIO LOGRAPHY 1, 263 0 2, 211 70.00 71.0		20 245	٥١	22 410			FO 00
54.00 05400 RADI DLOGY-DI AGNOSTIC 39,444 0 30,099 54.00			- 1				
60.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000		1 ' 1					
65.00 06500 RESPIRATORY THERAPY 4.925 0 6.083 65.00		1	-				
66.00 06600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 0600 06000 06000 06000 06000 070.00 0		1	71				
69-00 06900		1	-				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 253 0 0 0 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 0		1	-				1
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 8, 253 0 0 73. 00 073.00 DRUGS CHARGED TO PATIENTS 31, 838 0 0 0 73. 00 74.00 07400 IRENAL DIALYSIS 223 0 243 74. 00 74. 00 74.00 07400 IRENAL DIALYSIS 223 0 243 74. 00 74. 00 74.00 07400 IRENAL DIALYSIS 223 0 243 74. 00 74. 00 74. 00 07400 IRENAL DIALYSIS 223 0 243 74. 00 74. 00 75. 00 75. 00 07507 CARDIA CREHABILITATION 437 0 2, 343 76. 97 77. 00 0770 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 263	o	2, 211			70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 31,838 0 0 0 74.00 74. 00 07400 RENAL DIALYSIS 223 0 243 74.00 76. 07 0760 RENAL DIALYSIS 223 0 243 74.00 76. 07 07697 CARDIAC REHABILITATION 437 0 2,343 76.97 77. 00 07700 ALLOGENEIC HIST ACQUISTION 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 07900 BEREVATION BEDS (NON-DISTINCT PART 91.00 91. 00 09100 BERESHOY 92.00 92. 00 09200 DRIVENTINE SERVICE COST CENTERS 93.00 94. 00 09400 DRIVENTINE COST CENTERS 94.00 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96 0 1,928 96.00 102. 00 10200 0910 TREATMENT PROGRAM 0 0 0 0 118. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPICE 1,062 0 5,190 116.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 228,652 48,731 284,592 0 0 118. 00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 194. 00 07950 RENTAL SPACE 0 0 0 194.00 194. 00 07951 FUNDMATION 0 0 0 194.00 194. 00 07952 RETAIL SERVICES 0 0 0 194.00 194. 00 07954 REID PHYSICIAN ASSOC. 0 0 0 194.00 194. 00 07955 CONNERSYILLE LOCATION 0 0 0 194.00 194. 00 07955 HOME OFFICE 0 0 0 0 194.00 194. 00 07955 HOME OFFICE 0 0 0 0 194.00 194. 00 07955 HOME OFFICE 0 0 0 0 194.00 194. 00 07955 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 01 07957 HOME OFFICE 0 0 0 0 194.00 194. 02 07955 HOME OFFICE 0 0 0 0 194.00		1	0				
74. 00 07400 REMAL DI ALYSIS 223 0 243 74. 00 76. 00 76. 00 0750 ANCILLARY - OTHER 0 0 0 0 0 0 0 76. 00 76. 70 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		1	0				
76. 00 03950 ANCILLARY - OTHER		1	Ö	-			
77. 00 07700 ALLOGENEIC HISCT ACQUI SI TI ON 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 00 0 0 0 0 0 0 0			o				76.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00		1	0				
OUTPATIENT SERVICE COST CENTERS 91. 00 OTPO EMERGENCY 21, 496 11, 408 27, 114 91. 00 92. 00 OSERVATION BEDS (NON-DISTINCT PART 92. 00 O200 OSERVATION BEDS (NON-DISTINCT PART 93. 00 O4040 FAMILY PRACTICE 1, 623 0 9, 421 93. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 O50 DURABLE MEDI CAL EQUI P-RENTED 96 0 1, 928 96. 00 O200 O10200 O10 O1 TREATMENT PROGRAM 0 0 0 O O102. 00 O102. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 0002. 000		1	0	ū			
91. 00		UU	<u>U</u>	0			78.00
93. 00 04040 FAMILLY PRACTICE 1,623 0 9,421 93. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 1,928 96. 00 102. 00 10200 DURABLE MEDI CAL EQUI P-RENTED 96 0 1,928 96. 00 102. 00 10200 OPI 01 D TREATMENT PROGRAM 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 HOSPI CE 1,062 0 5,190 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 228,652 48,731 284,592 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19200 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 194. 01 07951 FOUNDATI ON 0 0 977 194. 02 07952 RETAIL SERVI CES 0 0 0 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 0 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 0 194. 06 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 194. 07 07957 194. 07 07957 194. 07 194. 07 07957 194. 07 07957 194. 07 07957 194. 07 07957 194. 07 194. 07 07957 194. 07 07	91. 00 09100 EMERGENCY	21, 496	11, 408	27, 114			
OTHER REIMBURSABLE COST CENTERS 96. 00 1,928 96. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 102.00 90. 00 103.			_	2 45			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96 0 1,928 96. 00 102.00 102.00 OI TREATMENT PROGRAM 0 0 0 0 102.00 OI OI TREATMENT PROGRAM 0 0 0 0 102.00 OI OI OI OI OI OI OI		1, 623	0	9, 421			93.00
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O		96	O	1, 928			96.00
113. 00 11300 INTEREST EXPENSE 113. 00 116	102.00 10200 OPI OI D TREATMENT PROGRAM						
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 228, 652 48, 731 284, 592 0 0 118. 00 118. 00 NONREI MBURSABLE COST CENTERS		T	T				1440 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 228,652 48,731 284,592 0 0 118.00		1 062	0	5 100			
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 194. 00 07950 RENTAL SPACE 0 0 0 0 194. 00 194. 01 07951 FOUNDATI ON 0 0 977 194. 01 194. 02 07952 RETAI L SERVI CES 0 0 0 951 194. 02 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 194. 02 194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 0 194. 04 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 0 194. 07 07957 194. 07 194. 07 190. 00 0 0 0 0 0 194. 07 194. 07 194. 07 194. 07 190. 00 0 0 0 0 194. 07 194. 07 194. 07 190. 00 0 0 0 0 194. 07 194. 07 194. 07 194. 07 194. 07 194. 07 194. 07 195. 00 0 0 0 194. 07 194. 07 194. 07 195. 00 0 0 0 196. 00 0 0 196. 00 0 0 196. 00 0 0 196. 00 0 0 196. 00 0 0 196. 00 0 197. 00 0 198. 00 0 198. 00 0 199. 00 0 199. 00 0 190. 00			48, 731			0	
192. 00			·				
194. 00 07950 RENTAL SPACE 0 0 0 0 194. 00 194. 01 07951 FOUNDATI ON 0 0 977 194. 02 07952 RETAL SERVI CES 0 0 951 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 194. 03 194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 0 194. 04 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 0 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 0 194. 07		0	0				
194. 01 07951 FOUNDATION 0 0 977 194. 01 194. 01 194. 02 194. 03 07952 RETAIL SERVICES 0 0 951 194. 02 194. 03 07953 REI D CONTRACTED SERVICES 0 0 0 0 194. 03 194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 0 194. 06 194. 07 07957 HOME OFFICE 0 0 0 0 194. 07		0	0				
194. 02 07952 RETAIL SERVICES 0 0 951 194. 02 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 194. 03 194. 04 07954 REID CONTRACTED SERVICES 0 0 0 194. 04 07954 REID PHYSICIAN ASSOC. 0 0 0 194. 04 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 0 194. 07 194. 07 07957 HOME OFFICE 0 0 0 0 194. 07			o				
194. 04 07954 REI D PHYSI CI AN ASSOC. 0 0 194. 04 194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 194. 06 194. 07 07957 HOME OFFICE 0 0 0 194. 07	194. 02 07952 RETAI L SERVI CES		Ö				
194. 05 07955 CONNERSVI LLE LOCATI ON 0 0 194. 05 194. 06 07956 VACANT SPACE 0 0 0 194. 06 194. 07 07957 HOME OFFICE 0 0 0 194. 07		0	o				
194. 06 07956 VACANT SPACE 0 0 0 194. 06 194. 07 07957 HOME OFFICE 0 0 0 194. 07		0	0				
194. 07 07957 HOME OFFICE 0 0 0 194. 07			0	-			
194. 08 07958 CAMBRI DGE RHC 0 0 0 194. 08			ő	-			
	194. 08 07958 CAMBRI DGE RHC	0	o	0			194. 08

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS REID HOSPITAL & HEALTH CARE SERVICES Provider CCN: 15-0048

						5/31/2024 2:0	U pm
					INTERNS &	RESI DENTS	
	Cost Center Description	MEDI CAL	SOCI AL	I NSERVI CE	SERVI CES-SALA	SERVI CES-OTHE	
		RECORDS &	SERVI CE	EDUCATI ON	RY & FRINGES	R PRGM COSTS	
		LI BRARY			APPRV	APPRV	
		16. 00	17. 00	17. 01	21. 00	22. 00	
194. 09 07959	REID HEALTH PAVILION - RES	0	0	6, 110			194. 09
200.00	Cross Foot Adjustments				5, 436	1, 233	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	228, 652	48, 731	292, 630	5, 436	1, 233	202.00

Health Financial Systems

REID HOSPITAL & HEALTH CARE SERVICES

In Lieu of Form CMS-2552-10

Provider CCN: 15-0048

Period:
From 01/01/2023
To 12/31/2023

Part II
Date/Time Prepared:
5/31/2024 2:00 pm

Cost Center Description

PARAMED ED Subtotal Intern & Total

Cost Center Pescription						Т	o 12/31/2023	Date/Time Prepared: 5/31/2024 2:00 pm	
DEBERRAL SERVICE COST CENTERS 23.00 24.00 25.00 26.00 26.00 27.0			Cost Center Description		Subtotal		Total	07 0 17 202 1 2. 00 pm	Î
PRIVEN SERVICE COST CENTRES 23 00 24 00 29 00				PRGM					
CAMP									
DEBRIENAL SERVICE COST CENTERS									
1.00 DITIONE CAP RELL COSTS-BLUE & FIRST 1.00		CENER	AN CERVICE COCT CENTERS	23. 00	24. 00	25. 00	26. 00		1
1.01 DOISH NEW CAP BLIG A FIXT - OFFSITE 2.00 DOCODO CAP BLIC OSS-PRINCELE COUNTY 3.01 DOISH AND AND ALL STREET COUNTY 5.01 DOISH AND AND ALL STREET COUNTY 5.01 DOISH AND AND ALL STREET COUNTY 5.02 DOSS OF AND ALL THE PROCESS STREET 5.03 DOSS OF AND ALL THE PROCESS STREET 5.04 DOSS OF AND ALL THE PROCESS STREET 5.05 DOSS OF AND ALL THE PROCESS STREET 5.06 DOSS OF AND ALL THE PROCESS STREET 5.07 DOSS OF AND ALL THE PROCESS STREET 5.08 DOSS OF AND ALL THE PROCESS STREET 5.09 DOSS OF AND ALL THE PROCESS STREET 5.00 DOSS OF AND ALL THE PROCESS STREET STRE	1 00							1 00	
0.00 0.000 DEPLOYEE BEREFITS DEPARTWENT									
5.01 0.0040 NORMATIENT TELEPHONES 5.01 5.02 5.02 5.05 0.0050 AND FROMESTAN BEREET WINE AND STORES 5.02 5.03 5.00 5.0			1						
5. DZ 000500 PRIVASIN RECEIVING AND STORES 5. DZ 5. DZ			1						
5.03 00560 NIROMASI NO RECEIVING AND STORES 5.03 5.04 00570 AUM TITMS 5.06 0.05 0.0			1						
5.05 0.0580 CASHI ERING/ACCOUNTS RECEIVABLE 5.06 7.00 0.0070 OPERATION OF FLANT 7.00		1	1						
0.0090 OFFRATION OF PLANT	5.04	1						5. 04	
7. 00 00700 DOPENTION OF PLANT 8. 00 8. 00 00800 LUBREY REPORT 8. 00 0. 00800 0. 00800 0. 00800 0. 00800 0. 00800 0. 008000 0. 00800 0. 00800 0. 008000 0. 008000 0. 00800 0. 008000 0. 008000 0. 008000 0. 008000 0. 008000 0. 008000 0. 008000 0.			1						
8.00 00800 LANIBRY & LINEN SERVICE 9.00 00900 JOUESEEPING 9.00 00900 JOESEEPING 9.00 009									
9.00 00900 00									
11.00 10.00 CAFETERIA			1						
13.00 01300 NURSING CORTNAL SERVICES & SUPPLY 14.00 01400 (CHTNAL SERVICES & SUPPLY 15.00		1	1						
14.00 1400 CENTRAL SERVICES & SUPPLY		1	1						
15.00 1500 PHARMACY									
17.00 01700 SOCIAL SERVICE 17.00 1701 10701 10701 108FRIVE DEDICATION 17.00 1701 108FRIVE DEDICATION 21.00 2202 200 2202 187 SERVICES-SALARY & FRINGES APPRIV 21.00 2202 200 2202 187 SERVICES-SALARY & FRINGES APPRIV 22.00 2202 200 2002 187 SERVICES-SALARY & FRINGES APPRIV 22.00 230 200 230 20									
17.0 10701 INSERVICE EDUCATION 21.00 2200 188 SERVICES SALARY & FRINGES APPRV 22.00 2200 188 SERVICES SALARY & FRINGES APPRV 22.00 2200 2200 188 SERVICES OTHER PROM COSTS APPRV 22.00 2200									
21.00		1	1						
22.00		1	1						
INPATI ENT ROUTI NE SERVICE COST CENTERS 3.0		1	1						
30.00	23. 00	02300	PARAMED ED PRGM	161, 865				23. 00	
31.00 03100 INTERSIVE CARE UNIT 793,691 0 793,691 31.00 43.00 43.00 24900 SUBPROVIDER - IRF 570,054 0 570,054 41.00 43.00 24900 24900 24.100 240.00 24.100	20.00				4 424 047		4 424 044	20.00	
41.00 04100 SUBPROVI DER - I RF 570,054 0 570,054 41.00							1 ' '		
NOTE LIARY SERVICE COST CENTERS 50.00									
50.00	43.00				80, 700		80, 700	43. 00	
S2 00 05200 05200 DELIVERY ROOM & LABOR ROOM 246, 344 52, 00	EO 00				2 110 270		2 110 270	FO 00	
54 00 05400 RADI DLOCY-DI AGNOSTIC 2, 264, 560 0 2, 264, 560 54, 00		1	1				1 ' '		
60.00 0.0000 LABORATORY 9.38, 742 0 9.38, 742 0 0.00			1						
65.00 06500 RESPIRATORY THERAPY 87, 405 0 87, 405 0 66.00 06600 PHYSICAL THERAPY 2, 386, 994 0 2, 386, 994 66.00 06900 06900 06900 06900 06900 06900 06900 06900 06900 070000 070000 070000 070000 070000 070000 070000 0700000 0700000000									
66.00 06600 PHYSI CAL THERAPY 2, 386, 994 0 2, 386, 994 66.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 06.00 07.00									
69-00 06900			1						
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00			1						
172.00 07200 IMPL DEV. CHARGED TO PATIENTS 37, 647 0 37, 647 72.00 07300 DRUGS CHARGED TO PATIENTS 431, 517 0 431, 517 73.00 07400 RENAL DIALYSIS 438, 619 0 43, 619 74.00 76.00 07400 RENAL DIALYSIS 438, 619 0 43, 619 74.00 76.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 76.00 076.00 076.00 076.00 076.00 076.00 0 0 0 0 0 0 0 0 0		1	1		•	l			
73. 00 07300 DRUGS CHARGED TO PATIENTS 431, 517 0 431, 517 73. 00 74. 00 07400 RENAL DIALYSIS 43, 619 0 43, 619 74. 00 76. 00 03950 ANCILLARY - OTHER 0 0 0 0 0 76. 00 76. 00 0770 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 0770 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78. 00 0770 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		1	1		-		1		
74. 00 07400 RENAL DI ALYSIS									
76. 97 07697 CARDI AC REHABILITATION 234,008 0 234,008 76. 97 77. 00 07700 ALIGGERIC CHSCT ACQUISITION 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			1		•				
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 1,032,737 0 1,032,737 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 93. 00 04040 FAMILY PRACTICE 68,785 0 68,785 93. 00 0THER REI MBURSABLE COST CENTERS 0 0 198,436 96. 00 102. 00 10200 OPIOI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0					U	1	-		
78. 00					234, 008				
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1,032,737 0 1,032,737 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 93.00 94.00 94.00 94.00 95.00 9					0		1		
92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 68, 785 0 68, 785 93. 00 93. 00 04040 FAMI LY PRACTI CE 93. 00 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 198, 436 0 198, 436 96. 00 102. 00 10200 0PI OI D TREATMENT PROGRAM 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 113. 00 11300 INTEREST EXPENSE 37, 262 0 37, 262 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 16, 937, 632 0 16, 937, 632 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 192. 00 19200 PHYSI CI ANS* PRI VATE OFFI CES 5, 300, 892 0 5, 300, 892 192. 00 194. 00 07950 RENTAL SPACE 961, 284 0 961, 284 194. 00 194. 01 07951 FOUNDATI ON 8, 144 0 8, 144 194. 01 194. 02 07952 RETAL SERVI CES 66, 683 0 66, 683 194. 02 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 0 194. 03 194. 04 07954 REI D PHYSI CI AN ASSOC. 15, 111 0 15, 111 194. 04 194. 05 07955 CONNERSVI LLE LOCATION 1, 230 0 1, 230 194. 05 194. 07 07957 HOME OFFI CE 0 0 0 194. 07 194. 07 07957 HOME OFFI CE 0 0 0 0 194. 07 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 195. 00 0 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 0 194. 07 07957 HOME OFFI CE 0 0 0 0 0 0 0 195. 00 00 00 00 00 00 0 0		OUTPA	TIENT SERVICE COST CENTERS		_	_	-		
93. 00 04040 FAMILY PRACTICE OTHERS OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 198, 436 0 198, 436 0 102. 00 1020 0PI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11600 HOSPI CE 37, 262 0 37, 262 116. 00 16, 937, 632 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 16, 937, 632 0 16, 937, 632 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 5, 300, 892 0 5, 300, 892 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 300, 892 0 5, 300, 892 192. 00 194. 00 7950 RENTAL SPACE 961, 284 0 961, 284 194. 01 194. 02 07952 RETAIL SERVI CES 66, 683 0 66, 683 194. 02 194. 03 07953 REI D CONTRACTED SERVI CES 66, 683 0 66, 683 194. 02 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 15, 111 194. 04 194. 04 07954 REI D PHYSI CI AN ASSOC. 15, 111 0 15, 111 194. 04 194. 05 07955 CONNERSVILLE LOCATI ON 1, 230 0 1, 230 194. 05 194. 05 07955 CONNERSVILLE LOCATI ON 1, 230 0 1, 230 194. 05 194. 07 07957 HOME OFFI CE 0 0 0 0 0 194. 07 194. 07 07957 HOME OFFI CE					1, 032, 737		1 ' '		
OTHER REIMBURSABLE COST CENTERS 96. 00 096000 DURABLE MEDI CAL EQUI P-RENTED 198, 436 0 198, 436 96. 00 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 0 102.00 091 01 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0					69 795		1		
96. 00 102. 00 103. 00	73.00				00, 703		08, 783	73.00	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11600 HOSPI CE 37, 262 0 37, 262 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 16, 937, 632 0 16, 937, 632 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 190.00 192.00 192.00 192.00 192.00 194.00 195.00 19		09600	DURABLE MEDICAL EQUIP-RENTED		198, 436				
113. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190. 0	102.00				0		0	102.00	
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 0 16, 937, 632 0 37, 262 0 18. 00 18. 00 18. 00 19	113 00							113 00	
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00		1			37, 262	C	37, 262		
190. 00	118.00			0	16, 937, 632	C	16, 937, 632	118. 00	
192. 00 192.00 19	100 00				0		ا	100.00	
194. 00 07950 RENTAL SPACE 961, 284 0 961, 284 194. 00 194. 01 07951 FOUNDATI ON 8, 144 0 8, 144 194. 01 194. 02 07952 RETAL L SERVI CES 66, 683 0 66, 683 194. 02 194. 03 07953 REI D CONTRACTED SERVI CES 0 0 0 194. 03 194. 04 07954 REI D PHYSI CI AN ASSOC. 15, 111 0 15, 111 194. 05 194. 05 07955 CONNERSVI LLE LOCATI ON 1, 230 0 1, 230 194. 05 194. 07 07957 HOME OFFI CE 2, 824, 301 0 2, 824, 301 194. 06 194. 07 07957 HOME OFFI CE 0 0 0 194. 07									
194. 02 07952 RETAIL SERVICES 66, 683 0 66, 683 194. 02 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 194. 03 194. 04 07954 REID PHYSICIAN ASSOC. 15, 111 0 15, 111 194. 04 194. 05 07955 CONNERSVILLE LOCATION 1, 230 0 1, 230 194. 05 194. 07 07957 HOME OFFICE 0 0 0 0 0 194. 07									
194. 03 07953 REID CONTRACTED SERVICES 0 0 0 194. 03 194. 04 07954 REID PHYSICIAN ASSOC. 15, 111 0 15, 111 194. 04 194. 05 07955 CONNERSVILLE LOCATION 1, 230 0 1, 230 194. 05 194. 06 07956 VACANT SPACE 2, 824, 301 0 2, 824, 301 194. 06 194. 07 07957 HOME OFFICE 0 0 0 0 194. 07									
194. 04 07954 REI D PHYSI CI AN ASSOC. 15, 111 0 15, 111 194. 04 194. 05 07955 CONNERSVI LLE LOCATI ON 1, 230 0 1, 230 194. 05 194. 06 07956 VACANT SPACE 2, 824, 301 0 2, 824, 301 194. 06 194. 07 07957 HOME OFFICE 0 0 0 194. 07			1				66, 683		
194. 05 07955 CONNERSVILLE LOCATION 1, 230 0 1, 230 194. 05 194. 06 07956 VACANT SPACE 2, 824, 301 0 2, 824, 301 194. 06 194. 07 07957 HOME OFFICE 0 0 0 0 194. 07					ŭ	· ·	15 111		
194. 06 07956 VACANT SPACE 2, 824, 301 0 2, 824, 301 194. 06 194. 07 07957 HOME OFFICE 0 0 0 0 194. 07								194. 05	
	194.06	07956	VACANT SPACE		2, 824, 301	C	2, 824, 301	194. 06	
174. 00 07730 ONIDAL ALIC 0 0 0 194. 08							1		
	174. 00	707738	PONIBILI DOL NIIC		0	1	, _I 0	1194.08	-

Health Financial Systems	REID I	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provi der CC		Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		enared:
						5/31/2024 2:0	
Cost Center Description		PARAMED ED	Subtotal	Intern &	Total		
		PRGM		Resi dents			
				Cost & Post			
				Stepdown			
				Adjustments			
		23. 00	24. 00	25.00	26. 00		
194.09 07959 REID HEALTH PAVILION -	RES		223, 256		0 223, 256		194. 09
200.00 Cross Foot Adjustments		161, 865	168, 534		0 168, 534		200.00
201.00 Negative Cost Centers		0	0		0 0		201.00
202.00 TOTAL (sum lines 118 th	rough 201)	161, 865	26, 507, 067		0 26, 507, 067		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				Ť	o 12/31/2023	Date/Time Pre 5/31/2024 2:0	
		CAP	TAL RELATED CO	OSTS		373172024 2.0	O pili
	Cost Contor Decement on	DIDC 0 FLVT	NEW CAR BLOC	MVBLE EQUIP	EMBL OVEE	NONDATI ENT	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	NEW CAP BLDG & FLXT -	(SQUARE FEET)	EMPLOYEE BENEFITS	NONPATI ENT TELEPHONES	
		(,	0FFSI TE	(===:,	DEPARTMENT	(PHONES)	
			(SQUARE FEET)		(GROSS		
		1. 00	1. 01	2. 00	SALARI ES) 4. 00	5. 01	
	GENERAL SERVICE COST CENTERS			2.00	00	0.01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	561, 254					1.00
1. 01 2. 00	00101 NEW CAP BLDG & FIXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP	0	229, 548	0			1. 01 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	400				4.00
5. 01	00540 NONPATIENT TELEPHONES	0	0	O	0	0	5. 01
5. 02	00550 DATA PROCESSING	0 074	0	0	0	0	5. 02
5. 03 5. 04	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	8, 871 462	0 1, 884	i o	77, 081	0	5. 03 5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	7, 820			Ö	5. 05
5. 06	00590 OTHER A&G	3, 832	l .	0	3, 116, 000	0	5.06
7. 00 8. 00	00700 OPERATION OF PLANT	11, 004		0	0	0	7. 00 8. 00
9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG		0	i o	0	0	9.00
10.00	01000 DI ETARY	18, 310	0	O	1, 168, 735	0	10.00
11.00	01100 CAFETERI A	9, 614		0		0	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 955	0	0	,	0	13. 00 14. 00
	01500 PHARMACY	9, 871	0			0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	4, 721	0		0	16. 00
	01700 SOCI AL SERVI CE	1, 241	0	0	3, 962, 065	0	17.00
	01701 INSERVICE EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRV	10, 409	0	i o	299, 230 1, 803, 728	0	17. 01 21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		Ö	Ö		ő	22.00
23. 00	02300 PARAMED ED PRGM	1, 061	2, 680	0	191, 622	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	131, 690	0		27, 647, 315	0	30.00
31. 00	03100 NTENSI VE CARE UNIT	24, 552				0	31.00
41. 00	04100 SUBPROVI DER – I RF	17, 898	0	O		0	41.00
43.00	04300 NURSERY	2, 681	0	0	458, 695	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	45, 662	13, 091		2, 067, 913	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 316		Ö		Ö	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	69, 942				0	54.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 579 29, 095	l .	0	2, 128, 470 5, 417, 333	0	59. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	1, 647			1, 902, 445	0	65.00
66.00	06600 PHYSI CAL THERAPY	8, 084		O	9, 190, 229	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	7, 809		0	1, 591, 460	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 892		516, 954	0 0	70.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		Ö		0	ő	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	O	0	0	
	07400 RENAL DI ALYSI S	1, 490	0	0	95, 503	0	74.00
	03950 ANCI LLARY - OTHER 07697 CARDI AC REHABI LI TATI ON	8, 185	0		551, 658	0	76. 00 76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0, 100	Ö	Ö	0	Ö	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	30, 962	0		9, 012, 012	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	30, 902			9, 012, 012		91.00
	04040 FAMILY PRACTICE	0	847	C	2, 076, 529	0	1
0/ 00	OTHER REIMBURSABLE COST CENTERS	4 774	0.070		200 474		0, 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10200 OPIOID TREATMENT PROGRAM	1, 774	2, 872 0		· ·	0	96. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS				J		102.00
	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	445		0			116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	480, 441	84, 365	0	99, 303, 790	0	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	108, 173		0		192.00
	07950 RENTAL SPACE 07951 FOUNDATI ON	206	19, 530	0	0 268, 804		194. 00 194. 01
	07951 FOUNDATION 07952 RETAIL SERVICES	2, 340	l .		179, 031		194. 01
194. 03	07953 REID CONTRACTED SERVICES	0	Ö		0	0	194. 03
	07954 REID PHYSICIAN ASSOC.	0	312		0		194. 04
	07955 CONNERSVILLE LOCATION 07956 VACANT SPACE	70, 753	0 17, 168		0		194. 05 194. 06
174.00	JOTTOO VACAINT STACE	10,755	17,100	1 0	ı U	1 0	11 74. 00

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				10	0 12/31/2023	5/31/2024 2: 0	
		CAPI	TAL RELATED CO	OSTS			
		BLDO & FLVT	LUEW OAR BURG	18/01 5 50/11 5	54DL 0V55	NONDATI ENT	
	Cost Center Description	BLDG & FIXT	NEW CAP BLDG	MVBLE EQUIP	EMPLOYEE	NONPATI ENT	
		(SQUARE FEET)	& FIXT - OFFSITE	(SQUARE FEET)	BENEFI TS	TELEPHONES	
			(SQUARE FEET)		DEPARTMENT (GROSS	(PHONES)	
			(SQUARE FEET)		SALARI ES)		
		1. 00	1, 01	2.00	4. 00	5. 01	
194. 07 0	07957 HOME OFFICE	0	0	0	0		194. 07
194. 08	07958 CAMBRI DGE RHC	0	0	0	0	0	194. 08
194. 09	07959 REID HEALTH PAVILION - RES	7, 514	0	0	1, 295, 047	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	15, 394, 242	11, 112, 825	0	20, 121, 191	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27. 428298	48. 411770	0. 000000	0. 199128	0. 000000	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)				19, 365	0	204. 00
205.00	Unit cost multiplier (Wkst. B, Part				0. 000192	0.000000	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)						I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0048

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Pre 5/31/2024 2:0	
	Cost Center Description	DATA	PURCHASI NG	ADMITTI NG		Reconciliatio	
		PROCESSING (TERMINALS)	RECEIVING AND STORES	(TOTAL REVE NUE)	COUNTS RECEI VABLE	n	
		(TERWITNALS)	(SUPPLY EXP	NOL)	(TOTAL REVE		
			ENSE)		NUE)		
	GENERAL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5A. 06	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW CAP BLDG & FIXT - OFFSITE						1. 01
2. 00	00200 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	1, 588					5. 01 5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	2	l .				5. 03
5.04	00570 ADMI TTI NG	16	5, 809	1, 240, 611, 068			5. 04
5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	_	0	1, 240, 611, 068	45 504 007	5. 05
5. 06 7. 00	00590 OTHER A&G 00700 OPERATION OF PLANT	288	77, 557 0	0	0	-45, 501, 837 0	5. 06 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2	0	0	0	0	1
9. 00	00900 HOUSEKEEPI NG	6	0	0	0	0	1
10.00	01000 DI ETARY	47	128, 221	0	0	0	10.00
11.00	01100 CAFETERI A	0	_	0	0	0	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	10		0	0	0	13. 00 14. 00
15. 00	01500 PHARMACY	64	1, 113, 740		0	0	15. 00
16.00		0		0	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	29		0	0	0	17.00
17. 01	01701 I NSERVI CE EDUCATI ON	41	10, 571	0	0	0	17. 01
21. 00 22. 00	02100 L&R SERVICES-SALARY & FRINGES APPRV 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	0 36	_	0	0	0	21.00 22.00
23. 00	02300 PARAMED ED PRGM	14		0	o	0	
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30.00	03000 ADULTS & PEDIATRICS	122				0	
31. 00 41. 00	03100 NTENSI VE CARE UNI T	22 17			9, 846, 705	0	31.00 41.00
41.00		0	68, 609 72, 515		4, 756, 800 1, 383, 248	0	43.00
10.00	ANCILLARY SERVICE COST CENTERS		72,010	1,000,210	1,000,210		10.00
50.00	05000 OPERATING ROOM	209			208, 397, 587	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	19			7, 579, 241	0	
54. 00 59. 00	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	150 23			212, 306, 018 131, 175, 384	0	54. 00 59. 00
60. 00	06000 LABORATORY	82			124, 250, 263	0	60.00
65.00	06500 RESPI RATORY THERAPY	12	397, 286	26, 763, 730	26, 763, 730	0	65.00
66.00	06600 PHYSI CAL THERAPY	155			30, 873, 908	0	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	40 18			35, 317, 387 6, 866, 598	0	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0, 000, 370	0, 000, 370	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	44, 853, 298	44, 853, 298	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		,,	173, 030, 975	0	73.00
74.00	07400 RENAL DI ALYSI S 03950 ANCI LLARY - OTHER	4	9, 978	1, 212, 998	1, 212, 998	0	74.00
	07697 CARDI AC REHABI LI TATI ON	6	14, 424	2, 377, 007	2, 377, 007	0	1
	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
01 00	OUTPATIENT SERVICE COST CENTERS	00	790, 059	11/ 027 201	114 007 201	0	01 00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	90	790,059	116, 827, 391	116, 827, 391	U	91. 00 92. 00
	04040 FAMILY PRACTICE	15	105, 261	8, 821, 675	8, 821, 675	0	1
	OTHER REIMBURSABLE COST CENTERS	1					
	09600 DURABLE MEDICAL EQUIP-RENTED	14	1		1	0	
102.00	D10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113.00	11300 INTEREST EXPENSE				I		113.00
	11600 H0SPI CE	26	259, 680	5, 770, 995	5, 770, 995	0	116.00
118.00		1, 579	8, 579, 093	1, 240, 611, 068	1, 240, 611, 068	-45, 501, 837	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	T 0	1 0		٥		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
	07950 RENTAL SPACE	0	5, 415	Ö	o		194. 00
	07951 FOUNDATI ON	5	8, 769		0		194. 01
	207952 RETAIL SERVICES	3	5, 432		0		194. 02
	307953 REID CONTRACTED SERVICES 407954 REID PHYSICIAN ASSOC.		0	0	0		194. 03 194. 04
	07955 CONNERSVILLE LOCATION	0	24, 294	0	0		194. 04
194. 06	07956 VACANT SPACE	0	0	0	0	0	194. 06
	7 07957 HOME OFFICE	0	0	0	0		194. 07
194.08	3 07958 CAMBRIDGE RHC	0	0	0	0	0	194. 08

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205.00

206.00

207.00

205.00

206.00

207.00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Cost Center Description DATA PURCHASI NG ADMITTI NG CASHIERING/AC Reconciliatio PROCESSI NG RECEIVING AND (TOTAL REVE COUNTS n (TERMI NALS) STORES NUE) RECEI VABLE (SUPPLY EXP (TOTAL REVE ENSE) NUE) 5. 02 5.03 5.04 5.05 5A. 06 194.09 07959 REID HEALTH PAVILION - RES 16, 968 0 0 194. 09 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 22, 438, 447 271, 576 2, 128, 213 463, 720 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 14, 130. 004408 0. 031433 0.001715 0.000374 203.00 Cost to be allocated (per Wkst. B, 204.00 243, 316 104, 059 378, 580 204.00

0.000000

0. 028162

0.000084

0.000305

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2023 Provi der CCN: 15-0048

				To	rom 01/01/2023 o 12/31/2023		
	Cost Center Description	OTHER A&G (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	5/31/2024 2: 0 DI ETARY (MEALS SERVED)	O pm
	GENERAL SERVICE COST CENTERS	5. 06	7. 00	8.00	9. 00	10. 00	
1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 10. 00 11. 00 14. 00 15. 00 17. 01 21. 00 22. 00 23. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CAP BLDG & FIXT - OFFSITE 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 DIETARY 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 APPRV	321, 753, 838 377, 247 28, 260 84, 780 4, 064, 044 1, 754, 464 654, 783 0 51, 180, 394 228, 552 5, 798, 253 2, 329, 937 2, 245, 248 1, 271, 780 553, 622	685, 390 0 18, 310 9, 614 1, 955 0 9, 640 438 9, 322	2, 204, 591 0 0 0 0 0 0 0 0 0 0	14, 478 411 0 0 0 0 72 63 0 0	41, 066 0 0 0 0 0 0 0	1. 00 1. 01 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 21. 00 22. 00 23. 00
30. 00 31. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	46, 250, 572 9, 080, 083 3, 252, 884 761, 768	24, 552 17, 898	160, 625 71, 414	·	32, 888 4, 214 3, 964 0	30. 00 31. 00 41. 00 43. 00
50. 00 52. 00 54. 00 59. 00 60. 00 65. 00 66. 00 71. 00 72. 00 73. 00 74. 00 76. 97 77. 00 78. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 ANCILLARY - OTHER 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	32, 589, 367 1, 529, 617 27, 418, 475 7, 966, 767 17, 514, 664 3, 418, 554 18, 290, 532 4, 011, 231 1, 217, 919 0 27, 273, 153 361, 462 929, 402 0 1, 052, 422 0	4, 593 20, 194 1, 194 48, 220 557 5, 400 0 0 0	104, 779 225, 143 106, 323 1, 351 0 19, 622 0 8, 937 0 0 0	235	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 77. 00 78. 00
91. 00 92. 00 93. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 863, 609 3, 151, 765				0	91.00 92.00 93.00
	09600 DURABLE MEDICAL EQUIP-RENTED 010200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	808, 506 0		1		0	96. 00 102. 00
		4, 204, 947 297, 519, 063		0 2, 124, 876	532 14, 002	0 41, 066	113. 00 116. 00 118. 00
192. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0	NONREI MBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 07950 RENTAL SPACE 1 07951 FOUNDATI ON 2 07952 RETAIL SERVI CES 3 07953 REID CONTRACTED SERVI CES 4 07954 REID PHYSI CI AN ASSOC. 5 07955 CONNERSVILLE LOCATI ON 6 07956 VACANT SPACE 7 07957 HOME OFFI CE 8 07958 CAMBRI DGE RHC 9 07959 REID HEALTH PAVILION - RES	10, 229, 957 6, 914, 775 522, 113 356, 296 0 15, 104 1, 246, 367 2, 975, 158 0 0	108, 173 22, 920 206 684 0 0 93, 036	72, 642 0 0 0 0 0 0 0 0 0	0 80 0 10 0 0 0 0 0 386	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. 08 194. 09

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

CUST ALLU	SUST ALLUCATION - STATISTICAL BASIS		Provider CCN: 15-0048		From 01/01/2023	worksneet B-1	
					To 12/31/2023		
	Cost Center Description	OTHER A&G	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		(ACCUM. COST)	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
			(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)	
				LAUNDRY)			
		5. 06	7. 00	8. 00	9. 00	10.00	
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	45, 501, 837	430, 597	32, 256	96, 769	4, 653, 023	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 141418	0. 628251	0. 014631	6. 683865	113. 305971	203. 00
204. 00	Cost to be allocated (per Wkst. B,	141, 001	377, 412	12	2 37	517, 910	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000438	0. 550653	0. 000005	0. 002556	12. 611650	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)						

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & (DRUGS) RECORDS & (MANHOURS) Ν **SUPPLY** LI BRARY (DIRECT NUR (MED SUPPLI (TOTAL REVE SING HRS) ES) NUE) 11. 00 13. 00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00540 NONPATIENT TELEPHONES 5.01 5.01 |00550|DATA PROCESSING 5.02 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00570 ADMITTING 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.05 5.06 00590 OTHER A&G 5.06 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPING 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 2, 452, 869 11.00 01300 NURSING ADMINISTRATION 13 00 2,080 1, 466, 263 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 126, 351 0 43, 390, 651 15.00 01600 MEDICAL RECORDS & LIBRARY 0 1, 240, 611, 068 16.00 0 16.00 0 01700 SOCIAL SERVICE 0 17.00 94.839 C 0 Λ 17.00 0 17.01 01701 INSERVICE EDUCATION 5, 627 0 0 0 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 37, 286 0 0 21.00 0 22 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 5 391 C 0 Ω 22 00 02300 PARAMED ED PRGM 23.00 4,940 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 681, 714 681, 714 0 6, 289 87, 677, 508 30.00 03100 INTENSIVE CARE UNIT 31 00 103, 691 103, 691 0 479 9, 846, 705 31 00 04100 SUBPROVI DER - I RF 0 41.00 47, 326 47, 326 16 4, 756, 800 41.00 04300 NURSERY 8, 942 0 1, 383, 248 43.00 8.942 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 61, 060 61, 060 208, 397, 587 0 139, 641 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 13, 407 13, 407 0 2,076 7, 579, 241 52.00 05400 RADI OLOGY-DI AGNOSTI C 230, 780 230, 780 212, 306, 018 54.00 895, 892 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 53.642 53, 642 0 3, 706 131, 175, 384 59.00 06000 LABORATORY 188.462 0 124, 250, 263 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 48,044 48,044 163 26, 763, 730 65.00 66 00 06600 PHYSI CAL THERAPY 251, 061 0 30, 873, 908 66.00 06900 ELECTROCARDI OLOGY 35, 317, 387 43.075 0 69.00 69.00 245,650 C 07000 ELECTROENCEPHALOGRAPHY 0 70.00 18.071 r 6, 866, 598 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 44, 853, 298 72.00 72.00 0 0 0 οl 41, 811, 271 07300 DRUGS CHARGED TO PATIENTS 73.00 173, 030, 975 73.00 74.00 07400 RENAL DIALYSIS 1, 939 1, 939 0 1, 212, 998 74.00 76 00 03950 ANCI LLARY - OTHER 0 0 O 76.00 07697 CARDIAC REHABILITATION 0 76. 97 2, 377, 007 19,028 19,028 5 76.97 0 77 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 116, 827, 391 91.00 196, 690 196, 690 0 122.594 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04040 FAMILY PRACTICE 76, 783 0 0 12, 792 8, 821, 675 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96 00 15, 746 0 2,893 522, 352 102.00 10200 OPI OID TREATMENT PROGRAM C 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 54, 751 124, 505 5, 770, 995 116. 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 2, 390, 726 1, 466, 263 43, 367, 981 1, 240, 611, 068 118. 00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 192.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 C 194.00 07950 RENTAL SPACE 0 0 0 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194. 01 7, 953 0 0 0 194. 02 07952 RETAIL SERVICES 0 0 0 194, 02 7.536 194. 03 07953 REID CONTRACTED SERVICES 0 0 0 0 194.03 0 194. 04 07954 REID PHYSICIAN ASSOC. o 0 194.04 0 0 0 0 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 0 194. 05 194.06 07956 VACANT SPACE 0 0 C 0 194.06 194. 07 07957 HOME OFFICE 0 0 194.07 194. 08 07958 CAMBRI DGE RHC 0 0 194.08

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

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (MANHOURS) ADMI NI STRATI O SERVICES & (DRUGS) RECORDS & SUPPLY LI BRARY Ν (DI RECT NUR (MED SUPPLI (TOTAL REVE SING HRS) ES) NUE) 11. 00 13.00 14.00 15.00 16.00 194.09 07959 REID HEALTH PAVILION - RES 46, 654 0 22, 670 0 194. 09 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2,008,617 750, 312 0 58, 527, 802 260, 873 202. 00

0.511717

0. 037707

55, 289

0.000000

0.000000

1.348857

344, 761

0.007946

0. 000210 203. 00

228, 652 204. 00

0.000184 205.00

206.00

207.00

0. 818885

270, 191

0. 110153

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

203.00

204.00

205.00

206.00

207.00

Health Financial Systems

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0048 Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm INTERNS & RESIDENTS PARAMED ED SOCI AL I NSERVI CE SERVI CES-SALA | SERVI CES-OTHE Cost Center Description SERVI CE **FDUCATION** RY & FRINGES R PRGM COSTS PRGM (TIME SPENT) (TIME SPENT) **APPRV APPRV** (IN HOUSE E (ASSI GNED (ASSI GNED D) TIME) TIME) 17. 00 17. 01 21.00 22. 00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00101 NEW CAP BLDG & FIXT - OFFSITE 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.01 00540 NONPATIENT TELEPHONES 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5 03 5 03 00570 ADMITTING 5.04 5.04 5.05 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.05 5.06 00590 OTHER A&G 5.06 00700 OPERATION OF PLANT 7 00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 76, 178 17.00 17.01 01701 INSERVICE EDUCATION 66, 190 17.01 02100 L&R SERVICES-SALARY & FRINGES APPRV 1.733 21 00 21 00 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 1, 733 22.00 02300 PARAMED ED PRGM 100 23.00 23.00 137 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 ADULTS & PEDIATRICS 50, 298 19, 736 1,443 1.443 0 31.00 03100 INTENSIVE CARE UNIT 2, 932 90 90 0 31.00 6, 126 04100 SUBPROVI DER - I RF 41.00 1, 324 0 0 0 41.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 43.00 251 0 0 43.00 0 0 50.00 05000 OPERATING ROOM 50.00 5,069 58 58 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 921 377 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 6,808 8 100 54.00 54.00 0 8 0 0 59.00 05900 CARDIAC CATHETERIZATION 0 1, 488 0 59.00 60.00 06000 LABORATORY 0 5, 348 0 0 0 60.00 0 06500 RESPIRATORY THERAPY 0 1, 376 0 65.00 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 7, 360 0 66,00 0 69.00 06900 ELECTROCARDI OLOGY 1, 207 67 67 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 500 0 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 55 0 0 74.00 0 03950 ANCI LLARY - OTHER 0 76.00 C 0 76.00 76.97 07697 CARDIAC REHABILITATION 530 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 0 o 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 17,833 6, 133 67 67 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04040 FAMILY PRACTICE 93 00 0 O 93.00 0 2 131 0 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 436 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 ol 0 102.00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 1, 174 76, 178 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 64, 372 1,733 1,733 100 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 0 0 194.00 07950 RENTAL SPACE C 0 0 194.00 194. 01 07951 FOUNDATION 221 0 0 194, 01 0 0 194. 02 07952 RETAIL SERVICES 0 0 194. 02 215 0 0 194. 03 07953 REID CONTRACTED SERVICES C 0 0 194.03 194. 04 07954 REID PHYSICIAN ASSOC. 0 0 194.04 C 194. 05 07955 CONNERSVILLE LOCATION 0 0 0 0 194.05 194.06 07956 VACANT SPACE 0 0 194.06

						5/31/2024 2:0	0 pm
				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 E	APPRV	APPRV	(TIME SPENT)	
			D)	(ASSI GNED	(ASSI GNED		
				TIME)	TIME)		
		17. 00	17. 01	21. 00	22. 00	23. 00	
	HOME OFFICE	0	0	0	0	l e	194. 07
	CAMBRIDGE RHC	0	0	0	0		194. 08
194. 09 07959	REID HEALTH PAVILION - RES	0	1, 382	0	0	0	194. 09
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	6, 696, 648	2, 670, 318	2, 593, 299	1, 456, 048	643, 250	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	87. 907900	40. 343224	1, 496. 421812	840. 189267	6, 432. 500000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	48, 731	292, 630	5, 436	1, 233	161, 865	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 639699	4. 421061	3. 136757	0. 711483	1, 618. 650000	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)						

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 62, 813, 917 62, 813, 917 0 62, 813, 917 30.00 03100 INTENSIVE CARE UNIT 11, 662, 191 0 11, 662, 191 31.00 11, 662, 191 31.00 41.00 04100 SUBPROVI DER - I RF 4, 291, 742 4, 291, 742 0 4, 291, 742 41.00 04300 NURSERY 893, 494 893, 494 43.00 0 893, 494 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 37, 759, 319 37, 759, 319 37, 759, 319 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1, 960, 573 1. 960. 573 1, 960, 573 52.00 05400 RADI OLOGY-DI AGNOSTI C 33, 814, 132 54.00 33, 814, 132 33, 814, 132 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 9, 262, 843 9, 262, 843 0 9, 262, 843 59.00 60.00 06000 LABORATORY 20, 402, 463 20, 402, 463 0 0 20, 402, 463 60.00 06500 RESPIRATORY THERAPY 4, 028, 363 4,028,363 4, 028, 363 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 21, 417, 524 21, 417, 524 21, 417, 524 66.00 06900 ELECTROCARDI OLOGY 5,002,474 5, 002, 474 5, 002, 474 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 430, 091 1, 430, 091 0 0 1, 430, 091 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 31, 139, 487 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 31, 139, 487 31, 139, 487 72.00 07300 DRUGS CHARGED TO PATIENTS 56, 846, 359 56, 846, 359 56, 846, 359 73.00 0 0 73.00 07400 RENAL DIALYSIS 74.00 1,067,588 1,067,588 1, 067, 588 74.00 03950 ANCI LLARY - OTHER 76.00 Ω 76.00 76.97 07697 CARDIAC REHABILITATION 1, 251, 028 1, 251, 028 0 1, 251, 028 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77.00 0 0 78 00 07800 CAR T-CELL IMMUNOTHERAPY O 78 00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 20, 403, 418 20, 403, 418 0 20, 403, 418 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 931, 813 14, 931, 813 14. 931. 813 92.00 04040 FAMILY PRACTICE 93.00 3, 767, 794 3, 767, 794 3, 767, 794 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 959, 763 959, 763 0 959, 763 96.00 102. 00 10200 OPI OLD TREATMENT PROGRAM 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 064, 507 5, 064, 507 5, 064, 507 116. 00 200.00 Subtotal (see instructions) 350, 170, 883 0 350, 170, 883 350, 170, 883 200. 00 0 14, 931, 813 201.00 Less Observation Beds 14, 931, 813 14, 931, 813 201. 00 202.00 Total (see instructions) 335, 239, 070 335, 239, 070 335, 239, 070 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 62, 096, 413 30.00 03000 ADULTS & PEDIATRICS 62, 096, 413 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 846, 705 9, 846, 705 31.00 04100 SUBPROVI DER - I RF 4, 756, 800 4, 756, 800 41.00 41.00 43.00 04300 NURSERY 1, 383, 248 1, 383, 248 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50, 654, 042 157, 743, 545 208, 397, 587 0. 181189 0.000000 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 6, 665, 273 913, 968 7, 579, 241 0.258677 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 43, 400, 962 0.159271 54.00 168, 905, 056 212, 306, 018 0.000000 54.00 50, 487, 749 05900 CARDI AC CATHETERI ZATI ON 0.070614 0.000000 59.00 80, 687, 635 131, 175, 384 59 00 60.00 06000 LABORATORY 41, 046, 395 83, 203, 868 124, 250, 263 0.164205 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 20, 845, 926 5, 917, 804 26, 763, 730 0.150516 0.000000 65.00 8, 796, 674 66.00 06600 PHYSI CAL THERAPY 30, 873, 908 0.000000 22, 077, 234 0.693710 66.00 69.00 06900 ELECTROCARDI OLOGY 7, 250, 149 28, 067, 238 35, 317, 387 0.141643 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 6,042 0. 208268 70.00 70 00 6,860,556 6, 866, 598 0.000000 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0.000000 71.00 71.00 0. 694252 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 999, 080 25, 854, 218 44, 853, 298 72 00 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 59, 069, 337 113, 961, 638 173, 030, 975 0. 328533 0.000000 73.00 73.00 74.00 07400 RENAL DIALYSIS 942, 387 270, 611 1, 212, 998 0.880123 0.000000 74.00 03950 ANCILLARY - OTHER 0.000000 76.00 0 0.000000 76.00 2, 377, 007 76.97 07697 CARDIAC REHABILITATION 821 2, 376, 186 0. 526304 0.000000 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 31, 008, 612 85, 818, 779 116, 827, 391 0.174646 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 795, 903 92.00 17, 785, 192 25, 581, 095 0.583705 0.000000 92.00 8, 795, 701 93.00 04040 FAMILY PRACTICE 25. 974 0.427106 0.000000 93.00 8, 821, 675 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 522, 352 522, 352 1.837387 0.000000 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 235, 428 4, 535, 567 5, 770, 995 116.00 200.00 Subtotal (see instructions) 426, 313, 920 814, 297, 148 1, 240, 611, 068 200.00 201.00 Less Observation Beds 201.00 202.00 426, 313, 920 Total (see instructions) 814, 297, 148 1, 240, 611, 068 202.00

5/31/2024 2:00 pm Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0. 181189 50.00 05200 DELIVERY ROOM & LABOR ROOM 0. 258677 52.00 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 159271 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.070614 59.00 60. 00 06000 LABORATORY 0. 164205 60.00 65. 00 06500 RESPIRATORY THERAPY 0.150516 65.00 66.00 06600 PHYSI CAL THERAPY 0.693710 66.00 69. 00 06900 ELECTROCARDI OLOGY 0. 141643 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 208268 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.694252 72.00 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 73.00 0. 328533 73.00 0.880123 74.00 74 00 76.00 03950 ANCI LLARY - OTHER 0.000000 76.00 07697 CARDIAC REHABILITATION 76. 97 0. 526304 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 0. 174646 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 583705 92.00 93.00 04040 FAMILY PRACTICE 0. 427106 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 1.837387 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00

202.00

202.00

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0048 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 62, 813, 917 62, 813, 917 0 62, 813, 917 30.00 03100 INTENSIVE CARE UNIT 11, 662, 191 0 11, 662, 191 31.00 11, 662, 191 31.00 41.00 04100 SUBPROVI DER - I RF 4, 291, 742 4, 291, 742 0 4, 291, 742 41.00 04300 NURSERY 893, 494 893, 494 43.00 0 893, 494 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 37, 759, 319 37, 759, 319 37, 759, 319 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1.960.573 1. 960. 573 1, 960, 573 52.00 05400 RADI OLOGY-DI AGNOSTI C 33, 814, 132 54.00 33, 814, 132 33, 814, 132 54 00 59.00 05900 CARDI AC CATHETERI ZATI ON 9, 262, 843 9, 262, 843 0 9, 262, 843 59.00 60.00 06000 LABORATORY 20, 402, 463 20, 402, 463 0 0 20, 402, 463 60.00 06500 RESPIRATORY THERAPY 4, 028, 363 4,028,363 4, 028, 363 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 21, 417, 524 21, 417, 524 21, 417, 524 66.00 06900 ELECTROCARDI OLOGY 5, 002, 474 5, 002, 474 5, 002, 474 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 430, 091 1, 430, 091 0 0 1, 430, 091 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 31, 139, 487 31, 139, 487 31, 139, 487 72.00 07300 DRUGS CHARGED TO PATIENTS 56, 846, 359 56, 846, 359 56, 846, 359 73.00 0 0 73.00 07400 RENAL DIALYSIS 74.00 1,067,588 1,067,588 1, 067, 588 74.00 03950 ANCI LLARY - OTHER 76.00 Ω 76.00 76.97 07697 CARDIAC REHABILITATION 1, 251, 028 1, 251, 028 0 1, 251, 028 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77.00 0 0 78 00 07800 CAR T-CELL IMMUNOTHERAPY O 78 00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 20, 403, 418 20, 403, 418 0 20, 403, 418 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 14, 931, 813 14, 931, 813 14. 931. 813 92.00 04040 FAMILY PRACTICE 93.00 3, 767, 794 3, 767, 794 3, 767, 794 93.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 959, 763 959, 763 0 959, 763 96.00 102. 00 10200 OPI OLD TREATMENT PROGRAM 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 5, 064, 507 5, 064, 507 5, 064, 507 116. 00 200.00 Subtotal (see instructions) 350, 170, 883 0 350, 170, 883 350, 170, 883 200. 00 0 14, 931, 813 201.00 Less Observation Beds 14, 931, 813 14, 931, 813 201. 00 202.00 Total (see instructions) 335, 239, 070 335, 239, 070 335, 239, 070 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0048 Peri od: Worksheet C From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 62, 096, 413 30.00 03000 ADULTS & PEDIATRICS 62, 096, 413 30.00 31.00 03100 INTENSIVE CARE UNIT 9, 846, 705 9, 846, 705 31.00 04100 SUBPROVI DER - I RF 4, 756, 800 4, 756, 800 41.00 41.00 43.00 04300 NURSERY 1, 383, 248 1, 383, 248 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50, 654, 042 157, 743, 545 208, 397, 587 0. 181189 0.000000 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 6, 665, 273 913, 968 7, 579, 241 0.258677 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 43, 400, 962 0.159271 54.00 168, 905, 056 212, 306, 018 0.000000 54.00 50, 487, 749 05900 CARDI AC CATHETERI ZATI ON 0.070614 0.000000 59 00 80, 687, 635 131, 175, 384 59 00 60.00 06000 LABORATORY 41, 046, 395 83, 203, 868 124, 250, 263 0.164205 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 20, 845, 926 5, 917, 804 26, 763, 730 0.150516 0.000000 65.00 8, 796, 674 66.00 06600 PHYSI CAL THERAPY 30, 873, 908 0.000000 22, 077, 234 0.693710 66.00 69.00 06900 ELECTROCARDI OLOGY 7, 250, 149 28, 067, 238 35, 317, 387 0.141643 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 6,042 0. 208268 70.00 70 00 6,860,556 6, 866, 598 0.000000 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0.000000 71.00 71.00 0. 694252 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 999, 080 25, 854, 218 44, 853, 298 72 00 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 59, 069, 337 113, 961, 638 173, 030, 975 0. 328533 0.000000 73.00 73.00 74.00 07400 RENAL DIALYSIS 942, 387 270, 611 1, 212, 998 0.880123 0.000000 74.00 03950 ANCILLARY - OTHER 0.000000 76.00 0 0.000000 76.00 07697 CARDIAC REHABILITATION 2, 377, 007 76.97 821 2, 376, 186 0. 526304 0.000000 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 31, 008, 612 85, 818, 779 116, 827, 391 0.174646 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 795, 903 92.00 17, 785, 192 25, 581, 095 0.583705 0.000000 92.00 8, 795, 701 93.00 04040 FAMILY PRACTICE 25. 974 0.427106 0.000000 93.00 8, 821, 675 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 522, 352 522, 352 1.837387 0.000000 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 1, 235, 428 4, 535, 567 5, 770, 995 116.00 200.00 Subtotal (see instructions) 426, 313, 920 814, 297, 148 1, 240, 611, 068 200.00 201.00 Less Observation Beds 201.00 202.00 426, 313, 920 Total (see instructions) 814, 297, 148 1, 240, 611, 068 202.00

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60. 00 06000 LABORATORY 0. 000000 60.00 06500 RESPIRATORY THERAPY 0.000000 65.00 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 PATIENT 0.000000 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 73.00 0.000000 73.00 0.000000 74.00 74 00 76.00 03950 ANCI LLARY - OTHER 0.000000 76.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 0. 000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 92.00 93.00 04040 FAMILY PRACTICE 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00

202.00

202.00

Total (see instructions)

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		nared·
				10 12/01/2020	5/31/2024 2:0	
			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)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		T				
30.00 ADULTS & PEDIATRICS	4, 434, 946		.,,			1
31.00 INTENSIVE CARE UNIT	793, 691	l e	793, 69			
41.00 SUBPROVI DER - I RF	570, 054	l e	0,0,00			
43. 00 NURSERY	80, 700		80, 70			1
200.00 Total (lines 30 through 199)	5, 879, 391		5, 879, 39	1 52, 596		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12, 825					30.00
31.00 INTENSIVE CARE UNIT	1, 550		•			31.00
41. 00 SUBPROVI DER - I RF	1, 691	243, 183				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	16, 066	1, 853, 408				200. 00

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D		
				From 01/01/2023			
				To 12/31/2023	Date/Time Pre		
		T: ±1 -	VV/I I I	11: 4-1	5/31/2024 2: 0	0 pm	
C+ C+ Di-+i	0: +-1		XVIII	Hospi tal	PPS		
Cost Center Description	Capi tal	Total Charges			Capital Costs		
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x		
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)		
	B, Part II,	col. 8)	col . 2)				
	col . 26)	2.00	3. 00	4.00	F 00		
ANGLI LADV CEDVI CE COCT CENTERC	1. 00	2. 00	3.00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS	2 110 270	200 207 507	0.01012	7 24 500 770	210 741	 	
50. 00 05000 OPERATING ROOM	2, 110, 370		0. 01012		· ·	50.00	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	246, 344		0. 03250			52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 264, 560				· ·	54.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	488, 497		0. 00372			59.00	
60. 00 06000 LABORATORY	938, 742		0. 00755			60.00	
65. 00 06500 RESPI RATORY THERAPY	87, 405				· ·	65. 00	
66. 00 06600 PHYSI CAL THERAPY	2, 386, 994			· · ·		66. 00	
69. 00 06900 ELECTROCARDI OLOGY	250, 200		0. 00708				
70. 00 07000 ELECTROENCEPHALOGRAPHY	201, 118	6, 866, 598			171	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	_	0.00000			71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 647	44, 853, 298	0. 00083			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	431, 517	173, 030, 975	0. 00249	4 22, 629, 139	56, 437	73.00	
74.00 07400 RENAL DIALYSIS	43, 619	1, 212, 998	0. 03596	0 414, 240	14, 896	74.00	
76. 00 03950 ANCI LLARY - OTHER	0	0	0. 00000	0	0	76.00	
76. 97 O7697 CARDIAC REHABILITATION	234, 008	2, 377, 007	0. 09844	6 190	19	76. 97	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0	0	77. 00	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0	0	78. 00	
OUTPATIENT SERVICE COST CENTERS							
91. 00 09100 EMERGENCY	1, 032, 737	116, 827, 391	0. 00884	0 12, 664, 650	111, 956	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 054, 261	25, 581, 095	0. 04121	3, 277, 741	135, 086	92.00	
93. 00 04040 FAMILY PRACTICE	68, 785	8, 821, 675	0. 00779	7 24, 452	191	93.00	
OTHER REIMBURSABLE COST CENTERS							
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	198, 436	522, 352	0. 37988	9 0	0	96.00	
200.00 Total (lines 50 through 199)	12, 075, 240	1, 156, 756, 907		141, 218, 907	1, 173, 287	200.00	
		•	•			•	

Health Financial Systems		REID HO	SPITAL &	HEALTH	CARE SER	VICES		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE	OTHER PASS	THROUGH	COSTS	Provi der	CCN: 1	5-0048	From 01/01/2023	Worksheet D Part III Date/Time Prepared

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS			Peri od: From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments	:	Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
41. 00 04100 SUBPROVI DER - RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patier	t Per Diem	I npati ent	
	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 & PEDIATRICS	0	0	43, 1	44 0.00	12, 825	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 2	14 0.00	1, 550	31.00
41. 00 04100 SUBPROVI DER - RF	0	0	3, 9	0.00	1, 691	41.00
43. 00 04300 NURSERY		0	1, 2	74 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	52, 59	96	16, 066	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	•	•				

					10 12/31/2023	5/31/2024 2: 0	
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	643, 250	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	0	59. 00
60.00	06000 LABORATORY	0	0	1	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	1	0	0	74.00
76.00	03950 ANCI LLARY - OTHER	0	0	1	0	0	76.00
	07697 CARDI AC REHABI LI TATI ON	0	0	1	0	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	1	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	O	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	(0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0			0	0	, , , , , ,
200.00	Total (lines 50 through 199)	0	0	1	0	643, 250	200.00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0048 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: THROUGH COSTS

			'		5/31/2024 2: 0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and		C, Part I,	(col. 5 ÷	
	Cost	4)	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 OPERATI NG ROOM	0	0	0			
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	., , =		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	643, 250	643, 250			
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	101,110,001		
60. 00 06000 LAB0RAT0RY	0	0	0	124, 250, 263		
65. 00 06500 RESPIRATORY THERAPY	0	0	0	26, 763, 730		
66. 00 06600 PHYSI CAL THERAPY	0	0	0	30, 873, 908		
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	35, 317, 387	l	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	6, 866, 598		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	44, 853, 298	l .	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	173, 030, 975		
74.00 07400 RENAL DIALYSIS	0	0	0	1, 212, 998		
76. 00 03950 ANCI LLARY - OTHER	0	0	0	0	0. 000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	2, 377, 007	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0. 000000	
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS				T		
91. 00 09100 EMERGENCY	0	0	0	1.0,02,,07.		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	25, 581, 095		
93. 00 04040 FAMILY PRACTICE	0	0	0	8, 821, 675	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0					
200.00 Total (lines 50 through 199)	0	643, 250	643, 250	1, 156, 756, 907		200. 00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0048	Peri od:	Worksheet D

		Provi der Co	CN: 15-0048	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/31/2024 2:0	pared:
		Title	: XVIII	Hospi tal	PPS	<u>o p</u>
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	3	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	21, 599, 779	•	0 40, 755, 144	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	14, 676		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 003030	18, 042, 621		· · · · ·		54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	23, 195, 202		0 28, 110, 609		59.00
60. 00 06000 LABORATORY	0. 000000	15, 904, 852		8, 491, 026	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	8, 297, 919		0 1, 191, 871	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 358, 594		0 117, 537	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 585, 505		9, 455, 262	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	5, 838		1, 434, 861	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 203, 509		7, 585, 388		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	22, 629, 139		0 36, 989, 483	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	414, 240		58, 391	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	190		736, 075	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	12, 664, 650		0 14, 993, 989	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	3, 277, 741	•	1, 484, 129		92.00
93. 00 04040 FAMILY PRACTICE	0. 000000	24, 452		0 2, 803, 438	0	93.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	1	0		96.00
200.00 Total (lines 50 through 199)		141, 218, 907	54, 66	9 195, 416, 733	124, 865	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm 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 40, 755, 144 0. 181189 7, 384, 384 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.258677 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 41, 209, 530 54.00 0. 159271 6, 563, 483 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.070614 28, 110, 609 0 0 1, 985, 003 59.00 60.00 06000 LABORATORY 0. 164205 8, 491, 026 0 0 1, 394, 269 60.00 06500 RESPIRATORY THERAPY 1, 191, 871 65.00 0.150516 0 179, 396 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.693710 117, 537 81, 537 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 141643 9, 455, 262 0 0 0 0 1, 339, 272 69.00 1, 434, 861 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 208268 298, 836 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.694252 7, 585, 388 0 5, 266, 171 72.00 07300 DRUGS CHARGED TO PATIENTS 36, 989, 483 12, 152, 266 73.00 0. 328533 13, 407 0 0 73.00 07400 RENAL DIALYSIS 58, 391 51, 391 74 00 0.880123 Ω 74 00 76.00 03950 ANCILLARY - OTHER 0.000000 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.526304 736, 075 0 0 387, 399 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 174646 14, 993, 989 0 0 2, 618, 640 91.00 0 ol 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.583705 1, 484, 129 866, 294 92.00 04040 FAMILY PRACTICE 0. 427106 2, 803, 438 0 1, 197, 365 93.00 93.00 0 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 1. 837387 96.00 0 200.00 Subtotal (see instructions) 13, 407 41, 765, 706 200. 00 195, 416, 733 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 195, 416, 733 13, 407 41, 765, 706 202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0048 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/31/2024 2:00 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000 52.00 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 405 0 73.00 73.00 4, 74. 00 07400 RENAL DIALYSIS 0 0 74 00 76. 00 03950 ANCI LLARY - OTHER 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 92.00 04040 FAMILY PRACTICE 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 Subtotal (see instructions) 200.00 4, 405 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

4, 405

0

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Provider CN: 15-0048	Heal th	Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
Component CCN: 15-T048 From 01/01/2023 Part II Component CCN: 15-T048 To 12/31/2023 Part III Date Title XVIII Subprovider - IRF								2002 10
Cost Center Description	7.1. 7. 0.11.	TOTAL OF THE TAXABLE PART OF TAXABLE PART	000.0			From 01/01/2023	Part II	
Capital Related Cost (From Wkst. Related Cost (From Wkst. B, Part II, col. 26) 1.00 2.00 3.00 4.00 5.00				Component	CCN: 15-T048	Γο 12/31/2023		
Cost Center Description				T: +1 o	VVIII	Cubanavi dan		U pm
Capit all Related Cost Capit all Related Cost Cost (from Wkst. B. Part II, col. 26) Col. 2) Col. 20 Col. 1 + col. 26) Col. 20 Col. 21 Col. 20 Col. 21 Col. 20 Col. 21 Col. 20 Co				Title	AVIII		PPS	
Related Cost (From Wkst. (From Wkst. (From Wkst. (C) Part II)		Cost Center Description	Cani tal	Total Charges	Ratio of Cost		Canital Costs	
Cross		oust defited beschiption						
B, Part II, col. 26)								
COL _ 26) 1.00 2.00 3.00 4.00 5.00			, ·		· `	3	.,	
1.00 2.00 3.00 4.00 5.00					,			
50.00 05000 0FERATI NG ROOM 2, 110, 370 208, 397, 587 0, 010127 65, 385 662 50.00 52.00 0520				2.00	3. 00	4. 00	5. 00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 246, 344 7, 579, 241 0.032502 0 0 52.00		ANCILLARY SERVICE COST CENTERS				<u>'</u>		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 264, 560 212, 306, 018 0. 010666 107, 826 1, 150 54. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 488, 497 131, 175, 384 0. 003724 2, 657 10 59. 00 65. 00 06000 LABORATORY 938, 742 124, 250, 263 0. 007555 286, 532 2, 165 60. 00 65. 00 06500 RESPI RATORY THERAPY 87, 405 26, 763, 730 0. 003266 249, 745 816 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 386, 994 30, 873, 908 0. 077314 1, 559, 089 120, 539 66. 00 69. 00 06900 ELECTROCARDI OLOGY 250, 200 35, 317, 387 0. 007084 1, 870 13 69. 00 70. 00 07000 ELECTROCARDI OLOGY 201, 118 6, 866, 598 0. 029289 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00	05000 OPERATING ROOM	2, 110, 370	208, 397, 587	0. 01012	7 65, 385	662	50.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 488, 497 131, 175, 384 0.003724 2, 657 10 59. 00 60. 00 06000 LABORATORY 938, 742 124, 250, 263 0.007555 286, 5522 2, 165 60. 00 65. 00 06500 RESPI RATORY THERAPY 87, 405 26, 763, 730 0.003266 249, 745 816 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 386, 994 30, 873, 908 0.07314 1, 559, 089 120, 539 66. 00 69. 00 06900 ELECTROCARDI OLOGY 250, 200 35, 317, 387 0.007084 1, 870 13 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 201, 118 6, 866, 598 0.029289 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0.000000 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 37, 647 44, 853, 298 0.000839 657 1 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 431, 517 173, 030, 975 0.002494 539, 205 1, 345 73. 00 74. 00 07400 RENAL DI ALYSI S 43, 619 1, 212, 998 0.035960 22, 820 821 74. 00 <td>52.00</td> <td>05200 DELIVERY ROOM & LABOR ROOM</td> <td>246, 344</td> <td>7, 579, 241</td> <td>0. 03250</td> <td>2 0</td> <td>0</td> <td>52.00</td>	52.00	05200 DELIVERY ROOM & LABOR ROOM	246, 344	7, 579, 241	0. 03250	2 0	0	52.00
60. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 264, 560	212, 306, 018	0. 01066	5 107, 826	1, 150	54.00
65. 00	59.00	05900 CARDI AC CATHETERI ZATI ON	488, 497	131, 175, 384	0. 00372	2, 657	10	59.00
66. 00	60.00	06000 LABORATORY	938, 742	124, 250, 263	0. 00755!	286, 532	2, 165	60.00
69. 00 06900 ELECTROCARDI OLOGY 250, 200 35, 317, 387 0. 007084 1, 870 13 69. 00 70.	65.00	06500 RESPI RATORY THERAPY	87, 405		0. 00326	5 249, 745	816	65.00
70. 00 07000 CARDING FELECTROENCEPHALOGRAPHY 201, 118 6, 866, 598 0.029289 0 0.000000 0 70.00	66. 00		2, 386, 994	30, 873, 908	0. 07731			66.00
71. 00	69. 00						13	
72. 00	70.00		201, 118	6, 866, 598			0	70.00
73. 00	71.00		0	0			0	
74. 00	72.00		37, 647	44, 853, 298				72.00
76. 00			431, 517	173, 030, 975				
76. 97			43, 619	1, 212, 998			821	
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0			_	0			0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 0 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	234, 008	2, 377, 007			0	
OUTPATIENT SERVICE COST CENTERS		1 1	0	0			0	1
91. 00	78. 00		0	0	0. 00000	0	0	78. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 25, 581, 095 0.000000 0 0 92. 00 000000 0 0 0 0 000000 0								
93. 00 04040 FAMILY PRACTICE 68, 785 8, 821, 675 0. 007797 0 0 93. 00 0716ER REI MBURSABLE COST CENTERS 096. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 198, 436 522, 352 0. 379889 0 0 96. 00 096. 00			1, 032, 737				97	
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 198, 436 522, 352 0. 379889 0 0 96. 00							0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 198, 436 522, 352 0. 379889 0 0 96. 00	93.00		68, 785	8, 821, 675	0. 00779	7 0	0	93.00
								1
200.00 Total (lines 50 through 199) 11,020,979 1,156,756,907 2,846,782 127,619 200.00					0. 37988			
	200.00	Total (lines 50 through 199)	11, 020, 979	1, 156, 756, 907		2, 846, 782	127, 619	200. 00

Health Financial Systems REID APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		ALTH CARE SERVI		In Lie	u of Form CMS-	2552-10
THROUGH COSTS	VICE UTHER PAS		CCN: 15-0048	From 01/01/2023 To 12/31/2023		epared: 00 pm
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0	0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	643, 250	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0		0	0	59. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74. 00 07400 RENAL DIALYSIS	0	l o		0 0	0	1
76. 00 03950 ANCI LLARY - OTHER	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93. 00 04040 FAMILY PRACTICE	0	0		0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS		1			1	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0		
200.00 Total (lines 50 through 199)	0	0		0 0	643, 250	J≥00. 00

Health Financial Systems	REI D	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-:	2552-10
	T/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der C		Period: From 01/01/2023	Worksheet D Part IV	
INKOUGH CUSIS			Component		To 12/31/2023		
			Title	· XVIII	Subprovi der -	PPS	•
		1 111 011	T		I RF	D 6.0	
Cost Center D	escription	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
		4.00	F 00	4 00	7.00	instructions)	
ANCLLI ADV. CEDVI CE	COCT CENTEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE (1 0			0 200 207 507	0.000000	50.00
		0	0		0 208, 397, 587	0. 000000 0. 000000	
52. 00 05200 DELI VERY ROOM		0	(42.250		7, 579, 241		
54. 00 05400 RADI OLOGY - DI A		0	643, 250			0.003030	
59. 00 05900 CARDI AC CATHE	TERIZATION	0	0		0 131, 175, 384	0.000000	
60. 00 06000 LABORATORY	THE DADY	0	0		0 124, 250, 263	0. 000000	1
65. 00 06500 RESPIRATORY T		0	0		26, 763, 730	0.000000	
66. 00 06600 PHYSI CAL THEF		0	0		30, 873, 908	0.000000	
69. 00 06900 ELECTROCARDI O		0	0		0 35, 317, 387	0. 000000	
70. 00 07000 ELECTROENCEPH		0	0		0 6, 866, 598	0. 000000	
	IES CHARGED TO PATIENT	0	0		0 0	0. 000000	
72. 00 07200 IMPL. DEV. CH		0	0	1	0 44, 853, 298	0. 000000	
73. 00 07300 DRUGS CHARGED		0	0	1	0 173, 030, 975	0. 000000	
74. 00 07400 RENAL DI ALYSI		0	0	1	0 1, 212, 998	0. 000000	
76. 00 03950 ANCI LLARY - 0		0	0		0 0	0.000000	
76. 97 07697 CARDI AC REHAE		0	0		0 2, 377, 007	0.000000	
77. 00 07700 ALLOGENEI C HS		0	0		0	0. 000000	
78. 00 07800 CAR T-CELL IN		0	0		0 0	0. 000000	78. 00
OUTPATIENT SERVICE	COST CENTERS	1 0			0 444 007 004	0.00000	04.00
91. 00 09100 EMERGENCY	SERG (NON DIGELINGE BART	0	1	•	0 116, 827, 391	0. 000000	
	SEDS (NON-DISTINCT PART	0	0		0 25, 581, 095	0.000000	
93. 00 04040 FAMILY PRACTI		1 0	0		0 8, 821, 675	0. 000000	93.00
OTHER REIMBURSABLE			_	1	0 500 050	0.000000	0, 00
96. 00 09600 DURABLE MEDIC		0		1	522, 352		1
200.00 Total (lines	50 through 199)	0	643, 250	043, 25	0 1, 156, 756, 907		200. 00

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu of Form CMS-2552-10									
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D			
THROUG	H COSTS		Component (From 01/01/2023 To 12/31/2023		pared: 0 pm		
			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	Charges	Pass-Through			
		(col. 6 ÷		Costs (col. 8		Costs (col. 9			
		col. 7)		x col. 10)		x col. 12)			
		9. 00	10. 00	11. 00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0. 000000	65, 385	(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. 003030	107, 826	32	7 0	0	54.00		
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 657	(0	0	59.00		
60.00	06000 LABORATORY	0. 000000	286, 532	(0	0	60.00		
65.00	06500 RESPI RATORY THERAPY	0. 000000	249, 745	(0	0	65.00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 559, 089	(0	0	66.00		
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 870	(0	0	69.00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	(0	0	71.00		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	657	(0	0	72.00		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	539, 205	(0	0	73.00		
74.00	07400 RENAL DIALYSIS	0. 000000	22, 820	(0	0	74.00		
76. 00	03950 ANCILLARY - OTHER	0. 000000	0	(0	0	76.00		
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	(0	0	76. 97		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77.00		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0	0	78.00		
	OUTPATIENT SERVICE COST CENTERS						1		
91.00	09100 EMERGENCY	0. 000000	10, 996	(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	(08	0	93.00		
İ	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)		2, 846, 782	32	7 80	0	200.00		
		•							

Health Financial Systems REID	HOSPITAL & HEA	LTH 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:	Worksheet D	
				From 01/01/2023		
		Component	CCN: 15-T048	To 12/31/2023		
		·			5/31/2024 2:0	0 pm
		Title	: XVIII	Subprovi der -	PPS	
				I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	

					I RF		
				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	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	0. 181189	0	0	0	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0. 258677	0	0	0	0	52.00
54.00 0540	O RADI OLOGY-DI AGNOSTI C	0. 159271	0	0	0	0	54.00
59. 00 0590	O CARDI AC CATHETERI ZATI ON	0. 070614	0	0	0	0	59. 00
60.00 0600	O LABORATORY	0. 164205	0	0	0	0	60.00
65. 00 0650	O RESPIRATORY THERAPY	0. 150516	0	0	0	0	65.00
66. 00 0660	O PHYSI CAL THERAPY	0. 693710	0	0	0	0	66.00
69. 00 0690	O ELECTROCARDI OLOGY	0. 141643	0	0	0	0	69. 00
70.00 0700	O ELECTROENCEPHALOGRAPHY	0. 208268	0	0	0	0	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0. 694252	0	0	0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 328533	0	0	110	0	73.00
74. 00 0740	O RENAL DIALYSIS	0. 880123	0	0	0	0	74.00
76. 00 0395	O ANCILLARY - OTHER	0. 000000	0	0	0	0	76. 00
76, 97 0769	7 CARDIAC REHABILITATION	0. 526304	0	l o	0	0	76. 97
	O ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
	O CAR T-CELL IMMUNOTHERAPY	0. 000000		0	0	0	78. 00
	ATIENT SERVICE COST CENTERS						
91.00 0910		0. 174646	0	0	0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0. 583705		0	0	0	92.00
	O FAMILY PRACTICE	0. 427106		0	0	34	93.00
	R REIMBURSABLE COST CENTERS			-			1
	O DURABLE MEDICAL EQUIP-RENTED	1. 837387	0	0	0	0	96.00
200.00	Subtotal (see instructions)	1.007007	80		110	34	200.00
201. 00	Less PBP Clinic Lab. Services-Program			0	0		201.00
_5	Only Charges			l			
202. 00	Net Charges (line 200 - line 201)		80	0	110	34	202. 00

Health Financial Systems REID APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	HOSPITAL & HEAL VACCINE COST	TH CARE SERVI Provider C		Peri od:	u of Form CMS- Worksheet D	2552-10
		Component	CCN: 15-T048	From 01/01/2023 To 12/31/2023	Part V Date/Time Pro 5/31/2024 2:0	
		Title	XVIII	Subprovi der -	PPS	
	Cos	ts		I RF		
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00	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 69.00 70.00 71.00 72.00 73.00
74. 00 07400 RENAL DIALYSIS 76. 00 03950 ANCILLARY - OTHER 76. 97 07697 CARDIAC REHABILITATION 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 00TPATIENT SERVICE COST CENTERS	0 0 0 0 0	36 0 0 0 0 0				74.00 76.00 76.97 77.00 78.00
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 93. 00 04040 FAMI LY PRACTI CE OTHER REI MBURSABLE COST CENTERS	0 0 0	0 0 0	•			91. 00 92. 00 93. 00
96.00 O9600 DURABLE MEDICAL EQUIP-RENTED 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program Only Charges	0 0 0	0 36				96. 00 200. 00 201. 00

36

202.00

202.00

Only Charges Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0048 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/31/2024 2:00 pm 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, 211, 096 50.00 0. 181189 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0. 258677 68, 586 52.00 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 159271 0 3, 575, 301 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.070614 936, 817 0 0 0 0 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 0.164205 1, 957, 008 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.150516 181, 602 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.693710 831, 922 0 66.00 06900 ELECTROCARDI OLOGY 0. 141643 361, 898 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 208268 59, 559 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.694252 288, 723 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 328533 3, 004, 263 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.880123 0 74.00 8, 205 0 76.00 03950 ANCI LLARY - OTHER 0.000000 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.526304 0 12, 350 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 0 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 o 78.00 78.00 0 O Ω OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 174646 3, 320, 299 0 0 91.00 ol 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.583705 0 640, 243 0 92.00 04040 FAMILY PRACTICE 93.00 93.00 0. 427106 0 122, 183 0 0 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 1. 837387 0 0 96.00 0 200.00 Subtotal (see instructions) 0 17, 580, 055 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 17, 580, 055 0 202.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0048 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/31/2024 2:00 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 400, 626 50.00 05200 DELIVERY ROOM & LABOR ROOM 17, 742 52.00 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 569, 442 0 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 66, 152 0 59.00 60.00 06000 LABORATORY 321, 350 0 60.00 65.00 06500 RESPIRATORY THERAPY 27, 334 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 577, 113 66.00 69.00 06900 ELECTROCARDI OLOGY 51, 260 69.00 12, 404 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 200, 447 0 72.00 07300 DRUGS CHARGED TO PATIENTS 987, 000 0 73.00 73.00 74. 00 07400 RENAL DIALYSIS 0 7, 221 74 00 76.00 03950 ANCI LLARY - OTHER 0 76.00 76. 97 07697 CARDIAC REHABILITATION 6,500 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 579, 877 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 373, 713 0 92.00

52, 185

4, 250, 366

4, 250, 366

0

0

0

0

93.00

96.00

200.00

201.00

202.00

04040 FAMILY PRACTICE

Only Charges

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

93.00

96.00

200.00

201.00

202.00

Health Financial Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0048	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/31/2024 2:0	pared: O pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS		·			
INDATI ENT DAVE					1

	<u> </u>	Title XVIII Hospital	PPS	
	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		43, 144	1.00
2.00	Inpatient days (including private room days, excluding swing-		43, 144	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only private room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ped days)	32, 888	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro			5. 00
	reporting period			
6. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through December 31 of the cost	0	7. 00
7.00	reporting period	m days) thi dagit becomes of or the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	the December (analysis of an and	12.025	0.00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding Swing-bed and	12, 825	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private 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		0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, & Swing-bed NF type inpatient days applicable to titles V or XI		0	12. 00
12.00	through December 31 of the cost reporting period	x only (therauting private room days)	o o	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI		0	13.00
14.00	after December 31 of the cost reporting period (if calendar y		0	14.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)		0	
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	cos after December 21 of the cost	0.00	18. 00
10.00	reporting period	tes after beceiiber 31 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of the cost	0. 00	19. 00
00.00	reporting period	Class Bassalas 24 a Calles and	0.00	00.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of the cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	ns)	62, 813, 917	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)	21 - 6 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	" 31 of the cost reporting period (fine a	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporting period (line	0	24. 00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting period (line 8	0	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)	62, 813, 917	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-be	ed and observation bed charges)		28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	. line 20)	0. 000000	
31.00	Average private room per diem charge (line 29 ÷ line 3)	- Title 20)		
32.00			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	line 22) (instructions)	0.00	
34.00	Average per diem private room charge differential (line 32 mi		0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private rest differential (1)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost differential (line	62, 813, 917	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see		1, 455. 91	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line		18, 672, 046	
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	9 + line 40)	18, 672, 046	41. 00

		HOSPITAL & HEA				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	eriod: from 01/01/2023 fo 12/31/2023	Worksheet D-1 Date/Time Pre 5/31/2024 2:0	pared:
				XVIII	Hospi tal	PPS	ло ріп
	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)	
10.00	Luparay (IIII V a VIV II)	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	0	0.00	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	11, 662, 191	4, 214	2, 767. 49	1, 550	4, 289, 610	44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 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)			33, 311, 667	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	neet D-6, Part		column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.(01)(see instru	ctions)		56, 273, 323	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D. sum	of Parts I and	1, 610, 225	50.00
00.00			·				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	1, 227, 956	51.00
52.00	Total Program excludable cost (sum of lines					2, 838, 181	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	ysician anesth	etist, and	53, 435, 142	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor	use onlv)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55)			0	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	m the cost ren	orting period	endina 1996	0 0. 00	
07.00	updated and compounded by the market basket)		ii the cost rep	or tring period	criairig 1770,	0.00	07.00
60.00						0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by	which operating	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					_	1
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVII	l only): for	0	66.00
	CAH, see instructions		•				
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost re	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00
72. 00	Program routine service cost (line 9 x line			_,			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00
, 0. 00	26, line 45)		3 00010 (110		a. t ,		70.00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		orovi der recor	ds)			79.00
80.00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (•				83.00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
86 00			n ough oo)				1 00.00
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THRUUGH CUST					
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions Adjusted general inpatient routine cost per)				10, 256 1, 455. 91	

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 CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 0 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			14, 931, 813	89. 00
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, 434, 946	62, 813, 917	0. 07060	14, 931, 813	1, 054, 261	90.00
91.00 Nursing Program cost	0	62, 813, 917	0.00000	0 14, 931, 813	0	91.00
92.00 Allied health cost	0	62, 813, 917	0.00000	0 14, 931, 813	0	92.00
93.00 All other Medical Education	О	62, 813, 917	0. 00000	14, 931, 813	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 01/01/2023	Worksheet D-1
	Component CCN: 15-T048	To 12/31/2023	Date/Time Prepared: 5/31/2024 2:00 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

		THE ATTENDED	I RF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 964	
2. 00	Inpatient days (including private room days, excluding swing-Private room days (excluding swing-bed and observation bed day		rivato room days	3, 964 0	2.00 3.00
3.00	do not complete this line.	ys). If you have only pr	Tvate Toom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 964	4.00
5. 00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	5.00
	reporting period		24 . 6 . 11		
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6.00
7. 00	Total swing-bed NF type inpatient days (including private roor	m davs) through December	31 of the cost	0	7.00
	reporting period	,			
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	- the December (and added		1 (01	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	1, 691	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (includina private r	room davs)	0	10.00
	through December 31 of the cost reporting period (see instructions)				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, er			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	x only (including privat	.e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	X only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lir	ne)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.0
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17.00
17.00	reporting period	es tri ough becomber or c	, the cost	0.00	''' '
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18.00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.00
20 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
20.00	reporting period	s arter becomber or or		0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			4, 291, 742	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	ng poriod (line A	0	23.00
23.00	x line 18)	31 of the cost reportin	ig perrou (Trile d	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26.00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 291, 742	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(****** = * ***** = * * ***** = * * *		.,,	1
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28.00
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	- TIME 28)		0. 000000 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 mir	nus line 33)(see instrud	ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	•	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 a	and private room cost di	fferential (line	4, 291, 742	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART II - HUSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			1
				1, 082. 68	38.00
38. 00	Adjusted general inpatient routine service cost per diem (see				
38. 00 39. 00	Program general inpatient routine service cost per diem (see	•		1, 830, 812	39.00
39. 00 40. 00		38) am (line 14 x line 35)		1, 830, 812 0 1, 830, 812	40.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL	Provider CC	CN: 15-0048	<u>In Lie</u> Period: From 01/01/2023	u of Form CMS-2 Worksheet D-1	
			Component (To 12/31/2023	Date/Time Pre 5/31/2024 2:0	
			Title	XVIII	Subprovi der -	PPS	ло рііі
	Cost Center Description	Total I npati ent	Total Inpatient	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x	
		1. 00	Days 2.00	3.00	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.0
3. 00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43.0
4.00	CORONARY CARE UNIT						44.0
5. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1. 00	
3. 00	Program inpatient ancillary service cost (Wk					1, 395, 278	
3. 01 9. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column I)	3, 226, 090	48. 49.
	PASS THROUGH COST ADJUSTMENTS			,			
0. 00	Pass through costs applicable to Program inp	oatient routine s	services (from	ı Wkst. D, sur	n of Parts I and	243, 183	50.
1. 00	Pass through costs applicable to Program inpand IV)	•	y services (fr	om Wkst. D, s	sum of Parts II	127, 946	
2. 00 3. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	lated, non-phy	sician anesth	netist, and	371, 129 2, 854, 961	1
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4. 00	Program di scharges					0	
5. 00 5. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
5. 02	Adjustment amount per discharge (contractor	use only)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55					0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	
). 00	updated and compounded by the market basket) .00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0. 00	60.
1. 00	Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 >	sser of 50% of t	he amount by w	which operatir	ng costs (line	0	61.
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.
3. 00	Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			o o	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
	instructions)(title XVIII only)	3					
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decembe	er 31 of the d	ost reportino	g period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVII	I only); for	0	66.
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through	December 31 c	of the cost re	eporting period	0	67.
. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Do	ecember 31 of	the cost repo	orting period	0	68.
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	IURSING FACILITY,	AND ICF/IID	ONLY		0	
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•		, ,)		70.
. 00	Program routine service cost (line 9 x line		inc 70 - Tille	-)			72.
	Medically necessary private room cost applic	able to Program					73.
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•	,		Part II, column		74. 75.
. 00	Per diem capital-related costs (line 75 ÷ li						76.
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 78.
. 00	Aggregate charges to beneficiaries for exces	ss costs (from p					79.
. 00	Total Program routine service costs for comp		ost limitation	ı (line 78 mir	nus line 79)		80.
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 82.
3. 00	Reasonable inpatient routine service costs (see instructions					83.
	Program inpatient ancillary services (see in	nstructi ons)					84.
4. 00	Helli and on more our served at an annual at the	(000 inct	nc)				
4. 00 5. 00	Utilization review - physician compensation Total Program inpatient operating costs (sun	•					85. 86.

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 (CCN: 15-T048	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0. 00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	•				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		ĺ		(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	570, 054	4, 291, 742	0. 13282	26 0	0	90.00
91.00 Nursing Program cost	0	4, 291, 742	0. 00000	0	0	91.00
92.00 Allied health cost	0	4, 291, 742	0. 00000	0	0	92.00
93.00 All other Medical Education	0	4, 291, 742	0. 00000	0	0	93.00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	KEID HOSITIME & HEALT	Provi der CCN: 15-0048	Peri od: From 01/01/2023	Worksheet D-1	1002 10
				Date/Time Pre 5/31/2024 2:0	pared: O pm
		Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description	<u> </u>				
				1. 00	
DADT I ALL DROVEDED COMPONENTS					

MATERIAL PROVIDER COMPONENTS			Title XIX	Hospi tal	Cost	<u> </u>
New York		Cost Center Description		-	1 00	
INVAILED TO AVX 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 43,144 2.00 1.00 Inpatient days (including private room days, excluding swing-bed and more room days (3,144 2.00 2.00 1.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatt ent days (Including private room days, excluding swing-bed and neeborn days) 17 you have only private room days. 3.0 0 0 0 0 0 0 0 0 0						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.0						•
do not complete this line. 4. 00 Sein-private room days (sectualing swing-bed and observation bed days) 7. 00 Total swing-bed SW Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed W Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8. 00 Total swing-bed W Type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9. 00 Total swing-bed W Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9. 01 Total swing-bed W Type inpatient days applicable to the Program (excluding swing-bed and newbork) (see instructions) 9. 02 Swing-bed SW Type inpatient days applicable to the Program (excluding swing-bed and newbork) (see instructions) 9. 01 Total swing-bed SW Type inpatient days applicable to the Program (excluding swing-bed and newbork) (see instructions) 9. 02 Swing-bed SW Type inpatient days applicable to the Program (excluding swing-bed and newbork) (see instructions) 9. 03 Swing-bed SW Type inpatient days applicable to the Program (excluding swing-bed swing-bed swing-bed swing-bed SW Type inpatient days applicable to Title sW III only (including private room days) 9. 01 10. 00 Swing-bed SW Type inpatient days applicable to Title SW III only (including private room days) 12. 02 Swing-bed NT Type inpatient days applicable to Title SW or XIX only (including private room days) 13. 00 Swing-bed NT Type inpatient days applicable to Title SW or XIX only (including private room days) 14. 00 Swing-bed NT Type inpatient days applicable to SW Type swing-bed SW S					•	
	3.00		ys). It you have only pr	ivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 0.6.00	4. 00		ed davs)		32, 888	4.00
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7				r 31 of the cost		•
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 0 reporting period (calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 8.00 reporting period (calendar year, enter 0 on this line) 9.01 Swing-bed SNF 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 XNIII only (including private room days) after December 31 of the cost reporting period (calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XX x only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XX x only (including private room days) 15.00 North of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 North of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 North of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Modical years and years are supplicable to services after December 31 of the cost 0.00 North of the cost of t		' 3 '				
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) Total inpatient days including private room days applicable to the Program (excluding swing-bed and roze of the program of the cost reporting period (if cal endar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and roze of through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Nursery days (title V or XIX only) Through December 31 of the cost of the cost of the cost of the reporting period (if cal endar year, enter 0 on this line) Nursery days (title V or XIX only) Nursery day	6. 00		om days) after December	31 of the cost	0	6.00
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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) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 30. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 31. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 32. 00 Average per diem private room cost differential (line 34 x line 31) 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) 35. 00 Average per diem private room cost differential (line 3 x line 35) 36. 00 Average per diem private room cost differential (line 3 x line 35) 37. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 3 x line 35) 38. 00 Average per diem private room cost differential (line 42 x line 36) Part II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 1, 455. 91 1, 123, 963 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	26. 00				0	26.00
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PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 455. 91 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 123, 963 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 455. 91 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 123, 963 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,123,963 39.00 40.00	38 00				1, 455, 91	38.00
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) 1,123,963 41.00		Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 123, 963	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEA		CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 2:0	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		(col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	893, 494	1, 274	701. 3	3 79	55, 405	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	11, 662, 191	4, 214	2, 767. 4	9 156	431, 728	43. 00
	CORONARY CARE UNIT	11,002,171	7, 217	2,707.4	7	431,720	44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	·					1. 00	
	Program inpatient ancillary service cost (Wk			III lima 10	column 1)	1, 760, 056	1
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				corumn 1)	0 3, 371, 152	
	PASS THROUGH COST ADJUSTMENTS		., (5/ 5 /	1
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	0	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	natient ancilla	rv services (f	rom Wkst D s	sum of Parts II	0	51.00
	and IV)		, (1				
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pn	ysician anestr	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						1
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	55. 00 55. 01
	Adjustment amount per discharge (contractor	0. 00					
	Target amount (line 54 x sum of lines 55, 55	0					
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	0					
59.00							
	updated and compounded by the market basket)						
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year	cost report, ι	updated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if lir	ne 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.00
	55.01, or line 59, or line 60, enter the les						
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	(60), OF 1 % OF	i the target a	mount (Tine 50	o), otherwise		
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)					_	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	oer 31 of the	cost reportino	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	na costs through	n December 31	of the cost re	anorting period	0	67.00
07.00	(line 12 x line 19)	ic costs till odgi	1 December 31	or the cost re	por tring period	Ü	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after [December 31 of	the cost repo	orting period	0	68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	e 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•		, ,	1		70.00
	Program routine service cost (line 9 x line		Title 70 - Title	2)			72.00
	Medically necessary private room cost applic						73.00
	Total Program general inpatient routine serv	,		•	Oart II column		74.00 75.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	TOULTHE SELVICE	= costs (110M	WUI KSIIREL B, F	art II, COTUMN		/ 5.00
	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital -related costs (line 9 x line						77. 00 78. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi der recor	ds)			79.00
	Total Program routine service costs for comp				nus line 79)		80.00
	Inpatient routine service cost per diem limi		1)				81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82.00
84. 00	Program inpatient ancillary services (see in		- /				84.00
85.00	Utilization review - physician compensation	(ccc inctructi	200)				85.00

85. 00 86. 00

10, 256 87. 00 1, 455. 91 88. 00

84.00 Program Inpatient ancillary services (see Instructions)
85.00 Utilization review - physician compensation (see Instructions)

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)

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES In Lieu					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2023	Worksheet D-1	
					Date/Time Prep 5/31/2024 2:00	pared: 0 pm
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			14, 931, 813	89.00
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, 434, 946	62, 813, 917	0.07060	5 14, 931, 813	1, 054, 261	90.00
91.00 Nursing Program cost	0	62, 813, 917	0.00000	0 14, 931, 813	0	91.00
92.00 Allied health cost	0	62, 813, 917	0.00000	0 14, 931, 813	0	92.00
93.00 All other Medical Education	o	62, 813, 917	0. 00000	0 14, 931, 813	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 01/01/2023	Worksheet D-1
	Component CCN: 15-T048	To 12/31/2023	Date/Time Prepared: 5/31/2024 2:00 pm
	Title XIX	Subprovi der -	Cost
		IDE	

1. (a) Impartient days (including private room days, excluding swing-bed and newborn days) 2. (a) Oprivate room days (excluding swing-bed and observation bed days). If you have only private room days (sock) and on or complete this line. 2. (a) Oprivate room days (excluding swing-bed and observation bed days). If you have only private room days (a) Oprivate room days (excluding swing-bed and observation bed days). 3. (a) Oprivate room days (excluding swing-bed and observation bed days). 4. (a) Oprivate room days (excluding swing-bed and observation bed days). 5. (b) Oprivate room days (excluding swing-bed and observation bed days). 5. (c) Oprivate room days (excluding swing-bed and observation bed days). 5. (c) Oprivate room days). 6. (c) Oprivate room days (excluding swing-bed and room days). 6. (c) Oprivate room days (excluding swing-bed and room days). 6. (c) Oprivate room days (excluding swing-bed and room days). 6. (c) Oprivate room days (excluding private room days). 6. (c) Oprivate room days). 6. (d) Oprivate room days). 6. (e) Oprivate room days). 7. (e) Oprivate room days. 8. (e) Oprivate room days. 8			TI LIE AIA	IRF	Cost	
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description			1 00	
MARTIENT PAYS		PART I - ALL PROVINER COMPONENTS			1.00	
1.00						
2.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do on not complete this line. ding swing-bed and observation bed days). 3,964. 4.00 Seel -private room days (excluding swing-bed and observation bed days). 5,00 Total swing-bed SNF type inputient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total swing-bed SNF type inputient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total swing-bed SNF type inputient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total inputient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Total inputient days applicable to title XVIII only (including private room days). 7.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days) after 5.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days). 7.00 Swing-bed SNF type inputient days applicable to title XVIII only (including private room days). 7.00 Swing-bed SNF type inputient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line). 7.00 Swing-bed SNF type inputient days applicable to title SV or XIX only (including private room days). 7.00 Swing-bed SNF type inputient days applicable to services after December 31 of the cost of the cost reporting period (including private room days). 7.00 Swing-bed SNF type inputient days applicable to services after December 31 of the cost of the cost reporting period (including the services after December 31 of the c	1.00				· ·	1.00
do not complete this I line. 4. Semi-private room days (excluding xwing-bed and observation bed days) 5. Co Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 7. Co Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 8. Co Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 9. Co Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 10. Total Inpatient days (ancluding private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 10. Total Inpatient days (ancluding private room days) applicable to the Program (excluding swing-bed and on through December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 10. Swing-bed SWF type inpatient days applicable to title XWIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 10. December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 10. December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 11. Co Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12. Total nursery days (title V or XX only) 13. Co Swing-bed SWF very later toom days applicable to the Program (excluding swing-bed days) 14. Co December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 15. Co Total nursery days (title V or XX only) 16. December 31 of the cost reporting period (if calendar year, enter 0 on this I ino) 17. Co Swing-bed cost applicable to SWF services applicable to services after December 31 of t						
Semi-private room days (excluding swing-bed and observation bed days)	3.00		ys). If you have only pr	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total inpatient days including private room days after December 31 of the cost reporting period (if callendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) Swing-bed SNF type inpatient days including private room days) Swing-bed SNF type inpatient days applicable to the treath of the swing swing-bed and period (if callendar year, enter 0 on this line) Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) The December 31 of the cost reporting period (if callendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) The December 31 of the cost reporting period (if callendar year, enter 0 on this line) The December 31 of the cost reporting period (if callendar year, enter 0 on this line) The December 31 of the cost reporting period (including private room days) The December 31 of the cost reporting period (including private room days) The December 31 of the cost reporting period (including private room days) The December 31 of the cost reporting period (including private room days) The December 31 of the cost reporting period (including private room days) The December 31 of the cost reporting period (including p	4. 00	•	ed days)		3, 964	4.00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 291, 742 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Pri vate 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, 291, 742) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 20 28. 00 28. 00 28. 00 29. 00 29. 00 20. 00 30. 00 20. 00 30. 00 30.	27.00					27 00
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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, 291, 742 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 4, 291, 742 4, 291, 742 37.00 37.00 40.00	34.00			ctions)		
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,082.68 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		27 minus line 36)	· · · · · · · · · · · · · · · · · · ·	`		
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,082.68 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			ICTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 39.00	38.00				1 082 68	38 00
	39.00		•			39.00
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 0 41.00	40.00					40.00
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)	l	01	41.00

	Financial Systems REID ATION OF INPATIENT OPERATING COST	HOSPITAL & HEAL	TH CARE SERVICES Provider CCN: 15-0048	In Lie	u of Form CMS-2 Worksheet D-1		
			Component CCN: 15-T048	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 2:0		
			Title XIX	Subprovi der -	Cost	о рііі	
	Cost Center Description	Total Inpatient Cost	Total Average Per Di em (col. Days ÷ col. 2)		Program Cost (col. 3 x col. 4)		
10.00	Investory (1) It is a visit of the	1. 00	2.00 3.00	4.00	5. 00	10.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0 0.	00 0	0	42.00	
43. 00 44. 00 45. 00 46. 00 47. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0 0.	00 0	0	43. 00 44. 00 45. 00 46. 00 47. 00	
	Cost Center Description		·		1. 00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)		1.00	48. 00	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS), column 1)	0		
50.00	Pass through costs applicable to Program inp	patient routine s	services (from Wkst. D, s	um of Parts I and	0	50. 00	
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	atient ancillary	services (from Wkst. D,	sum of Parts II	0	51.00	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ıding capital rel	ated, non-physician anes	thetist, and	0	52. 00 53. 00	
54. 00 55. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge				0.00		
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)			0. 00 0. 00	•	
56. 00	Target amount (line 54 x sum of lines 55, 55				0.00	56.00	
57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (line 56 minus	s line 53)	0	57. 00 58. 00	
58. 00 59. 00							
60. 00							
61. 00	61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						
62. 00	enter zero. (see instructions) Relief payment (see instructions)				0	62. 00	
63. 00	PROGRAM INPATIENT ROUTINE SWING BED COST				0	63.00	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the cost repor	ting period (See	0	64. 00	
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	its after Decembe	er 31 of the cost reporti	ng period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 6	o4 plus line 65)(title XV	<pre>II only); for</pre>	0	66. 00	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 of the cost	reporting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of the cost re	porting period	0	68. 00	
	Total title V or XÍX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID ONLY		0		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service o	•	,	7)		70. 00 71. 00	
72. 00	Program routine service cost (line 9 x line		70 - 11110 27			72.00	
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	•	•			73. 00 74. 00	
75. 00	Capital -related cost allocated to inpatient 26, line 45)		75.00				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line					76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minu	ıs line 77)				78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,	•	nus lina 70)		79. 00 80. 00	
81. 00	Inpatient routine service costs for comp		ost friiii tatroir (friie 76 iii	nus ime 79)		81.00	
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)				82. 00	
83.00	Reasonable inpatient routine service costs (5)			83.00	
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)			84. 00 85. 00	
	Total Program inpatient operating costs (sum	•	•			86.00	
87 ∩∩	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions				0	87. 00	
	Trotal observation bed days (see Tristi dell'olis	")			U	1 07.00	

Health Financial Systems REID	HOSPITAL & HEA	LTH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0048 Period:			Worksheet D-1		
					Date/Time Pre 5/31/2024 2:0	
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ĺ		(from line	(col. 3 x	
				89)	col. 4) (see	
				ĺ	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	570, 054	4, 291, 742	0. 13282	6 0	0	90.00
91.00 Nursing Program cost	0	4, 291, 742	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 291, 742	0. 00000	0	0	92.00
93.00 All other Medical Education	0	4, 291, 742	0. 00000	0	0	93.00

Health Financial Systems REID HOSPITAL & HEAL	TH CARE SERVI	CES	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023		
	Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos- 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		•	_		
30. 00 03000 ADULTS & PEDIATRICS			22, 812, 678		30.00
31.00 03100 INTENSIVE CARE UNIT			3, 205, 077		31.00
41. 00 04100 SUBPROVI DER - 1 RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 18118			
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 25867			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15927		2, 873, 666	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 07061			
60. 00 06000 LABORATORY		0. 16420			
65. 00 06500 RESPI RATORY THERAPY		0. 15051			
66. 00 06600 PHYSI CAL THERAPY		0. 69371		1, 636, 180	66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 14164			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 20826			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0.00000		0	71.00
72. 00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 69425			72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 32853			73.00
74. 00 07400 RENAL DI ALYSI S		0. 88012		1	74.00
76. 00 03950 ANCI LLARY - OTHER		0.00000		0	76. 00 76. 97
76. 97 07697 CARDI AC REHABI LI TATI ON 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0. 52630 0. 00000		100	76.97
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		0	78.00
OUTPATIENT SERVICE COST CENTERS		0.00000	<u>U</u>	0	70.00
DOTTATION SERVICE COST CENTERS					1

12, 664, 650 3, 277, 741

141, 218, 907 0 141, 218, 907

24, 452

2, 211, 830 91.00

92.00

93.00

0 96.00

1, 913, 234

10, 444

33, 311, 667 200. 00 201. 00 202. 00

0. 174646

0. 583705

0. 427106

1.837387

91. 00 09100 EMERGENCY

04040 FAMILY PRACTICE

93.00

200. 00 201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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)

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

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0048	Peri od:	Worksheet D-3	}
		Component	CCN: 15-T048	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 2:0	
		Title	× XVIII	Subprovi der -	PPS	<u>o p</u>
				I RF		
	Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	-
30. 00			T			30.0
30.00	03100 NTENSIVE CARE UNIT					31.0
41.00	04100 SUBPROVI DER – I RF			2, 025, 542		41.0
41.00	04300 NURSERY			2, 023, 342		43.0
+3.00	ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00			0, 18118	39 65, 385	11, 847	50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 25867		0	1
54.00			0. 15927		17, 174	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0706		188	1
50.00	06000 LABORATORY		0. 16420	·	47, 050	1
55.00	06500 RESPIRATORY THERAPY		0. 15051	·	37, 591	
56. 00	06600 PHYSI CAL THERAPY		0. 6937		1, 081, 556	
59. 00	06900 ELECTROCARDI OLOGY		0. 14164		265	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 20826		0	70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	00 0	0	71.0
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 69425	52 657	456	72.0
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 32853	33 539, 205	177, 147	73.0
74. 00	07400 RENAL DIALYSIS		0. 88012	23 22, 820	20, 084	74.0
76.00	03950 ANCI LLARY - OTHER		0.00000	00	0	76.0
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 52630	04	0	76. 9
77. 00			0.00000	00	0	77. C
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78. C
	OUTPATIENT SERVICE COST CENTERS					
71.00	09100 EMERGENCY		0. 17464		1, 920	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 58370		0	
93.00			0. 42710	06 0	0	93.0
	OTHER REIMBURSABLE COST CENTERS		1 05===		_	١
	09600 DURABLE MEDI CAL EQUI P-RENTED		1. 83738		0	1
200.00				2, 846, 782	1, 395, 278	
201.00		y charges (line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)			2, 846, 782		202.0

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVI	I CES	In Lie	u of Form CMS-2	552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (Peri od: From 01/01/2023	Worksheet D-3	
				Date/Time Pre 5/31/2024 2:0	
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	

				То	12/31/2023	Date/Time Pre 5/31/2024 2:0	
		Ti tl	e XIX	. Н	lospi tal	Cost	
	Cost Center Description		Ratio of Cos	-	npati ent	I npati ent	
			To Charges			Program Costs	
					Charges	(col. 1 x	
						col . 2)	
-	NEATHERIT POLITINE OFFICE COOT OFFITTED		1. 00		2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1		4 007 077		
	03000 ADULTS & PEDI ATRI CS				1, 897, 277		30.00
	03100 NTENSI VE CARE UNI T				453, 089		31.00
	04100 SUBPROVI DER - I RF				0		41.00
	04300 NURSERY				180, 899		43. 00
	ANCILLARY SERVICE COST CENTERS		0.4044	20	000 745	450.454	F0 00
	D5000 OPERATING ROOM		0. 18118		828, 715	150, 154	50.00
	D5200 DELIVERY ROOM & LABOR ROOM		0. 25867		377, 135	97, 556	52.00
	D5400 RADI OLOGY-DI AGNOSTI C		0. 15927		1, 113, 842	177, 403	54.00
	D5900 CARDI AC CATHETERI ZATI ON		0. 07061		372, 076	26, 274	59.00
	D6000 LABORATORY		0. 16420		1, 342, 987	220, 525	60.00
	06500 RESPI RATORY THERAPY		0. 15051	-	715, 716	107, 727	65.00
	D6600 PHYSI CAL THERAPY		0. 6937		174, 278	120, 898	
	D6900 ELECTROCARDI OLOGY		0. 14164		165, 074	23, 382	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0. 20826		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 69425		115, 329	80, 067	72.00
	D7300 DRUGS CHARGED TO PATIENTS		0. 32853		1, 732, 102	569, 053	73.00
	D7400 RENAL DIALYSIS		0. 88012		40, 453	35, 604	74.00
	03950 ANCI LLARY - OTHER		0. 00000		0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON		0. 52630		0	0	76. 97
1	07700 ALLOGENEIC HSCT ACQUISITION		0. 00000		0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	0	78. 00
	DUTPATIENT SERVICE COST CENTERS						
	D9100 EMERGENCY		0. 17464		866, 972	151, 413	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 58370		0	0	92.00
-	04040 FAMILY PRACTICE		0. 42710	06	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
1	09600 DURABLE MEDICAL EQUIP-RENTED		1. 83738	37	0	0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)				7, 844, 679	1, 760, 056	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)			0		201. 00
202.00	Net charges (line 200 minus line 201)				7, 844, 679		202. 00

	n Financial Systems REID HOSPITAL & I LENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		In Lie Period:	Worksheet D-3	3
				From 01/01/2023		
		· ·	CCN: 15-T048	To 12/31/2023	Date/Time Pre 5/31/2024 2:0	
		Ti tl	e XIX	Subprovi der -	Cost	
	Cost Center Description		Ratio of Cos	I RF st I npati ent	Inpati ent	
	Cost Center Description		To Charges		Program Costs	
			10 charges	Charges	(col. 1 x	
				onal ges	col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41.00	04100 SUBPROVI DER - I RF			93, 070		41.00
43.00						43.00
	ANCILLARY SERVICE COST CENTERS					
50.00			0. 1811		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 2586		0	
54.00			0. 1592		0	
59.00			0. 0706		0	
60.00	06000 LABORATORY		0. 1642		0	
65.00			0. 1505		0	
66.00			0. 6937		0	
69.00			0. 1416		0	
70.00			0. 2082		0	
71.00			0.0000		0	
			0. 6942		0	
73. 00 74. 00			0. 3285 0. 8801		0 0	
	03950 ANCI LLARY - OTHER		0. 8801.		0	
	07697 CARDI AC REHABI LI TATI ON		0. 5263		0	
77. 00			0. 0000		0	
	07800 CAR T-CELL IMMUNOTHERAPY		0.0000		0	
70.00	OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	70.00
91. 00			0. 1746	46 0	0	91.00
92.00			0. 5837		ő	
93.00	1 1		0. 4271		ő	
	OTHER REIMBURSABLE COST CENTERS					1
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		1.8373	87 0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98	3)		0	0	200.00
201.00				0		201.00
202.00		. , ,		0		202.00

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lieu of Form CMS-2552-10
CALCULATION OF DELMBURSEMENT SETTLEMENT	Drovi don CCN, 15 0049	Dori od: Workshoot E

near th Frhancial Systems	KEID HOSFITAL & HEALIH CARE SERVICES	III LI C	u or roriii civi3-2	1002-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	
			5/31/2024 2: 00	O pm
	Title XVIII	Hospi tal	PPS	

	Title XVIII Hospital	5/31/2024 2: 0 PPS	о рііі
	DADT A LADATIENT HOCDITAL CEDVICEC UNDED LDDC	1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see linstructions)	32, 162, 983	
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10, 954, 796	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2. 00 2. 01
2. 01	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	1
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	243, 862	
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	68, 221	
3.00	Managed Care Simulated Payments	22, 735, 373	1
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	154. 90	4.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending or	17. 91	5.00
0.00	or before 12/31/1996. (see instructions)	17.71	0.00
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0. 00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR $\S412.105(f)(1)(iv)(B)(1)$ ACA $\S5503$ reduction amount to the IME cap as specified under 42 CFR $\S412.105(f)(1)(iv)(B)(2)$ If the	0. 00 0. 00	
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0. 00	
7.02	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	
9. 00	instructions)	17. 91	
	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.	14. 32 0. 00	
12. 00	Current year allowable FTE (see instructions)	14. 32	
13. 00	Total allowable FTE count for the prior year.	16. 37	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	16. 44	14.00
45.00	otherwise enter zero.	45.74	45.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)	_	15. 00 16. 00
17. 00	Adjustment for residents displaced by program or hospital closure		17.00
18.00	Adjusted rolling average FTE count	15. 71	1
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 101420	•
20.00	Prior year resident to bed ratio (see instructions)	0. 100184	•
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 100184 2, 294, 944	•
22. 00	IME payment adjustment - Managed Care (see instructions)	1, 210, 090	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	1,210,070	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	-3. 59	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25. 00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0. 000000 0	1
28. 00	IME add-on adjustment amount - Managed Care (see instructions)	0	
29. 00	Total IME payment (sum of lines 22 and 28)	2, 294, 944	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	1, 210, 090	1
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 26	30.00
31.00	Percentage of Medicaid patient days (see instructions)	24. 77	31.00
32.00	Sum of lines 30 and 31	30. 03	1
33.00	Allowable disproportionate share percentage (see instructions)	13. 99	33.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	PPS	<u> </u>
				1 00	
34 00	Disproportionate share adjustment (see instructions)			1. 00 1, 508, 044	34 00
01.00	broker tronate share adjustment (see thisti astrons)		Prior to 10/1		01.00
			1. 00	2. 00	
05 00	Uncompensated Care Payment Adjustment		/ 074 400 450	5 000 00/ 757	1 05 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000172527	5, 938, 006, 757 0. 000182113	•
35. 02	Hospital UCP, including supplemental UCP (see instructions)		1, 186, 020	1, 081, 388	
35. 03	Pro rata share of the hospital UCP, including supplemental UC	CP (see instructions)	887, 078	271, 824	
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1, 158, 902		36.00
40. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges (see instructions)	scharges (lines 40 thro	ugh 46)		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	i ons)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instructions	5)	0. 00		45.00
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47.00	Subtotal (see instructions)		48, 391, 752		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sonly. (see instructions)	small rural hospitals	57, 165, 776		48. 00
	join y. (See Tristi detrois)			Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instructions			58, 375, 866	1
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.			3, 431, 204 0	50.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			573, 339	ı
53.00	Nursing and Allied Health Managed Care payment	,		57, 038	
54.00	Special add-on payments for new technologies			70, 751	54.00
54. 01	Islet isolation add-on payment	0)		0	54.01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cellular therapy acquisition cost (see instructions)	59)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		through 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)	-	54, 669	•
59.00	Total (sum of amounts on lines 49 through 58)			62, 562, 867	1
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	line 60)		22, 173 62, 540, 694	•
62. 00	Deductibles billed to program beneficiaries	3 TTHE 00)		4, 642, 512	
63.00	Coinsurance billed to program beneficiaries			36, 000	63.00
	Allowable bad debts (see instructions)			451, 318	
	Adjusted reimbursable bad debts (see instructions)			293, 357	65.00
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		162, 125 58, 155, 539	66. 00 67. 00
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (see instructions)	0 0	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70.50
70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	70. 75 70. 87
. 0. 01	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70. 88	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70. 89
70. 88 70. 89	HSP bonus payment HVBP adjustment amount (see instructions)			0	•
70. 89 70. 90				0	70. 91
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-	1
70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-	70. 92 70. 93

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

	Financial Systems REID HOSPITAL & HEALTH ATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0048	Peri od:	u of Form CMS-2 Worksheet E	2002-1L
CALCUL	ATTON OF REIMBORSEMENT SETTLEMENT	FIOVIDEI C	CN. 13-0046	From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		Title	e XVIII	Hospi tal	5/31/2024 2: 0 PPS	o pm
		11 11		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70 07	the corresponding federal year for the period prior to 10/1)					70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3	ter 10/1)		0	0	70. 98
	HAC adjustment amount (see instructions)			-	0	1
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			57, 719, 988	71.00
	Sequestration adjustment (see instructions)				1, 154, 400	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs		1		0	71.02
	Interim payments				57, 118, 363	1
	Interim payments-PARHM				51, 112, 222	72. 01
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	2, 72, and			-552, 775	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
	Protested amounts (nonallowable cost report items) in accorda	nce with			0	
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc				0	
70.00	Trille varue or money for capital related expenses (see firstruc	ti ons)		Prior to 10/1		70.00
				1. 00	2. 00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	0	100.00
	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0.000000000		102.00
	HRR Adjustment for HSP Bonus Payment	,				
	HRR adjustment factor (see instructions)			0.0000	0. 0000	
	HRR adjustment amount for HSP bonus payment (see instructions			0	0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	i i od dildei	the 213t			200.00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
	Medicare discharges (see instructions)					202.00
	Case-mix adjustment factor (see instructions)	first year	of the curre	nt 5-year demons		203. 00
203. 00	Computation of Demonstration Target Amount Limitation (N/A in		or the curre	iit 3-year deliloris	iti ati on	
203. 00	Computation of Demonstration Target Amount Limitation (N/A in period)					
	,					204. 00
204. 00 205. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					205.00
204. 00 205. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)					
204. 00 205. 00 206. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement					205. 00 206. 00
204. 00 205. 00 206. 00 207. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ructions)				205. 00 206. 00 207. 00
204. 00 205. 00 206. 00 207. 00 208. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ructions)				205. 00 206. 00 207. 00 208. 00
204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ructions) line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ructions) line 59)				205. 00 206. 00 207. 00 208. 00 209. 00
204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ructions) line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ructions) line 59)				205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00	period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ructions) line 59)	mbursement)			205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0048	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 2:00 pm
		T1 11 \0.0011		200

		T: +1 - W/// 1		5/31/2024 2: 0	0 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	ma)		4, 405	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS or REH payments	ns)		41, 640, 841 48, 999, 085	2. 00 3. 00
4. 00	Outlier payment (see instructions)			24, 264	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		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 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direct (araduato modical oduc	ation costs from	124 965	8. 00 9. 00
9.00	Wkst. D, Pt. IV, col. 13, line 200	graduate medicar educ	atron costs from	124, 865	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 405	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges		T	10 107	40.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	40)		13, 407 0	12.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	69)		13, 407	14.00
14.00	Customary charges			13, 407	14.00
15.00	Aggregate amount actually collected from patients liable for payr	ment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for pa	ayment for services o	n a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only i	if line 18 eveneds li	no 11) (soo	13, 407 9, 002	18. 00 19. 00
17.00	instructions)	Title to exceeds th	110 11) (366	7, 002	19.00
20.00	Excess of reasonable cost over customary charges (complete only i	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			4, 405	21.00
22. 00	Interns and residents (see instructions)	+i ono)		0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructional prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tions)		0 49, 148, 214	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			47, 140, 214	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	4 (for CAH, see instr	uctions)	8, 334, 899	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	s the sum of lines 22	and 23] (see	40, 817, 720	27.00
20.00	instructions)	FO)		400 E70	20.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, line REH facility payment amount (see instructions)	50)		402, 573	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			41, 220, 293	
31.00	Primary payer payments			10, 479	31.00
32. 00	Subtotal (line 30 minus line 31)			41, 209, 814	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	<u> </u>		0	22.00
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			988, 260	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			642, 369	
	Allowable bad debts for dual eligible beneficiaries (see instruct	tions)		594, 247	
37.00	Subtotal (see instructions)	,		41, 852, 183	
38. 00	MSP-LCC reconciliation amount from PS&R			163	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			2	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	devices (see mistrue	111 0113)	0	39. 99
40.00	Subtotal (see instructions)			41, 852, 020	40.00
40. 01	Sequestration adjustment (see instructions)			837, 040	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			42, 002, 046	41.00
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only)			U	42.00
43. 00	Balance due provider/program (see instructions)			-987, 066	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,	0	44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR		ı	2	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92.00	The rate used to calculate the Time Value of Money			0. 00	
93. 00	Time Value of Money (see instructions)				93.00
			<u>'</u>		

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0048	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	
				5/31/2024 2:0)O pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2023	Worksheet E
		Component CCN: 15-T048		
		Title XVIII	Subprovi der -	PPS

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS or REH payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges (from Wkst. D, A, Dt. LLL, col. 4 Line 60)	36 34 38 0 0.000 0.000 0 0.000	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS or REH payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	36 34 38 0 0 0.000 0.000 0 0.00	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS or REH payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 5.00 Line 2 times line 5 5.00 Sum of lines 3, 4, and 4.01, divided by line 6 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 0.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	34 38 0 0 0.000 0.000 0.00 0	2. 00 3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
3.00 OPPS or REH payments 4.00 dullier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	38 0 0 0.000 0 0.000 0	3. 00 4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	0 0.000 0.000 0.000 0	4. 00 4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	0 0.000 0 0.00 0	4. 01 5. 00 6. 00 7. 00 8. 00 9. 00
5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	0. 00 0. 00 0	6. 00 7. 00 8. 00 9. 00
7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	0. 00 0 0	7. 00 8. 00 9. 00
8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges	0	8. 00 9. 00
9.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service other pass through costs including REH direct graduate medical education costs from Vkst. D, Pt. IV, col. 13, line 200 Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	0	9. 00
Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges		10 00
11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges		1 10 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12. 00 Ancillary service charges	30	1
Reasonable charges 12.00 Ancillary service charges	$\overline{}$	11.00
		İ
12 OO Organ acquicition charges (from West D / Dt III ast / line (O)		12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	110	
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges	110	14.00
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	0	16.00
had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.	000000	17 00
18.00 Total customary charges (see instructions)	110	
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	74	1
instructions)		00.00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00 Lesser of cost or charges (see instructions)	36	21.00
22.00 Interns and residents (see instructions)	0	
23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0 38	
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	30	24.00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	0	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	74	27.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50 REH facility payment amount (see instructions)		28. 50
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29)	0 74	
31.00 Primary payer payments	0	
32.00 Subtotal (line 30 minus line 31)	74	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 34.00 Allowable bad debts (see instructions)	0	
35.00 Adjusted reimbursable bad debts (see instructions)	0	1
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	0	00.00
37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R	74 0	1
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39.75 N95 respirator payment adjustment amount (see instructions)	0	1
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION	0	1
40.00 Subtotal (see instructions)	74	1
40.01 Sequestration adjustment (see instructions)	1	40.01
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs	0	40. 02 40. 03
41.00 Interim payments	60	1
41.01 Interim payments-PARHM		41.01
42.00 Tentative settlement (for contractors use only)	0	
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions)	13	42. 01 43. 00
43.01 Balance due provider/program-PARHM (see instructions)	.5	43. 01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
§115. 2		
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions)	0	90.00
91.00 Outlier reconciliation adjustment amount (see instructions)	Ö	1
92.00 The rate used to calculate the Time Value of Money	0. 00	92.00

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2023	Worksheet E Part B	
		Component CCN: 15-T048	To 12/31/2023		pared: 0 pm
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
93.00 Time Value of Money (see instructions)				0	93.00
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Peri od:

1.00

2.00

8 00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0048 Worksheet E-1 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 56, 961, 263 41, 403, 946 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 09/20/2023 216, 000 09/20/2023 598, 100 3.01 3.02 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 06/07/2023 58, 900 0 3.50 0 3.51 3.51 0 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 157, 100 598, 100 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 42, 002, 046 4.00 57, 118, 363 (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 6.01 0 SETTLEMENT TO PROGRAM 6.02 552, 775 987, 066 6.02 41, 014, 980 7.00 Total Medicare program liability (see instructions) 56, 565, 588 7.00 Contractor NPR Date Number (Mo/Day/Yr)

8.00 Name of Contractor

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

Inpatient Part A			Title	e XVIII	Subprovi der - I RF	PPS	о рііі
1.00			I npati er	nt Part A		t B	
1.00							
Interim payments payable on individual bills, either solub submitted or to be submitted for the cost reporting period. If none, write "NONE" or enter a zero. 3.00			1. 00				
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero							
Services rendered in the cost reporting period. If none, write "MONE" or enter a zero.	2. 00				0	0	2.00
write "MONE" or enter a zero 3.00 1.00 1.00 2.00 3.00 1.00 1.00 3.00							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		1 91					
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 3.02 3.03 3.03 3.04 3.05 Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines appropriate) 1.0 B COMPLETE BY CONTRACTOR 1.0 Its separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Provider to Program 1.0 Its separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 1.0 E COMPLETE BY CONTRACTOR 1.0 Its roll of the contractor of the contrac	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 Total is separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 0 3.50 3.51 3.52 3.53 3.54 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3.50-3.98) 5.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 1, 2, and 3.99) 7.00 Total interim payments (sum of lines 2, 2, and 3.99) 7.00 Total interim payments (sum of lines 3.01-3.49 minus sum of lines 5.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Determined net settlement amount (balance due) based on the cost report. (1) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Determined net settlement amount (balance due) based on the cost report. (1) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 8.00 Total interim payments (sum of lines 5.01-5.49 minus sum of lines 6.00 Total interim payments (sum of	3. 01				0	0	3. 01
3.04	3.02				0	0	3.02
3.05 Provider to Program	3.03				0	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3.50							
ADJUSTMENTS TO PROGRAM	3.05				0	0	3. 05
3.51 3.52 0							
3.52 3.53 3.54 3.99 3.50-3.98 3.50-3.99 3.305, 197 6.00 4.0		ADJUSTMENTS TO PROGRAM		l .			
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					-	_	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3,305,197 60 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 3,305,197 60 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 3,305,197 60 4.00					~	_	
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 2 01 2 40 minus sum of lines		1			
A . 00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 77				O		3. 77
Circumsfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			3 305 19	7	60	4 00
appropriate TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider TENTATI VE TO PROVI DER 0 0 0 5.01	5.00						5.00
Program to Provider							
TENTATIVE TO PROVIDER							
5.02	E 01			1			E 01
5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 0 0 5.50 5.51 5.52 0 0 0 5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 6.01 SETTLEMENT TO PROVIDER 54,069 13 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 7.00 Total Medicare program liability (see instructions) 3,359,266 73 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00		TENTATIVE TO PROVIDER		l .			
Provider to Program							
TENTATI VE TO PROGRAM 0 0 5.50	5. 05	Provider to Program			0	0	3.03
5.51	5. 50				0	0	5. 50
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1. 00 2. 00	5. 51			1			
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1.00 2.00	5. 52				o	0	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) O 1.00 2.00	5. 99				0	0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00		1					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) SETTLEMENT TO PROGRAM 9 0 0 6.02 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 9 13 6.01 1 7.00 1 7.00 1 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
7.00 Total Medicare program liability (see instructions) 3,359,266 73 7.00 Contractor NPR Date (Mo/Day/Yr)				54, 06	9		
Contractor NPR Date (Mo/Day/Yr)				2 250 27	4	_	
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program frability (see Instructions)		3, 359, 26			7.00
0 1.00 2.00							
				0			
	8. 00	Name of Contractor					8.00

Hool +h	Financial Systems DELD HOSDITAL & HEALT	TH CADE CEDVICES	In Lie	u of Form CMS-	2552 10	
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0048 Period:					
	From 01/01/2023 F To 12/31/2023 F					
		Title XVIII	Hospi tal	5/31/2024 2: 0 PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	V				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00	
2.00	Medicare days (see instructions)				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days (see instructions)				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	CAH only - The reasonable cost incurred for the purchase of a	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00	
9. 00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and I	line 31) (see instructio	ns)		32.00	

Heal th	Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0048	Peri od: From 01/01/2023	Worksheet E-3 Part III	
			Component CCN: 15-T048			
			Title XVIII	Subprovi der - I RF	PPS	
					1. 00	
	PART III - MEDICARE PART A SERVICES -	IRF PPS				
1.00	Net Federal PPS Payment (see instructi	ons)			3, 261, 187	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see	e instructions)			0. 0218	2.00
3.00	Inpatient Rehabilitation LIP Payments	(see instructions)			193, 715	3.00
4.00	Outlier Payments				11, 243	4.00
5.00	Unweighted intern and resident FTE cou	unt in the most recent of	cost reporting period e	nding on or prior	0.00	5. 00

	1. 00	
PART III - MEDICARE PART A SERVICES - IRF PPS		
.00 Net Federal PPS Payment (see instructions)	3, 261, 187	1.0
.00 Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0218	2.0
.00 Inpatient Rehabilitation LIP Payments (see instructions)	193, 715	3.00
.00 Outlier Payments	11, 243	4.0
.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)		
.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5.0
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)		
.00 New Teaching program adjustment. (see instructions)	0.00	6.0
.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7.0
teaching program" (see instructions)		
.00 Current year's unweighted L&R FTE count for residents within the new program growth period of a "new	0.00	8.0
teaching program" (see instructions)		
.00 Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9.0
0.00 Average Daily Census (see instructions)	10. 860274	10.0
1.00 Teaching Adjustment Factor (see instructions)	0. 000000	
2.00 Teaching Adjustment (see instructions)	0	12.0
3.00 Total PPS Payment (see instructions)	3, 466, 145	
4.00 Nursing and Allied Health Managed Care payments (see instruction)	0, 100, 110	14. 0
5.00 Organ acqui si ti on (DO NOT USE THIS LINE)	J	15. 0
6.00 Cost of physicians' services in a teaching hospital (see instructions)	0	16. 0
7. 00 Subtotal (see instructions)	3, 466, 145	
8.00 Primary payer payments	3, 400, 145	
9.00 Subtotal (line 17 less line 18).	3, 462, 489	
0.00 Deductibles		
	23, 956	
1.00 Subtotal (line 19 minus line 20)	3, 438, 533	
2. 00 Coi nsurance	12, 800	
3.00 Subtotal (line 21 minus line 22)	3, 425, 733	
4.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)	2, 711	
5.00 Adjusted reimbursable bad debts (see instructions)	1, 762	
6.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.0
7.00 Subtotal (sum of lines 23 and 25)	3, 427, 495	
8.00 Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.0
9.00 Other pass through costs (see instructions)	327	29.0
0.00 Outlier payments reconciliation	0	30.00
1.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.0
1.50 Pioneer ACO demonstration payment adjustment (see instructions)	0	31.5
1.98 Recovery of accelerated depreciation.	0	31. 9
1.99 Demonstration payment adjustment amount before sequestration	0	31. 9
2.00 Total amount payable to the provider (see instructions)	3, 427, 822	32.0
2.01 Sequestration adjustment (see instructions)	68, 556	32.0
2.02 Demonstration payment adjustment amount after sequestration	0	32.0
3.00 Interim payments	3, 305, 197	33.0
4.00 Tentative settlement (for contractor use only)	0	34.0
5.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	54, 069	35.0
6.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.0
§115. 2		
TO BE COMPLETED BY CONTRACTOR		
0.00 Original outlier amount from Wkst. E-3, Pt. III, line 4	11, 243	50.0
1.00 Outlier reconciliation adjustment amount (see instructions)	0	51.0
2.00 The rate used to calculate the Time Value of Money	0. 00	
3.00 Time Value of Money (see instructions)	0.00	53.0
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (TH		33.0
COVID-19 PHE)	L LIND OF THE	
9.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	م مو
9.01 Calculated Teaching Adjustment Factor for the current year. (see instructions)		
	0.000000	l ga n

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

From 01/01/2023 To 12/31/2023 Part VII Date/Time Prepared: 5/31/2024 2:00 pm Hospi tal Title XIX Cost Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 3, 371, 152 1.00 Inpatient hospital/SNF/NF services Medical and other services 2 00 2.00 4, 250, 366 3.00 Organ acquisition (certified transplant programs only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 3, 371, 152 4, 250, 366 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 3, 371, 152 4, 250, 366 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 8.00 Ancillary service charges 7, 844, 679 17, 580, 055 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 11 00 Incentive from target amount computation 11 00 Total reasonable charges (sum of lines 8 through 11) 12.00 7, 844, 679 17, 580, 055 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 15.00 Total customary charges (see instructions) 17, 580, 055 16.00 16.00 7.844.679 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 4, 473, 527 13, 329, 689 17.00 line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 18.00 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 20.00 4, 250, <u>366</u> Cost of covered services (enter the lesser of line 4 or line 16) 3, 371, 152 21.00 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. Other than outlier payments 22.00 22.00 0 0 23.00 Outlier payments 0 23.00 Program capital payments 0 24.00 24.00 o 25.00 Capital exception payments (see instructions) 25.00 Routine and Ancillary service other pass through costs 0 26,00 Ω 26 00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 O 28.00 Titles V or XIX (sum of lines 21 and 27) 4, 250, 366 3, 371, 152 29.00 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3, 371, 152 4, 250, 366 31.00 32.00 Deductibles Λ 32.00 33.00 Coi nsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 4, 250, 366 36,00 3, 371, 152 36,00 37.00 ZERO OUT MEDICAID -4, 250, 366 37.00 38.00 Subtotal (line 36 \pm line 37) 3, 371, 152 38.00 39 00 Direct graduate medical education payments (from Wkst. E-4) 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 3, 371, 152 0 40.00 0 41.00 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 3, 371, 152 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43.00 43 00 0

chapter 1, §115.2

Health Florestel Codes	DELD HOODITAL A HEALTH CADE CEDWICE	1 . 12 .	. C. E OHC	2550 40	
Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	In Lieu of Form CMS-2552-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0048	Peri od:	Worksheet E-3		
		From 01/01/2023	Part VII		
	Component CCN: 15-T048	To 12/31/2023			
			5/31/2024 2: 0	0 pm	
	Title XIX	Subprovi der -	Cost	<u> </u>	
		I RF			
		I npati ent	Outpati ent		
		1. 00	2. 00		

		I RF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XI>	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	2.00
3.00	Organ acquisition (certified transplant programs only)	o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5. 00	Inpatient primary payer payments	o	_	5.00
6. 00	Outpatient primary payer payments	1	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES	<u> </u>		7.00
	Reasonable Charges			
8. 00	Routi ne servi ce charges	0		8.00
9. 00	Ancillary service charges	o	0	9.00
10.00	Organ acquisition charges, net of revenue	ol	U	10.00
11. 00	Incentive from target amount computation	0		11.00
	Total reasonable charges (sum of lines 8 through 11)	o	0	12.00
12.00	CUSTOMARY CHARGES	U	U	12.00
12 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
13. 00		۷	U	13.00
14. 00	basis Amounts that would have been realized from nationts liable for nowment for services on	o	0	14.00
14.00	Amounts that would have been realized from patients liable for payment for services on	٩	Ü	14.00
15 00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0 000000	0 000000	15 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	1
16.00	Total customary charges (see instructions)	0	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	0	17. 00
10.00	line 4) (see instructions)		0	40.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	0	0	10 00
19.00	· · · · · · · · · · · · · · · · · · ·	٩	-	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	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			00.00
22. 00	1 3	0	0	22.00
23. 00		0	0	23.00
24. 00	9 1 1 3	0		24.00
	Capital exception payments (see instructions)	0	_	25.00
26. 00	Routine and Ancillary service other pass through costs	0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	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)	o	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38. 00	Subtotal (line 36 ± line 37)	0	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0	_	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41. 00	Interim payments	0	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)	o	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43.00
.0.00	chapter 1, §115. 2	Ĭ	O	
	Ondptol 1, 3110.2	I		ı

D	Financial Systems REID HOSPITAL & HEALTH GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	5/31/2024 2: 0 PPS	Орш
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.		cost report	ing periods	0. 00	1.00
1. 01 2. 00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFF	,	(1) (coo inci	ructions)	17. 91 0. 00	1. 01 2. 00
2. 26	Rural track program FTE cap limitation adjustment after the cathe CAA 2021 (see instructions)				0.00	2. 26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA				0. 00	3.00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)			•	0. 00	3. 01
3. 02	Adjustment (increase or decrease) to the hospital's rural track programs with a rural track Medicare GME affiliation agreement 49075 (August 10, 2022) (see instructions)				0.00	3. 02
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and of IGME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		programs due	e to a Medicare	0. 00	4. 00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instraddling 7/1/2011)		cost report	ing periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap sld instructions)	ots under §1	26 of the CA	AA 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line			nus lines 3 and	17. 91	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic precords (see instructions)	programs for	the current	year from your	14. 32	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri maru Car	0+hor	14. 32	7. 00
		ŀ	Primary Car 1.00	e <u>Other</u> 2.00	Total 3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteopa program for the current year.	athi c	14.		14. 32	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount		14.	0. 00	14. 32	9. 00
	6. For cost reporting periods beginning on or after October 1, if Worksheet S-2, Part I, line 68, is "Y", see instructions.					
	Weighted dental and podiatric resident FTE count for the curre			0.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cur		14	0. 00		10. 01
10. 01		rrent year	14. 15.	0. 00 0. 00		
10. 01 11. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep	rrent year g year (see		0. 00 32 0. 00 99 0. 00		10. 01 11. 00
10. 01 11. 00 12. 00 13. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions)	rrent year g year (see	15. · 15. ·	0. 00 32 99 0. 00 0. 00 85 0. 00		10. 01 11. 00 12. 00 13. 00
10. 01 11. 00 12. 00 13. 00 14. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	rrent year g year (see	15. 15. 15.	0. 00 32 99 0. 00 85 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00
10. 01 11. 00 12. 00 13. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	rrent year g year (see porting by 3).	15. 15. 15. 0.	0. 00 32 99 0. 00 85 0. 00 39 0. 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	g year (see porting by 3).	15. 15. 15.	0. 00 32 99 0. 00 85 0. 00 39 00 00 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr	rrent year g year (see porting by 3). rograms sure	15. 15. 15. 0.	0. 00 32 99 0. 00 85 0. 00 39 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produjustment for residents displaced by program or hospital closs Unweighted adjustment for residents displaced by program or hospital closs closure Adjusted rolling average FTE count	rrent year g year (see porting by 3). rograms sure	15. 15. 15. 0. 0. 0.	0. 00 32 99 0. 00 85 0. 00 39 00 0. 00 00 0. 00 00 00 00 00 00 00 00 00 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	rrent year g year (see porting by 3). rograms sure	15. 15. 15. 0. 0. 0. 15. 104, 184.	0. 00 32 99 0. 00 85 0. 00 39 00 00 00 00 00 00 00 00 00 0		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 17. 00 18. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new produstment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	rrent year g year (see porting by 3). rograms sure	15. 15. 15. 0. 0. 0.	0. 00 32 99 0. 00 85 0. 00 39 0. 00 00 00 00 00 00 00 00 00 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 01 17. 00 18. 00 18. 01 19. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	rrent year g year (see porting by 3). rograms sure pospital	15. 15. 0. 0. 0. 15. 104, 184. 0. 1, 603, 4	0. 00 32 0. 00 99 0. 00 85 0. 00 39 00 00 00 00 00 00 00 00 00 0	1, 603, 405	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00 19. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4)	g year (see porting by 3). rograms sure pospital	15. 15. 0. 0. 0. 15. 104, 184. 0. 1, 603, 4	0. 00 32 0. 00 99 0. 00 85 0. 00 39 00 00 00 00 00 00 00 00 00 0	1, 603, 405 1. 00 0. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	g year (see porting by 3). rograms sure pospital	15. 15. 0. 0. 0. 15. 104, 184. 0. 1, 603, 4	0. 00 32 0. 00 99 0. 00 85 0. 00 39 00 00 00 00 00 00 00 00 00 0	1, 603, 405 1. 00 0. 00 0. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruct Allowable additional direct GME FTE Resident Count (see instruct	g year (see porting by 3). rograms sure pospital	15. 15. 0. 0. 0. 15. 104, 184. 0. 1, 603, 4	0. 00 32 0. 00 99 0. 00 85 0. 00 39 0. 00 00 00 00 00 00 00 00 00 39 0. 00 00 39 0. 00 87 104, 184, 87 00 05 00 00 00 00 00 00 00 00 00 00 00	1, 603, 405 1. 00 0. 00 0. 00 0. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	Unweighted dental and podiatric resident FTE count for the cur Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost rep year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr Adjustment for residents displaced by program or hospital clos Unweighted adjustment for residents displaced by program or ho closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME FT Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	g year (see porting by 3). rograms sure pospital	15. 15. 0. 0. 0. 15. 104, 184. 0. 1, 603, 4	0. 00 32 0. 00 99 0. 00 85 0. 00 39 0. 00 00 00 00 00 00 00 00 00 39 0. 00 00 39 0. 00 87 104, 184, 87 00 05 00 00 00 00 00 00 00 00 00 00 00	1, 603, 405 1. 00 0. 00 0. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der C	CN: 15-0048	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Pre 5/31/2024 2:0	pared:
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
			Inpatient Part A	Managed Care	Total	
			1.00	2.00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	16, 0	66 9, 331		26.00
27. 00	Total Inpatient Days (see instructions)		41, 2	27 41, 227		27.00
28. 00	Ratio of inpatient days to total inpatient days		0. 3896			28.00
29. 00			624, 8		987, 743	
29. 01	Percent reduction for MA DGME			3. 26		29. 01
	Reduction for direct GME payments for Medicare Advantage			11, 831	11, 831	
31.00	Net Program direct GME amount				975, 912	31.00
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL	F XVIII ONI	Y (NURSING PE	ROGRAM AND PARAME		
	EDUCATION COSTS)	L AVIII OIL	(10101110 11	COOLUMN TIND I THOUSE	DI ONE	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum	of col. 20 ar	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, 212, 998	33.00
34. 00	Ratio of direct medical education costs to total charges (lin			,	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		35)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				1
	Part A Reasonable Cost					١
37.00					59, 499, 413	
38. 00 39. 00	Organ acquisition and HSCT acquisition costs (see instruction Cost of physicians' services in a teaching hospital (see inst				0	38.00
	Primary payer payments (see instructions)	i uctions)			25, 829	1
	Total Part A reasonable cost (sum of lines 37 through 39 minu	ıs line 40)			59, 473, 584	
	Part B Reasonable Cost				077 1707 001	1
42. 00					41, 770, 181	42.00
43. 00	Primary payer payments (see instructions)				10, 479	43.00
44. 00	Total Part B reasonable cost (line 42 minus line 43)				41, 759, 702	44.00
45. 00	Total reasonable cost (sum of lines 41 and 44)				101, 233, 286	
	Ratio of Part A reasonable cost to total reasonable cost (lin				0. 587490	
47. 00	Ratio of Part B reasonable cost to total reasonable cost (lin		45)		0. 412510	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B			075 515	٠
	Total program GME payment (line 31)	(!!			975, 912	
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				573, 339	
JU. UU	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see mstr	uc (1 0115)		402, 573	I DU. UL

Heal th	Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES	In Lieu	u of Form CMS-2	552-10
OUTLIE	ER RECONCILIATION AT TENTATIVE SETTLEMEN	NT	Provider CCN: 15-0048	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 2:00	
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E,	Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, I	ine 2			0	2.00
3.00	Operating outlier reconciliation adjus	tment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustm	ent amount (see instruc	tions)		0	4.00
5.00	The rate used to calculate the time va	lue of money (see instr	uctions)		0.00	5.00
6.00	Time value of money for operating expe	nses (see instructions)			0	6.00
7. 00	Time value of money for capital relate	d expenses (see instruc	tions)		o	7. 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

oni y)				127 017 2020	5/31/2024 2:0	0 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	10.750.407				
1.00	Cash on hand in banks	43, 758, 436		0	0	1.00
2.00	Temporary investments	494, 565, 726	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	148, 532, 554		0	0	3. 00 4. 00
5. 00	Other receivable	668, 977, 494	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		1	0	0	6.00
7. 00	Inventory	8, 788, 493		0	0	7.00
8. 00	Prepai d expenses	10, 266, 686		0	0	8.00
9. 00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	100	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1, 290, 344, 064	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	18, 482, 409	1	0	0	12.00
13. 00	Land improvements	10, 348, 915	1	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14.00
15. 00	Bui I di ngs	356, 701, 594	0	0	0	15.00
16. 00	Accumulated depreciation	-222, 057, 944	0	0	0	16.00
17. 00	Leasehold improvements	13, 645, 110		0	0	17.00
18.00	Accumulated depreciation	-10, 063, 115		0	0	18.00
19.00	Fixed equipment	2, 209, 359	0	0	0	19.00
20.00	Accumulated depreciation	-2, 038, 211	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	Maj or movable equipment	230, 687, 531	0	0	0	23.00
24. 00	Accumulated depreciation	-183, 411, 422		0	0	24.00
25. 00	Minor equipment depreciable Accumulated depreciation	0	0	0	0	25. 00 26. 00
26. 00 27. 00	HIT designated Assets		0	0	0	27.00
28. 00	Accumulated depreciation		0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e		0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	214, 504, 226	-	0		30.00
30.00	OTHER ASSETS	214, 304, 220	<u> </u>	<u> </u>		30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	75, 206, 126	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	75, 206, 126	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1, 580, 054, 416	0	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	22, 722, 030	I	0	0	37.00
38. 00	Salaries, wages, and fees payable	16, 516, 575		0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	14, 931, 476	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments Due to other funds	4, 414, 367	0	0	0	42.00
43. 00 44. 00	Other current liabilities		0	0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	58, 584, 448	-	0		
45.00	LONG TERM LIABILITIES	30, 304, 440	0	U	U	45.00
46. 00	Mortgage payable		0	0	0	46.00
47. 00	Notes payable	326, 560, 789	-	0	0	47. 00
48. 00	Unsecured Loans	020,000,707	0	0	0	48. 00
49. 00	Other long term liabilities	2, 875, 444	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	329, 436, 233		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	388, 020, 681	1	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1, 192, 033, 735				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
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	1, 192, 033, 735	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	1, 580, 054, 416	0	0	0	60.00
	[59]	I	I I	ļ	l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0048

					10 12/31/2023	5/31/2024 2:0	
		Genera	l Fund	Speci al	Purpose Fund	Endowment	ļ
				·		Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		1, 134, 239, 734		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		216, 438, 187				2.00
3.00	Total (sum of line 1 and line 2)		1, 350, 677, 921		0		3.00
4. 00	Additions (credit adjustments) (specify)	0			0	0	
5. 00		0			0	0	1
6. 00		0			0	0	
7.00		0			0	0	
8.00		0			0	0	
9.00	Tatal additions (sum of line 4.0)	0			0	0	
10.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		U 1 250 477 021		0		10.00
11.00	, ,	1/1 00/ 752	1, 350, 677, 921		0	0	11.00
12. 00 13. 00	AMOUNTS INCLUDED ON HO COST REPORT AMOUNTS INCLUDED ON HO COST REPORT	161, 904, 753 -3, 260, 567			0		
14. 00	AMOUNTS INCLUDED ON HO COST REPORT	-3, 200, 307			0		
15. 00		0			0		
16. 00		0			0	0	
17. 00		0			0	0	
18. 00	Total deductions (sum of lines 12-17)		158, 644, 186		0	Ĭ	18.00
19. 00	Fund balance at end of period per balance		1, 192, 033, 735	1	0		19.00
	sheet (line 11 minus line 18)		.,,,				
		Endowment	PI ant	Fund			
		Fund					
	I -	6. 00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0			0		2.00
4. 00	Additions (credit adjustments) (specify)	U	_		U		4.00
5. 00	Additions (credit adjustments) (specify)		0				5.00
6. 00			0				6.00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10. 00	Total additions (sum of line 4-9)	0			o		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11.00
12.00	AMOUNTS INCLUDED ON HO COST REPORT		0				12.00
13.00	AMOUNTS INCLUDED ON HO COST REPORT		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				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)			l			

From 01/01/2023 Parts I & II Date/Time Prepared: 12/31/2023 5/31/2024 2:00 pm 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 89, 438, 597 89, 438, 597 2.00 SUBPROVIDER - IPF 2.00 SUBPROVIDER - IRF 3.00 4, 771, 521 4, 771, 521 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 0 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) 94, 210, 118 94, 210, 118 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11, 578, 304 11, 578, 304 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13 00 13 00 SURGICAL INTENSIVE CARE UNIT 14.00 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 16,00 11, 578, 304 11, 578, 304 16,00 11 - 15) 17.00 105, 788, 422 105, 788, 422 Total inpatient routine care services (sum of lines 10 and 16) 17.00 Ancillary services 310, 958, 137 720, 810, 542 1, 031, 768, 679 18.00 18.00 30, 473, 477 19.00 Outpatient services 96, 190, 945 126, 664, 422 19.00 RURAL HEALTH CLINIC 20.00 0 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER O 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, 816, 649 5, 816, 649 26.00 7, 235, 731 27.00 OTHER PATIENT REVENUE 4, 829, 205 2, 406, 526 27.00 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 452, 049, 241 825, 224, 662 1, 277, 273, 903 28.00 G-3, line 1) PART II - OPERATING EXPENSES 29 00 Operating expenses (per Wkst. A, column 3, line 200) 348 760 119 29 00 30.00 ADD (SPECIFY) 0 30.00 31.00 0 31.00 32.00 0 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 39.00 0 39.00 0 40.00 40.00 ō 41.00 41.00 42.00 Total deductions (sum of lines 37-41) 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 348, 760, 119 43.00

Provider CCN: 15-0048

Peri od:

to Wkst. G-3, line 4)

Health Financial Systems	REID HOSPITAL & HEALTH CARE SERVICES	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0048	Peri od:	Worksheet G-3	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	pared:
			5/31/2024 2:0	Opm
			1. 00	
1.00 Total patient revenues (from Wkst	G-2. Part L. column 3. line 28)		1, 277, 273, 903	1.00

	To 12/31/2023	Date/Time Pre 5/31/2024 2:00	
		1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1, 277, 273, 903	1.00
2.00	Less contractual allowances and discounts on patients' accounts	786, 999, 158	2.00
3.00	Net patient revenues (line 1 minus line 2)	490, 274, 745	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	348, 760, 119	4.00
5.00	Net income from service to patients (line 3 minus line 4)	141, 514, 626	5.00
	OTHER I NCOME		
6.00	Contributions, donations, bequests, etc	1, 039, 527	6.00
7.00	Income from investments	59, 824, 340	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	
9.00	Revenue from television and radio service	0	9. 00
10.00	Purchase discounts	0	10.00
11. 00	Rebates and refunds of expenses	0	
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14. 00	Revenue from meals sold to employees and guests	4, 055, 041	
15. 00	Revenue from rental of living quarters	0	
16. 00	Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17. 00	Revenue from sale of drugs to other than patients	0	17. 00
18. 00	Revenue from sale of medical records and abstracts	577	
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)	54, 781	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21. 00	Rental of vending machines	10, 058	1
22. 00	Rental of hospital space	8, 243, 401	
23. 00	Governmental appropriations	0	23. 00
24.00	OTHER INCOME	1, 695, 836	
24. 50	COVI D-19 PHE Fundi ng	0	
25. 00	Total other income (sum of lines 6-24)	74, 923, 561	
26. 00	Total (line 5 plus line 25)	216, 438, 187	
27. 00	OTHER EXPENSES (SPECIFY)	0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)	0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)	216, 438, 187	29. 00

Provider CCN: 15-0048

Peri od:

From 01/01/2023 Hospi ce CCN: 15-1524 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm 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 8 567 2 00 8, 567 8.567 3.00 EMPLOYEE BENEFITS DEPARTMENT* 106, 961 106, 961 25, 484 132, 445 3.00 520, 718 ADMINISTRATIVE & GENERAL* 585, 475 598, 337 4.00 64, 757 12,862 4.00 5.00 PLANT OPERATION & MAINTENANCE* 5.00 0 C 0 LAUNDRY & LINEN SERVICE* 6.00 0 0 0 6 00 7.00 HOUSEKEEPI NG* 0 0 7.00 0 8.00 DI FTARY* 0 2, 432 2, 432 0 2, 432 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* 0 105, 496 105, 496 o 105, 496 12.00 0 VOLUNTEER SERVICE COORDINATION* 0 13 00 0 0 13.00 14.00 PHARMACY* 0 124, 505 124, 505 0 124, 505 14.00 PHYSICIAN ADMINISTRATIVE SERVICES* 0 0 15.00 15.00 OTHER GENERAL SERVICE* 0 0 16,00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25 00 INPATIENT CARE-CONTRACTED* 0 0 n 25.00 PHYSICIAN SERVICES** 26,00 0 C 0 0 0 26.00 27.00 NURSE PRACTITIONER** C 0 27.00 28.00 REGISTERED NURSE** 908.348 908, 348 249, 834 1, 158, 182 28.00 29.00 LPN/LVN** 125, 453 29.00 114, 267 0 114, 267 11, 186 PHYSI CAL THERAPY** 30.00 C \cap 0 0 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 COUNSELING - OTHER** 36.00 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES** 115, 994 37 00 115 994 Ω 59 243 175 237 37 00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 C C 0 38.00 39.00 PATIENT TRANSPORTATION** 0 0 0 0 39.00 C 40.00 IMAGING SERVICES** 0 0 0 40.00 0 LABS & DLAGNOSTICS*3 0 41 00 0 41 00 MEDICAL SUPPLIES-NON-ROUTINE** 42.00 0 252, 975 252, 975 39,866 292, 841 42.00 DRUGS CHARGED TO PATIENTS** 0 42.50 42.50 43 00 OUTPATIENT SERVICES* 0 C O 0 43 00 0 PALLIATIVE RADIATION THERAPY** 0 44.00 C 0 0 0 44.00 PALLIATIVE CHEMOTHERAPY** 0 0 45.00 45.00 0 0 OTHER PATIENT CARE SERVICES (SPECIFY) ** 0 691, 091 691, 091 691, 091 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 C 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 3, 017, 911 396, 3, 414, 586 100. 00 100.00 TOTAL 1, 659, 327 1, 358, 584 675

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

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

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/31/2024 2:00 pm 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				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	8, 567		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	132, 445		3.00
4.00	ADMINISTRATIVE & GENERAL*	-6, 196	592, 141		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	0		7. 00
8.00	DI ETARY*	0	2, 432		8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDI CAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	105, 496		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0)	13.00
14.00	PHARMACY*	0	124, 505		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0)	15.00
16.00	OTHER GENERAL SERVI CE*	0	0)	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED**	0	0		25. 00
26.00	PHYSI CI AN SERVI CES**	0	0)	26. 00
27.00	NURSE PRACTITIONER**	0	0)	27. 00
28.00	REGISTERED NURSE**	0	1, 158, 182		28.00
29. 00	LPN/LVN**	0	125, 453	•	29.00
30. 00	PHYSI CAL THERAPY**	0	0		30.00
31. 00	OCCUPATIONAL THERAPY**	0	0	•	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33. 00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34. 00	SPIRITUAL COUNSELING**	0	0	1	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	175, 237	1	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39. 00	PATIENT TRANSPORTATION**	0	0	1	39.00
40. 00	I MAGI NG SERVI CES**	0	0	1	40.00
41. 00	LABS & DI AGNOSTI CS**	0	0	1	41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**	0	292, 841	1	42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0	1	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	691, 091	1	46. 00
40.00	NONREI MBURSABLE COST CENTERS	<u> </u>	071, 071	I.	40.00
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61. 00	VOLUNTEER PROGRAM *	0	0	1	61.00
62. 00	FUNDRAI SI NG*	0	0	1	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0	1	64.00
	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
	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
	THRIFT STORE*	0	0		69.00
	NURSING FACILITY ROOM & BOARD*	0	0	•	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	1	71.00
	TOTAL	-6, 196	3, 408, 390		100.00
	usfer the amounts in column 7 to Wkst 0-5 co			'I	

^{*} 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.

					0,01,2021 210	0 0
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED						25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	0.00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27.00
28. 00 REGI STERED NURSE	908, 348	0	908, 348	0	908, 348	
29. 00 LPN/LVN	114, 267	0	114, 267	0	114, 267	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00 DIETARY COUNSELING	0	0	0	0	0	35.00
36. 00 COUNSELING - OTHER	O	0	0	o	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	115, 994	o	115, 994	o	115, 994	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	o	0	o	0	38.00
39. 00 PATIENT TRANSPORTATION	o	0	0	ol	0	39.00
40.00 I MAGING SERVICES	o	0	0	ol	0	40.00
41.00 LABS & DIAGNOSTICS	o	o	0	o	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	o	252, 975	252, 975	o	252, 975	42.00
42.50 DRUGS CHARGED TO PATIENTS	o	0	0	o	0	l
43. 00 OUTPATIENT SERVICES	o	o	0	ol	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	o	o	0	ol	0	44.00
45. 00 PALLIATIVE CHEMOTHERAPY	o	o	0	ol	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	o	691, 091	691, 091	ol	691, 091	46.00
100. 00 TOTAL *	1, 138, 609	944, 066	2, 082, 675	ol	2, 082, 675	
* Transfer the amount in column 7 to Wkst O.E. col		,	, ,	-1	, ,	

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS		I		
25. 00	I NPATI ENT CARE-CONTRACTED	_	_		25. 00
26. 00	PHYSI CI AN SERVI CES	0	0		26. 00
27. 00	NURSE PRACTITIONER	0	0		27. 00
28. 00	REGI STERED NURSE	0	908, 348	1	28. 00
29. 00	LPN/LVN	0	114, 267		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	115, 994		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	252, 975		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	691, 091		46.00
100.00	TOTAL *	0	2, 082, 675		100.00

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

From 01/01/2023 To 12/31/2023 RESPITE CARE Date/Time Prepared: 5/31/2024 2:00 pm Hospi ce CCN: 15-1524

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED		0	0	0	0	
26.00 PHYSICIAN SERVICES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	0	0	42, 297	42, 297	ı
29. 00 LPN/LVN	0	0	0	1, 894	1, 894	
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, 030	10, 030	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/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	6, 749	6, 749	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	60, 970	60, 970	100. <u>0</u> 0
* Transfer the amount in column 7 to Wkst 0-5 col	ump 1 lino 52					

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

ADJUSTMENTS TOTAL (col . 5 ± col . 6)					
DIRECT PATIENT CARE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ADJUSTMENTS	TOTAL (col. 5	
DIRECT PATIENT CARE SERVICE COST CENTERS				± col. 6)	
25. 00 INPATIENT CARE-CONTRACTED 0 0 0 26. 00 26. 00 26. 00 27. 00 0 26. 00 27. 00 0 0 28. 00 27. 00 0 0 28. 00 27. 00 0 28. 00 29. 00 0 29. 00 29			6. 00	7. 00	
26. 00 PHYSI CI AN SERVI CES 0 0 0 0 27. 00 NURSE PRACTI TI ONER 0 0 0 27. 00 NURSE PRACTI TI ONER 0 0 0 27. 00 NURSE PRACTI TI ONER 0 0 0 27. 00 NURSE PRACTI TI ONER 0 0 42, 297 28. 00 PHYSI CAL TRERAPY 0 1, 894 29. 00 29. 00 PHYSI CAL THERAPY 0 0 0 0 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 32. 00 31. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32. 00 33. 00 MEDI CAL SCOL AL SERVI CES 0 0 0 0 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 35. 00 COUNSELI NG - OTHER 0 0 0 35. 00 DI WABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10, 030 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38. 00 40. 00 1 MAGI NG SERVI CES 0 0 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 41. 00 LABS & DI AGNOSTI CS 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 44. 00 44. 00 PALLI ATTI VE CADI DATI THERAPY 0 0 0 44. 00 44. 00 PALLI ATTI VE CHEMOTHERAPY 0 0 0 44. 00 44. 00 PALLI ATTI VE CHEMOTHERAPY 0 0 0 44. 00 44. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00		DIRECT PATIENT CARE SERVICE COST CENTERS			
27. 00 NURSE PRACTITIONER 0 0 27. 00 28. 00 REGISTERED NURSE 0 42, 297 28. 00 29. 00 LPN/LVN 0 1, 894 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 MEDI CAL SOCI AL SERVI CES 0 0 0 34. 00 SPIRI TUAL COUNSELI NG 0 0 0 35. 00 DISTARY COUNSELING 0 0 0 36. 00 COUNSELING - OTHER 0 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 0 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI IENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGING SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 41. 00 42. 50	25.00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
28. 00 REGISTERED NURSE 0 42, 297 28. 00 29. 00 LPN/LVN 0 1, 894 29. 00 30. 00 PHYSI CAL THERAPY 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 31. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 36. 00 COUNSELI NG - 0 THER 0 0 0 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10, 030 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 40. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00	26.00	PHYSI CI AN SERVI CES	0	0	26.00
29. 00 LPN/LVN	27.00	NURSE PRACTITIONER	0	0	27.00
30. 00 PHYSI CAL THERAPY 0 0 0 0 31. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 0 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10, 030 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I IMAGI NG SERVI CES 0 0 0 0 39. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 42. 50 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 6	28. 00	REGI STERED NURSE	0	42, 297	28. 00
31. 00 OCCUPATI ONAL THERAPY 0 0 0 32. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 0 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10, 030 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6, 749 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0	29. 00	LPN/LVN	0	1, 894	29. 00
32.00 SPEECH/LANGUAGE PATHOLOGY 33.00 MEDI CAL SOCI AL SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	PHYSI CAL THERAPY	0	0	30.00
33. 00 MEDI CAL SOCI AL SERVI CES 34. 00 SPI RI TUAL COUNSELI NG 35. 00 DI ETARY COUNSELI NG 36. 00 COUNSELI NG O O O 36. 00 COUNSELI NG O O O 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 39. 00 PATI ENT TRANSPORTATI ON O O 39. 00 IMAGI NG SERVI CES 0 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 O O O 41. 00 LABS & DI AGNOSTI CS 0 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 CALBO DRUGS CHARGED TO PATI ENTS 0 DO O O 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 CALBO DRUGS CHARGED TO PATI ENTS 0 DRUGS CHARGED TO PATI ENTS 0 O O O 45. 00 PALLI ATI VE RADI ATI ON THERAPY 0 PALLI ATI VE CHEMOTHERAPY 0 O THER PATI ENT CARE SERVI CES (SPECI FY) 0 O O O 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)	31.00	OCCUPATI ONAL THERAPY	0	0	31.00
34. 00 SPIRITUAL COUNSELING 0 0 0 35. 00 35. 00 DI ETARY COUNSELING 0 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 10, 030 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 41. 00 LABS & DIAGNOSTICS 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 6, 749 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 0 42. 50 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 44. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46. 00	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
35. 00 DI ETARY COUNSELI NG 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10,030 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 41. 00 LABS & DI AGNOSTI CS 0 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6,749 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 43. 00 UTPATI ENT SERVI CES 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0	33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
36. 00 COUNSELING - OTHER 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10, 030 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 41. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6, 749 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 00 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 46. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00	34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 10,030 37.00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38.00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39.00 40. 00 I MAGI NG SERVI CES 0 0 40.00 41. 00 LABS & DI AGNOSTI CS 0 0 41.00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6,749 42.00 42. 00 DRUGS CHARGED TO PATI ENTS 0 0 42.50 43. 00 OUTPATI ENT SERVI CES 0 0 43.00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44.00 45. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46.00	35.00	DI ETARY COUNSELING	0	0	35.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 39. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6, 749 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 42. 50 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 46. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00	36.00		0	0	36.00
39.00 PATIENT TRANSPORTATION 0 0 0 0 0 40.00 1 MAGING SERVICES 0 0 0 0 41.00 LABS & DIAGNOSTICS 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 6,749 42.00 DRUGS CHARGED TO PATIENTS 0 0 0 42.50 UTPATIENT SERVICES 0 0 0 42.50 43.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 46.00 UTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	10, 030	37.00
40.00 IMAGING SERVICES	38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
41.00 LABS & DIAGNOSTICS 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 6,749 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00	39. 00	PATI ENT TRANSPORTATION	0	0	39.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 6,749 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46. 00	40.00	I MAGING SERVICES	0	0	40.00
42.50 DRUGS CHARGED TO PATIENTS 0 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0	41.00	LABS & DIAGNOSTICS	0	0	41.00
43.00 OUTPATIENT SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	6, 749	42.00
44.00 PALLIATIVE RADIATION THERAPY 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	43.00	OUTPATI ENT SERVI CES	0	0	43.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	44.00		0	0	44.00
		l control of the cont	0	0	45.00
100. 00 TOTAL * 0 60, 970 100. 00			0	0	46.00
	100.00	TOTAL *	0	60, 970	100.00

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

					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						
25.00	I NPATI ENT CARE-CONTRACTED		0	0	0	0	25.00
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	207, 537	207, 537	
29. 00	LPN/LVN	0	0	0	9, 292	9, 292	29. 00
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	SPI RI TUAL COUNSELI NG	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	49, 213	49, 213	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	33, 117	33, 117	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	299, 159	299, 159	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5. col	umn 1. line 53.				·	

 $^{^{\}star}$ 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	INPATIENT 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	207, 537	28. 00
29. 00	LPN/LVN	0	9, 292	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	49, 213	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 & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	33, 117	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	299, 159	100.00

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

Health Financial Systems	REID HOSPITAL & HEALT	H CARE SERVICES	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - DETERMINATION OF	HOSPITAL-BASED HOSPICE NET	Provi der CCN: 15-0048		Worksheet 0-5
EXPENSES FOR ALLOCATION		H CON 15 1524	From 01/01/2023	

EXPENS	ES FOR ALLOCATION	Hospi ce CCI		From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 2:0	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
	·		DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)		2)	
			ĺ	(see	ŕ	
				instructions)		
			1.00	2.00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FLXT		(12, 206	12, 206	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		8, 56	7 0	8, 567	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		132, 445	396, 753	529, 198	3.00
4.00	ADMI NI STRATI VE & GENERAL		592, 14°	1, 027, 088	1, 619, 229	4.00
5.00	PLANT OPERATION & MAINTENANCE		(0	0	5.00
6.00	LAUNDRY & LINEN SERVICE		(0	0	6.00
7.00	HOUSEKEEPI NG		(3, 556	3, 556	7.00
8. 00	DIETARY		2, 432		2, 432	8.00
9. 00	NURSI NG ADMI NI STRATI ON		, (0	9.00
10.00	ROUTINE MEDICAL SUPPLIES		(0	0	10.00
11. 00	MEDICAL RECORDS		(1, 212	1, 212	11. 00
12. 00	STAFF TRANSPORTATION		105, 496	· ·	105, 496	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		(00)		0	13.00
14. 00	PHARMACY		124, 50	167, 939	292, 444	14. 00
	PHYSI CI AN ADMI NI STRATI VE SERVI CES		.2., 000	107,707	0	15. 00
16. 00	OTHER GENERAL SERVICE		Ċ	0	0	16. 00
	PATIENT/RESIDENTIAL CARE SERVICES			47, 363	47, 363	17. 00
	LEVEL OF CARE			,	11,000	
50.00	HOSPICE CONTINUOUS HOME CARE		(0	50.00
51. 00	HOSPICE ROUTINE HOME CARE		2, 082, 67		2, 082, 675	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE		60, 970		60, 970	52.00
53. 00	HOSPI CE GENERAL I NPATI ENT CARE		299, 159		299, 159	53.00
	NONREI MBURSABLE COST CENTERS			· <u> </u>		
60.00	BEREAVEMENT PROGRAM		(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	RESI DENTI AL CARE		(0	66.00
67. 00	ADVERTI SI NG		Č		0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		Č		0	68. 00
69. 00			Č		0	69.00
70. 00	NURSING FACILITY ROOM & BOARD		ì		0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)		Č		Ö	71.00
99. 00	NEGATI VE COST CENTER		ì	ol .	0	99.00
100.00			3, 408, 390	1, 656, 117	Ŭ	
	1 · - · · · -	!	5, .55, 67	., 555, 117	5,55.,567	

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

From 01/01/2023 Part I Hospi ce CCN: 15-1524 12/31/2023 Date/Time Prepared: To 5/31/2024 2:00 pm Hospi ce I TOTAL CAP REL BLDG CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions **EXPENSES** & FIX EQUI P **BENEFITS DEPARTMENT** 0 1.00 2.00 3.00 ЗА GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 12, 206 12, 206 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 8, 567 2.00 8.567 3.00 EMPLOYEE BENEFITS DEPARTMENT 529, 198 4, 283 533, 481 3.00 ADMINISTRATIVE & GENERAL 1, 619, 229 12, 206 140, 064 1, 771, 499 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 5.00 0 LAUNDRY & LINEN SERVICE 0 6.00 0 C 0 0 6.00 7.00 HOUSEKEEPI NG 3, 556 0 3, 556 7.00 8.00 DI ETARY 2, 432 0 0 0 2, 432 8.00 0 NURSING ADMINISTRATION 0 9.00 0 0 9.00 0 ROUTINE MEDICAL SUPPLIES 0 0 10.00 0 Λ 10.00 11.00 MEDICAL RECORDS 1, 212 0 0 0 0 1, 212 11.00 12.00 STAFF TRANSPORTATION 105, 496 0 105, 496 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 0 0 0 13.00 14.00 PHARMACY 292, 444 0 0 0 292, 444 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 0 0 0 OTHER GENERAL SERVICE 0 16.00 16.00 0 0 0 0 PATIENT/RESIDENTIAL CARE SERVICES 0 47, 363 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 n 50.00 HOSPICE ROUTINE HOME CARE 2, 082, 675 298.883 2, 381, 558 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 60, 970 C 722 16, 005 77, 697 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 299, 159 0 3, 562 78, 529 381, 250 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 0 0 0 61.00 FUNDRAI SI NG 0 o 62.00 0000000 0 0 62.00 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 0 63.00 0 PALLIATIVE CARE PROGRAM 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 0 RESIDENTIAL CARE 0 0 66.00 0 66.00 67 00 ADVERTI SI NG 0 0 0 67 00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 0 0 68.00 0 69.00 THRIFT STORE C 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 0 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71 00 O 71.00 C 0 0 99.00 NEGATIVE COST CENTER 0 C 0 99.00

5, 064, 507

12, 206

8, 567

533, 481

5, 064, 507 100. 00

Provi der CCN: 15-0048

Peri od:

100.00 TOTAL

0

3, 740 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 15-1524 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm Hospi ce I ADMI NI STRATI V PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY Descriptions 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 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 1, 771, 499 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 1, 913 5, 469 7.00 8.00 DI ETARY 1, 308 0 0 3,740 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 652 0 11.00 12.00 STAFF TRANSPORTATION 56, 752 0 12.00 0 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 0 14.00 PHARMACY 157, 323 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 OTHER GENERAL SERVICE 0 16.00 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 17.00 25, 479 C 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 50.00 HOSPICE ROUTINE HOME CARE 1, 281, 178 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 41, 798 C 0 922 633 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 205, 096 0 0 4,547 3, 107 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 62.00 0000000 0 0 0 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 0 68.00 68.00 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 71.00 0 0 0 99.00

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1, 771, 499

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5, 469

99.00 NEGATIVE COST CENTER

100.00 TOTAL

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0 99.00

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0

162, 248

1, 864

68.00

69.00

70.00

71.00

0 100.00

In Lieu of Form CMS-2552-10 Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2023 Part I Date/Time Prepared: Hospi ce CCN: 15-1524 12/31/2023 5/31/2024 2:00 pm 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 1,864 11.00 12.00 STAFF TRANSPORTATION 162, 248 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 50.00 162, 248 0 50.00 0 1, 757 HOSPICE ROUTINE HOME CARE 51.00 51.00 0 0 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 18 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 89 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

0 0 0

68.00

69.00

70.00

71 00

100.00 TOTAL

THRIFT STORE

99.00 NEGATIVE COST CENTER

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

0

0 99.00

5, 064, 507 100. 00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provi der CCN: 15-0048 Peri od: Worksheet 0-6 From 01/01/2023 Part I Hospi ce CCN: 15-1524 12/31/2023 Date/Time Prepared: To 5/31/2024 2:00 pm 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 449, 767 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 OTHER GENERAL SERVICE 16,00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 72, 842 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 162, 248 50.00 0 HOSPICE ROUTINE HOME CARE 423, 939 4, 088, 432 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 4, 372 0 12, 331 137, 771 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 21, 456 0 60, 511 676,056 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

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0

449, 767

0

0

0

72, 842

71 00

100.00 TOTAL

99. 00 NEGATI VE COST CENTER

Health Financial Systems	REID HOSPITAL & HEALTH	I CARE SERVICES		In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-0048	Peri od:	Worksheet 0-6

	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE TICAL BASIS	ERVICE COSTS	Provi der CC Hospi ce CCI		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
					Heeni ee I	5/31/2024 2:0	0 pm
	Cost Center Descriptions	CAD DEL DIDO	CAP REL MVBLE	EMPLOYEE	Hospi ce I	ADMI NI STRATI V	
	cost center bescriptions	& FLX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT	IV	(ACCUMULATED	
		(SQUARE LELT)	VALUE)	(GROSS		COSTS)	
			VALUE)	SALARI ES)		(0313)	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00		1. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	445					1.00
2. 00	CAP REL COSTS-MVBLE EQUIP		890				2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0			8		3.00
4. 00	ADMI NI STRATI VE & GENERAL	445		533, 580		3, 293, 008	4.00
5. 00	PLANT OPERATION & MAINTENANCE	0	l ő		0 0	0,2,0,000	5.00
6. 00	LAUNDRY & LINEN SERVICE	0	l ő		0	0	6.00
7. 00	HOUSEKEEPI NG	0	0		0	3, 556	7.00
8. 00	DI ETARY	0	0		0	2, 432	8.00
9. 00	NURSING ADMINISTRATION	0	0			0	9.00
10. 00	ROUTINE MEDICAL SUPPLIES	0				Ö	10.00
11. 00	MEDICAL RECORDS	0				1, 212	
12. 00	STAFF TRANSPORTATION	0				105, 496	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0				0 103, 470	13.00
14. 00	PHARMACY	0)		292, 444	l
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		l '		272, 444	15.00
16. 00	OTHER GENERAL SERVICE	0		l '	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		,	0	-	•
17.00	LEVEL OF CARE	0	0			47, 303	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE			1, 138, 60	-		•
52. 00	HOSPICE INPATIENT RESPITE CARE	0	75			,	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	l .			, , , , , , , , , , , , , , , , , , , ,	1
00.00	NONREI MBURSABLE COST CENTERS		070	277, 10	,, ,	001, 200	00.00
60. 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0		0	0	61.00
62. 00	FUNDRAI SI NG	0	0			Ō	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	l ő		0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	l ő		0	0	65.00
66. 00	RESI DENTI AL CARE	0	l ő		0	Ö	66.00
67. 00	ADVERTI SI NG	0	l o		0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	l o		0	Ö	68.00
69. 00	THRIFT STORE	l 0	l o		0 0	o o	69.00
70. 00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	n		ol o	0	71.00
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	12, 206	8, 567	533, 48 ⁻	1	1, 771, 499	1
	UNIT COST MULTIPLIER	27. 429213				0. 537958	
	1				1	1 2:22:700	

Health Financial	Systems	REID HOSPITAL & HEALTH	H CARE SERVICES	I	n Lieu of Form CMS-2552-10
COCT ALLOCATION	LIOCOL TAL D	ACED HOSDICE CENEDAL CEDVICE COCTS	Dravi dan CCN, 1E 0040	Darri ad.	Waskahaat O (

Peri od: From 01/01/2023 To 12/31/2023 OST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Worksheet 0-6 Part II STATISTICAL BASIS Date/Time Prepared: Hospi ce CCN: 15-1524 5/31/2024 2:00 pm Hospi ce I Cost Center Descriptions LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG PLANT (IN-FACILITY OPERATION & LINEN SERVICE (SQUARE FEET) ADMI NI STRATI O MAI NTENANCE (IN-FACILITY DAYS) (DI RECT NURS. (SQUARE FEET) DAYS) HRS.) 5. 00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 1 00 1 00 CAP REL COSTS-BLDG & FIXT 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 5.00 445 5.00 6.00 LAUNDRY & LINEN SERVICE 0 445 6.00 0 7.00 HOUSEKEEPI NG 445 7.00 8.00 DIFTARY 1, 211 8.00 \cap NURSING ADMINISTRATION 9.00 0000 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 11.00 MEDICAL RECORDS 0 11.00 0 0 STAFF TRANSPORTATION 12.00 0 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 13.00 0 0 14.00 **PHARMACY** 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 16.00 OTHER GENERAL SERVICE 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 0 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 50.00 51.00 HOSPICE ROUTINE HOME CARE 0 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 75 75 75 205 0 52.00 53 00 HOSPICE GENERAL INPATIENT CARE 370 370 370 1,006 Ω 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 00000000 0 61.00 0 62 00 FUNDRAI SI NG 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 64.00 OTHER PHYSICIAN SERVICES 65.00 0 0 65.00 66.00 RESIDENTIAL CARE 0 Ω 66.00 0 0 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 71.00 99.00 99. 00 NEGATI VE COST CENTER 0 100.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 5.469 3.740

0.000000

0.000000

12. 289888

3.088357

0.000000 101.00

101.00 UNIT COST MULTIPLIER

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

Hear th	Financiai Systems Reid	HUSPITAL & HEALT	IH CARE SERVI	CES	in Lie	u of form CMS	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	ERVICE COSTS	Provi der C	CN: 15-0048	Peri od: From 01/01/2023	Worksheet 0-6 Part II)
STATES	TICAL BASIS		Hospi ce CC		To 12/31/2023	Date/Time Pre	pared:
					Hospi ce I	5/31/2024 2:0	00 pm
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	Cost center beserretrons	MEDI CAL	RECORDS	TRANSPORTATIO		(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON	(======================================	
		(PATIENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)	ŕ	, ,	SERVICE)		
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00 10. 00	NURSI NG ADMI NI STRATI ON	21, 088					9.00
11. 00	ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS	21,088	21, 088				11.00
12.00	STAFF TRANSPORTATION		21,088	1, 00			12.00
13. 00	VOLUNTEER SERVICE COORDINATION			1	0 0		13.00
14. 00	PHARMACY				0 0	21, 088	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	21,000	1
16. 00	OTHER GENERAL SERVICE			1		0	1
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	1, 00	0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	19, 877	19, 877		0	19, 877	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205	205		0 0	205	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 006	1, 006		0	1, 006	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			1	0	0	
61. 00	VOLUNTEER PROGRAM			1	0	0	61.00
62. 00	FUNDRAI SI NG				0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	
64.00	PALLIATIVE CARE PROGRAM				0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65.00
66. 00 67. 00	RESI DENTI AL CARE				0	0	66. 00 67. 00
68.00	ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG				0 0	0	68.00
69.00	THRIFT STORE			1	0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					U	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	1
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	1, 864	162, 24	8 0	449, 767	
	UNIT COST MULTIPLIER	0. 000000	0. 088392				
	1						

Health Financial Systems REID HOSPITAL & HEALTH CARE SERVICES

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

STATISTICAL BASIS Provi der CCN: 15-0048 | Peri od: From 01/01/2023 | Worksheet 0-6 | Part II |

Hospi ce CCN: 15-1524 | To 12/31/2023 | Date/Ti me Prepared: 5/31/2024 2: 00 pm

						5/31/2024 2:0	00 pm
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICES			
		(PATI ENT	BASIS)	(IN-FACILITY			
		DAYS)		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9.00
10.00							1
	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14. 00	PHARMACY						14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	21, 088					15.00
16. 00	OTHER GENERAL SERVICE		1, 211				16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			1, 211			17. 00
	LEVEL OF CARE				1		
50. 00	HOSPICE CONTINUOUS HOME CARE	0		1			50.00
51. 00	HOSPICE ROUTINE HOME CARE	19, 877	l .				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	205					52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 006	1, 006	1, 006			53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		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 PHYSICIAN SERVICES		0				65.00
66.00	RESI DENTI AL CARE	0	0	0			66.00
67.00	ADVERTI SI NG						67.00
68.00	TELEHEALTH/TELEMONI TORI NG						68.00
69.00	THRI FT STORE		0				69.00
70. 00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0			71.00
99. 00	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	n	0	72, 842			100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000				101.00
	I The state of the			1	I .		1

LEVEL OF CARE

Cost Center Descriptions
Cost Center Descriptions
Part I, Col. 9 line
Part I, Col. 9 line
Part I, Col. 9 line
Second S
ANCILLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS
1.00 PHYSI CAL THERAPY 66.00 0.693710 0 0 0 1.00
3. 00 SPEECH PATHOLOGY 68. 00 3. 00 4. 00 4. 00 DRUGS CHARGED TO PATIENTS 73. 00 0. 328533 0 0 0 0 4. 00 5. 00 5. 00 DURABLE MEDI CAL EQUI P-RENTED 96. 00 1. 837387 0 0 0 0 5. 00 6. 00 0. 164205 0 0 0 0 0 0. 00 0 0 0
4. 00 DRUGS CHARGED TO PATIENTS 5. 00 DURABLE MEDICAL EQUIP-RENTED 96. 00 1. 837387 0 0 0 0 5. 00 6. 00 LABORATORY 60. 00 0. 164205 0 0 0 0 6. 00 7. 00 MEDICAL SUPPLIES CHARGED TO PATIENT 71. 00 0. 000000 0 0 0 0 7. 00 8. 00 FAMILY PRACTICE 93. 00 0. 427106 0 0 0 0 8. 00 10. 00 ANCILLARY - OTHER 76. 00 0. 000000 0 0 0 0 10. 00 10. 97 CARDIAC REHABILITATION 11. 00 Total's (sum of lines 1-11) Charges by LOC (from Provider Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
S. 00 DURABLE MEDI CAL EQUI P-RENTED 96.00 1.837387 0 0 0 5.00
60.00 Charges by Cost Center Descriptions Cost Center Description Cost Cen
7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 71. 00 0. 000000 0 0 0 0 7. 00 8. 00 FAMI LY PRACTI CE 93. 00 0. 427106 0 0 0 8. 00 9. 00 10. 00 ANCI LLARY - OTHER 76. 00 0. 000000 0 0 0 0 10. 00 10. 00 10. 97 Total s (sum of lines 1-11) Charges by LOC (from Provi der Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 2 HGIP (col.
8. 00 FAMILY PRACTICE 93. 00 0. 427106 0 0 0 8. 00 9. 00 10. 00 10. 00 9. 00 10
9. 00 RADI OLOGY-THERAPEUTI C 55. 00 10. 00 ANCI LLARY - OTHER 76. 00 76. 00 0. 000000 0 0 0 10. 00 10. 97 CARDI AC REHABI LI TATI ON 76. 97 0. 526304 0 0 0 0 10. 97 11. 00 Total's (sum of lines 1-11) Charges by LOC (from Provi der Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
10. 00 ANCI LLARY - OTHER 76. 00 0. 000000 0 0 0 10. 00 10. 97 CARDI AC REHABI LI TATI ON 76. 97 0. 526304 0 0 0 10. 97 11. 00 Total's (sum of lines 1-11) Charges by LOC (from Provi der Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
11.00 Totals (sum of lines 1-11) Charges by LOC (from Provi der Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
Charges by LOC (from Provi der Records) Cost Center Descriptions Charges by Shared Service Costs by LOC HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
LOC (from Provi der Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
Provider Records) Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
Records Records HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
Cost Center Descriptions HGIP HCHC (col. 1 HRHC (col. 1 HIRC (col. 1 HGIP (col. 1
x col. 2) x col. 3) x col. 4) x col. 5)
5.00 6.00 7.00 8.00 9.00
ANCILLARY SERVICE COST CENTERS 1 00 PHYSICAL THERAPY 0 0 0 0 0 0 1 00
1. 00 PHYSI CAL THERAPY 0 0 0 0 1. 00 2. 00 OCCUPATI ONAL THERAPY 2. 00
3. 00 SPEECH PATHOLOGY 3. 00
4.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 4.00
5. OO DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 5. OO
6.00 LABORATORY 0 0 0 0 0 6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 7.00
8.00 FAMILY PRACTICE 0 0 0 0 8.00
9. 00 RADI OLOGY-THERAPEUTI C 9. 00 10. 00 ANCI LLARY - OTHER 9. 00 0 0 10. 00
10. 00 ANCI LLARY - OTHER
11. 00 Totals (sum of lines 1-11)

n Financial Systems	REID HOSPITAL & HEALTH	I CARE	E SER	VI CES	In Lie	ı of Form	CMS-2552-10

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Heal th	Financial Systems REID HOSPITAL & HEALTI	H CARE SERVI	CES		In Lie	u of Form CMS-2	2552-10
Hospice CDN: 15-1524 To 12/31/2023 Date/Time Prepared: 5/31/2024 2:00 pm	CALCUI	ATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provi der CC	CN: 15-0048			Worksheet 0-8	
HOSPICE CONTINUOUS HOME CARE			Hoopi oo CCN	N. 1E 1E24			Doto/Timo Dro	narad:
Hospice Hospice Hospice Hospice			nospi ce cci	N. 15-1524	10	12/31/2023		
NEDICARE MEDICAID					H	Hospice I		
HOSPICE CONTINUOUS HOME CARE				TITLE XVIII		TITLE XIX	TOTAL	
HOSPICE CONTINUOUS HOME CARE				MEDI CARE		MEDI CAI D		
Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)				1.00		2. 00	3. 00	
1								
Total unduplicated days (Wkst. S-9, col. 4, line 10)	1. 00		7, col. 6,				162, 248	1. 00
Total average cost per diem (line 1 divided by line 2) 0.00 3.00 4.00 4.00 4.00 6.00								
4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 0 0 0 0 5.00							- 1	
5.00 Program cost (line 3 times line 4) 0 0 0			>			_	0. 00	
HOSPICE ROUTINE HOME CARE 6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 17, 341 369 9.00 Program cost (line 8 times line 9) 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 12.00 Total average cost per diem (line 11 divided by line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated days (Wkst. S-9, col. 4, line 12) 15.00 Program cost (line 13 times line 14) HOSPICE GENERAL INPATIENT CARE 16.00 Total unduplicated days (Wkst. S-9, col. 4, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13)			ie 10)		-			
6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 17, 341 369 9.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 10, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 10, 00 Total unduplicated days (Wkst. S-9, col. 4, line 13)	5.00				0	0		5.00
I ine 11 Total unduplicated days (Wkst. S-9, col. 4, line 11) 19,877 7.00 19,877 7.00 10			7 7 1				4 000 400	
7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 17, 341 369 9.00 Program cost (line 8 times line 9) HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 12.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19,877 7.00 205.69 8.00 9.00 10.00	6.00		·/, COI. /,				4, 088, 432	6.00
8.00 Total average cost per diem (line 6 divided by line 7) 205.69 8.00 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 17,341 369 9.00 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11) 137,771 11.00 137,771 11.00 13.00 14.00 Unduplicated days (Wkst. S-9, col. 4, line 12) 205 12.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 15.00 HOSPICE GENERAL INPATIENT CARE 13,576 0 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00	7 00						10 077	7 00
9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 17,341 369 75,900 10.00 Program cost (line 8 times line 9) 3,566,870 75,900 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, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 205 12.00 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 Program cost (line 13 times line 14) 113,576 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, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00								
10.00 Program cost (line 8 times line 9) 3,566,870 75,900 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, line 11) 205 12.00 13.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 205 12.00 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 15.00 Program cost (line 13 times line 14) 113,576 0 15.00 HOSPICE GENERAL INPATIENT CARE 10.00 Total unduplicated days (Wkst. S-9, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 676,056 16.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00			no 11)	17.0	11	240	205. 69	
HOSPICE INPATIENT RESPITE CARE			ne ii)					
11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 169 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 17.00 Total unduplicated days (Wkst. S-9, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13)	10.00			3, 300, 6	70	75, 900		10.00
1 ine 11 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 205 12.00 13.00 Total average cost per diem (line 11 divided by line 12) 672.05 13.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 15.00 Program cost (line 13 times line 14) 113,576 0 15.00 HOSPICE GENERAL INPATIENT CARE 676,056 16.00 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00	11 00		7 col 9				127 771	11 00
12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 205 12.00 13.00 14.00 14.00 14.00 15.00 16.00 1	11.00		7, 601. 0,				137, 771	11.00
13.00 Total average cost per diem (line 11 divided by line 12) 672.05 13.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 15.00 Program cost (line 13 times line 14) 113,576 0 15.00 HOSPICE GENERAL INPATIENT CARE Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 676,056 16.00 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00	12 00						205	12 00
14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 169 0 14.00 15.00 Program cost (line 13 times line 14) 113,576 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, line 11) 676,056 16.00 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00								
15.00 Program cost (line 13 times line 14) 113,576 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, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00			ne 12)	1	69	0		
HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 13)			,			- 1		
line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00				,		- 1		
17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 1,006 17.00	16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,				676, 056	16.00
		line 11)						
	17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					1, 006	17.00
18.00 Total average cost per diem (line 16 divided by line 17) 672.02 18.00	18.00	Total average cost per diem (line 16 divided by line 17)					672. 02	18.00
19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 884 27 19.00	19.00		ne 13)	8	84			
20.00 Program cost (line 18 times line 19) 594,066 18,145 20.00	20.00			594, 0	66	18, 145		20.00
TOTAL HOSPICE CARE								
21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 5,064,507 21.00								
22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 21,088 22.00								
23.00 Average cost per diem (line 21 divided by line 22) 240.16 23.00	23. 00	Average cost per diem (line 21 divided by line 22)	l				240. 16	23. 00

				6.5. 000	
	Financial Systems REID HOSPITAL & HEALTATION OF CAPITAL PAYMENT	Provi der CCN: 15-0048	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 2:0	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			3, 265, 246	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			22, 940	2.00
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost r			0 103. 27	2. 01 3. 00
3. 00 4. 00	Number of interns & residents (see instructions)	eporting period (see ins	tructions)	103. 27	4.00
5. 00	Indirect medical education percentage (see instructions)			4. 38	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the	ne sum of lines 1 and 1.0	1. columns 1 and	143, 018	6.00
	1.01) (see instructions)		.,	1	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8.00
9. 00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instruction	ıs)		0. 00	
11.00	Disproportionate share adjustment (see instructions)			0	11.00
12. 00	Total prospective capital payments (see instructions)			3, 431, 204	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		Ö	2.00
3. 00	Net program inpatient capital costs (line 1 minus line 2)	,		0	3.00
4.00	Applicable exception percentage (see instructions)			0. 00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00

1 00			
	CAPITAL FEDERAL AMOUNT	2.275.247	1 00
1.00	Capital DRG other than outlier	3, 265, 246	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier	0	1. 01
2. 00	Capital DRG outlier payments	22, 940	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	103. 27	3.00
4. 00	Number of interns & residents (see instructions)	15. 71	4. 00
5.00	Indirect medical education percentage (see instructions)	4. 38	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)	143, 018	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7. 00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00		3, 431, 204	12.00
		1. 00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	l ol	2.00
3. 00	Total inpatient program capital cost (line 1 plus line 2)	l ol	3. 00
4. 00	Capital cost payment factor (see instructions)	0	4. 00
5. 00	Total inpatient program capital cost (line 3 x line 4)	0	5. 00
0.00	Trotal Theatrant program out tar cost (The C x The Ty		
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS	1.00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)		
1.00	Program inpatient capital costs (see instructions)	0	1. 00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions)	0	1. 00 2. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2)	0 0	1. 00 2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	0 0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions)	0 0 0 0.00 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7)	0 0 0 0.00 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14)	0 0 0 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0 0 0 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14) 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)	0 0 0 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14) 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) Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0 0 0 0.00 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14) 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) Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0 0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions) Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable) 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 (from prior year Worksheet L, Part III, line 14) 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) Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see instructions)	0 0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00